

**Submission to the Joint Committee of Public Accounts and Audit
resolved to review the *Auditor-General's Report No. 25 (2014-15)*
*Administration of the Fifth Community Pharmacy Agreement.***

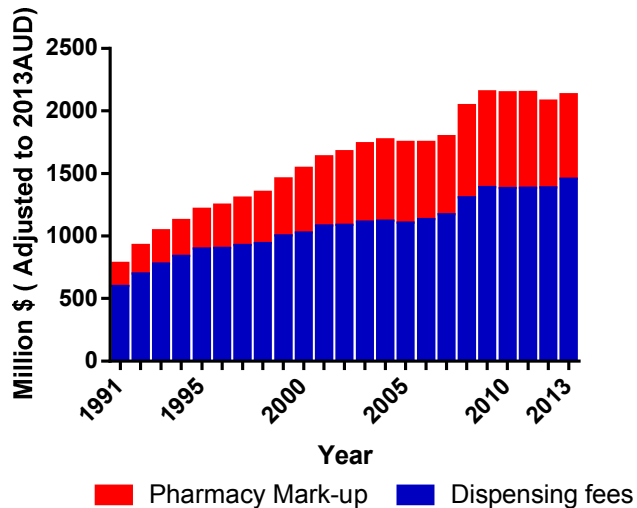
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My submission will pertain only to the reporting of statistics relating to pharmacy remuneration as contained in Report No. 25 (2014-15) Administration of the Fifth Community Pharmacy Agreement (hereafter ANAO Report), This information which is contained in Appendices 5 and 10 of the ANAO Report provides very valuable information both on the distribution and on the level of total PBS related remuneration over time.

Appendix 10 quantifies the remuneration pharmacies have received from government since the early 1990s, when the first Community Pharmacy Agreement was put in place. The figure below shows payments pharmacies receive for dispensing and mark-ups have tripled in real terms from around \$750 million in 1991 to over \$2 billion by 2013, while the numbers of pharmacies has remained virtually the same.

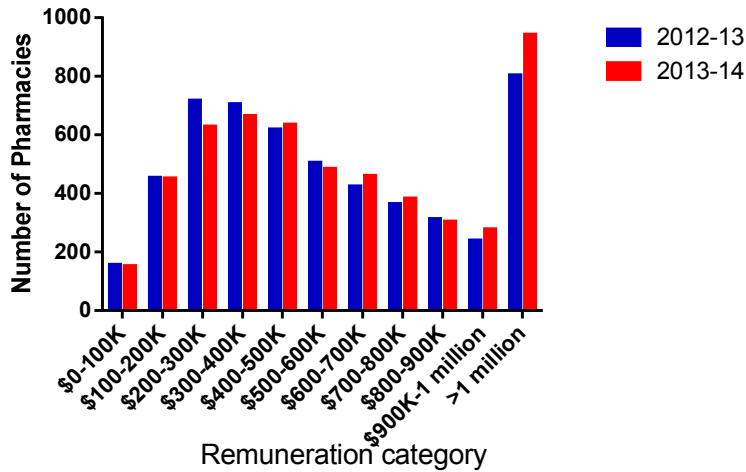
Figure 1: Total remuneration to pharmacies from markup and dispensing fees over time



Note: Based on information provided in Appendix 10 of Australian National Audit Office, *Administration of the Fifth Community Pharmacy Agreement*, ANAO Report No.25 2014–15.

The ANAO Report also provides a breakdown of this remuneration across pharmacies with different levels of remuneration (Appendix 5). As the graph below shows, around 18% of pharmacies receive more than \$1 million in remuneration from dispensing drugs listed on the Pharmaceutical Benefits Scheme. A comparison of the 2012 and 2013 financial years indicates a further 140 pharmacies moved into this top-earning bracket.

Figure 2: Distribution of under and over copayment remuneration



Note: Based on Figure 3.6 from from Australian National Audit Office, *Administration of the Fifth Community Pharmacy Agreement*, ANAO Report No.25 2014–15

For there to be ongoing public accountability, comparable statistics should continue to be reported routinely by the Department of Health (DOH) to determine the impact of future Community Pharmacy Agreements on this industry.

Not only is this important for accountability, it also allows independent assessment of claims by stakeholders regarding the likely impact of government policies on profitability. For example, the Pharmacy Guild of Australia ran a campaign in 2013, after changes to the rules regarding price disclosure of generic medications in which it argued:

“These changes, done without consultation, will save the Federal Government \$835 million over four years starting in 2014-2015. But they will also have the unintended consequence of reducing the bottom line of the average pharmacy by about \$30,000 a year, in addition to a \$60,000 impact from the existing arrangements.... The pre-election surprise announcement pushes many pharmacies over the tipping point.” (Quilty 2013)

It is hard to assess the veracity of such a claim unless reliable statistics are routinely published, by the DOH, or the underlying data is made available that would allow external parties to undertake impartial analysis.

Furthermore, a full analysis of trends would require remuneration data to be reported in such a way that can allow adjustment for inflation. Currently the ANAO Report produces statistics in nominal terms, so while the overall level of remuneration can be easily adjusted for inflation using a price deflator, the reporting of distributional statistics is more problematic as categories, such as remuneration \$900k-\$1m, represent different amounts in real terms over time.

Inconsistent reporting standards by the Department of Health

It is important to note that the DOH provides a much greater transparency when reporting statistics for other industries in receipt of public funds from the Pharmaceutical Benefits Scheme. The annual *PBS Expenditure Reports* provide firm level data on total PBS revenue for the top 20 companies on annual basis (i.e. see Top 20 Responsible Persons by Total Cost, year ending: Jun 2014 - Section 85 only in its annual Expenditure and prescriptions reports). Figure 3 as a recent example of the level of financial detail routinely reported.

Figure 3: Pharmaceutical industry revenue statistics routinely reported by the DOH.

Table14(a): Top 20 Responsible Persons by Total Cost, year ending: Jun 2014 - Section 85 only

Rank	Manufacturer	Script Volume	Govt Cost (\$)	Total Cost (\$)	Derived Ex-Manufacturer Sales (\$)
1	Pfizer	16,434,424	738,679,704	917,738,471	689,846,760
2	AstraZeneca	17,618,547	679,523,749	864,486,573	626,953,460
3	Apotex	25,164,655	453,398,182	611,226,583	356,765,178
4	Novartis Pharmaceuticals	3,134,106	551,132,269	579,272,411	507,289,972
5	Alphapharm	28,231,376	390,098,815	546,457,280	293,783,190
6	sanofi-aventis	12,654,740	438,104,638	518,669,175	371,033,510
7	Merck Sharp & Dohme	8,599,944	400,170,812	482,920,213	358,741,648
8	AbbVie *	3,646,092	391,900,934	422,127,696	359,098,444
9	GlaxoSmithKline	9,879,505	308,593,442	389,101,412	274,664,424
10	Aspen Pharmacare	19,296,122	278,760,582	385,790,646	210,146,905
11	Janssen-Cilag	2,940,663	323,189,951	346,932,846	289,967,243
12	Boehringer Ingelheim	7,177,678	252,796,974	298,045,574	209,308,705
13	Bayer	1,727,655	276,699,999	295,094,813	252,723,639
14	Sandoz	10,136,468	189,462,967	254,662,175	152,201,150
15	Mundipharma	3,830,531	176,212,937	201,674,320	137,073,711
16	Novo Nordisk Pharmaceuticals	1,044,665	153,486,149	164,127,527	135,741,345
17	Eli Lilly	1,769,755	134,630,306	158,786,627	124,317,158
18	Bristol-Myers Squibb	943,409	143,743,027	153,486,232	130,643,654
19	Ascent Pharma	4,677,692	93,717,545	124,324,189	76,539,666
20	Servier Laboratories	5,527,226	88,408,622	122,755,440	70,415,763
	Others	25,380,750	845,848,766	1,015,934,907	718,259,574
	Total	209,816,003	7,308,560,369	8,853,615,109	6,345,515,097

Note: Includes branded and unbranded scripts and Doctor's bag scripts. 'Others' contains scripts written for Extemporaneously-prepared items and where the manufacturer is unknown.

Total Cost Includes cost to the patient and cost to the government

* Includes Abbott Australasia.

Importantly, this information identifies individual companies, and therefore it is clear, that DOH has recognized that the need for public scrutiny has overridden any commercial concerns of individual firms for confidentiality.

There is currently no comparable firm level data provided regarding total pharmacy remuneration. Ideally, this should be made available on an identified basis, to keep level of transparency and accountability consistent with that of the pharmaceutical industry. If this is not deemed possible, then de-identified data should be routinely reported at a level of aggregation that would prevent spontaneous recognition, although it would need to be in sufficient detail to allow meaningful analysis at a regional level and across time.

Implementation issues

When developing a statistical reporting protocol, the DOH should consult with researchers to ensure that statistics and data are reported in a way that will make them meaningful and useful for analysis. Further the compilation of statistics is time consuming and costly and this should be reflected in adequate funding of the DOH to ensure this are produced at least annually and in a timely fashion. Given the very high level of public funds that are distributed annually through Community Pharmacy Agreements, spending funds to ensure a much greater level of accountability surrounding pharmacy remuneration is a small price to pay.

References

Quilty D. Your local pharmacy under threat, Pharmacy Guild of Australia, 2013.

Department of Health, Expenditure and Prescriptions twelve months to 30 June 201, 2015.