Chapter 3

Chemotherapy funding

Concerns raised by Private Providers

3.1 The committee heard concerns from various private providers of chemotherapy services about the sustainability of the current level of funding for the provision of chemotherapy drugs under the PBS. Some private hospitals and cancer clinics considered that increased costs, either as a result of fees imposed by community pharmacies to recoup costs or the reduction in cross-subsidy for in-house chemotherapy preparation, would have the potential to impact on services. UnitingCare Health noted in their submission that:

> The 'collateral damage' of increased costs associated with the supply of chemotherapy treatments will extend to the UCH's ability to invest into staff training, hospitals redevelopment and purchasing the latest technology required to maintain high standards of care delivered to the Australian community. Another indirect impact of a potentially reduced capacity of private hospitals in the provision of chemotherapy services to Australians will be a shift of chemotherapy treatments to the already overloaded public health system.[1]

3.2 During the hearing, Mr Noun, Executive Chairman Northern Cancer Institute, noted that:

> I am also very concerned that these further PBS price reductions will add to the Northern Cancer Institute's already high costs in treating patients with cancer. As I mentioned earlier, we have five pharmaceutical staff supporting our efforts. It is through these additional costs of chemotherapy medication supply that we become very concerned about our ability to continue to provide that service. We are concerned because we would not be able to recover these additional costs from the health funds. In our facility we do not charge the patient for anything. We are contracted straight-out with the health funds or, in the case of the Riverina Cancer Care Centre, we have a contract with New South Wales Health to provide all of those services. Consequently, there is no financial impact to the patient, but that financial impact will flow on to us. Equally, if we try to do that with the health funds, they would not permit these costs. We certainly have tried as things have been changing. We have already made a significant investment in all of our facilities, and I do not consider that it is reasonable for the additional drug funding shortfall to come from places like the Northern Cancer Institute.[2]

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1 UnitingCare Health, *Submission 26*, p 2.

2 Mr Tony Noun, Executive Chairman Northern Cancer Institute, *Committee Hansard*, 28 March 2013, pp. 8–9.

3.3 Dr Robinson, CEO of the Integrated Clinical Oncology Network (ICON) also referred to health fund contracts, noting that:

> ICON cannot find funding solutions from health funds. The department seems to think there are opportunities there. We have contracts that do not allow for that to happen. At this point we are not seeking to charge our patients, and ultimately it is the smaller regional providers that will shut down. Services will contract. Our doctors that are travelling to those regions will not be able to travel there. And those patients will be drawn into the public system or into major tertiary centres.[3]

3.4 The viability of regional and rural chemotherapy services was of particular concern in both the hearing and in submissions received. Submissions from the Clinical Oncological Society of Australia and ICON argued that private clinics established in rural and regional areas on the back of recent government initiatives may now encounter funding difficulties:

> Capital funding for the establishment of 20 regional cancer centres across the country under the Rural Cancer Centres Initiative has the potential to reduce geographic inequity in cancer care outcomes. However, the current federal investment is capital funding only; there is no coordinated intergovernmental plan to underpin the sustainability of these and other regional cancer centres.
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> A national analysis published by the Clinical Oncological Society of Australia in 2006 showed that the further an individual cancer patient is located from a metropolitan or larger regional hospital, the poorer their access to chemotherapy services. The availability and sustainability of cancer pharmacy services in small regional hospitals in particular is limited, by comparison with larger centres.
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> If centres in regional and rural locations were forced to close, patients would have to travel substantially further to access chemotherapy or have delayed access to treatment. Any threat to the viability of oncology pharmacy services in remote locations poses a significant threat to patient access to appropriately administered chemotherapy. Compromising access to chemotherapy would risk a further widening in the geographic gap in cancer treatment outcomes.[4]

3.5 During the hearing, Dr Robinson noted that regional providers often have to source doctors and pharmacy services from third parties:

> The challenge will be for us in regional centres where our doctors are travelling to providers where we are not the pharmacy provider, and there are examples in Mackay. We fly doctors into Mackay and they have a very small, five-chair service that is being supported by a local community

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3 Dr Brett Robinson, Chief Executive Officer Integrated Clinical Oncology Network, *Committee Hansard*, 28 March 2013, p. 44.

4 Clinical Oncological Society of Australia and Cancer Pharmacists Group, *Submission 16*, p. 5, and Integrated Clinical Oncology Network, *Submission 19*, p. 9.

> pharmacy. …The regional centres have not got the infrastructure or the capital to build compounding centres. They fly it all in from the third-party providers… They would be the sorts of centres that would go first.[5]

3.6 The committee also received submissions from regional community pharmacies detailing the higher costs of preparing and supplying chemotherapy drugs away from metropolitan centres. Augusta Road Capital Chemist noted that:

> The provision of an adequate service to the population of southern Tasmania comes at a cost. Due to Tasmania's smaller population our facility is relatively small and has high overheads despite careful cost management. Specialist technicians are required to travel from Melbourne to service and validate the facility to National Association of Testing Authorities (NATA) specification. Interstate travel is required for staff training. Relatively small numbers of infusions mean that the average cost per unit is high.[6]

3.7 The Pharmacy Guild also highlighted that:

> in non-metropolitan areas it is more common for the dose (and any associated devices) provided by the third party reconstitution provider to not be used due to a last minute change in dosage or treatment. In this case no reimbursement is available from government and the pharmacy bears the cost. This is particularly common in non-metropolitan areas as the patient may travel 100km (or more) to see their oncologist so for logistical reasons the pre-treatment consultation with the oncologist does not occur until the morning of the scheduled chemotherapy treatment. The dose has been ordered by the community pharmacy from the third party compounder and made available to the hospital or clinic, all costs being borne by the pharmacy, only for the dose to be changed following the morning consultation. The community pharmacy must then re-order the dose (and the infusor if applicable) and has no way of recouping the cost of the dose and infusor that was originally ordered. One community pharmacist, servicing one private hospital and one public hospital in the Albury-Wodonga area, reports that losses as a result of these changes can run to well over $10,000 per year.
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> Other concerns in more remote areas include the inability to access prepared doses in a timeframe that allows them to be provided to the patient before expiry…
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> This has been a particular problem in Tasmania. As some drugs cannot be transported from the nearest third party compounder (Melbourne) within the required timeframes to allow patient treatment, community pharmacies in Tasmania have been compelled to invest capital in their own

5 Dr Brett Robinson, Chief Executive Officer Integrated Clinical Oncology Network, *Committee Hansard*, 28 March 2013, p. 45.

6 Augusta Road Capital Chemist, *Submission 29*, p. 1.

> reconstitution facilities to ensure patient access to chemotherapy in the state.[7]

3.8 The committee was made aware of one instance where a pharmacy provider has begun to offset costs in preparing chemotherapy medicines through charging fees to one private hospital to which it supplies chemotherapy drugs. The APHS Pharmacy Group submission notes that it commenced charging an $85 fee per infusion from 1 March, which increased to $100 from 1 April and that:

> Currently the hospital is absorbing this charge, which we understand remains a challenge to the financial metrics of their Cancer Centre. This is a difficult scenario for the hospital and APHS. The St Andrew's Hospital Pharmacy owned by APHS has been a provider of care in the community over many years, and has worked positively with the hospital to be a vital part of the healthcare landscape in the Darling Downs region.[8]

Negotiations concerning chemotherapy funding

3.9 All parties to the inquiry agreed that there is a need for specialised funding arrangements for the supply of chemotherapy drugs. The past existence of a long-running and previously hidden cross-subsidy within Commonwealth pharmaceutical payments was also acknowledged by all parties. In response to concerns about the impact of the price reduction of Docetaxel, the Department has been engaging in fact finding and stakeholder consultation to determine the effect of the reduction in cross-subsidy for cancer medicines on pharmacies, hospitals and consumers since late 2012. As part of this process the Department and the Guild have engaged in 'informal' negotiations 'to work in good faith towards agreeing a cost basis for … chemotherapy funding and a source of funding for any changes.'[9] These discussions have to date not resulted in a resolution of the issue.

3.10 The primary dispute in negotiations between the Department and the Guild appears to concern the potential source of any adjustments to pharmacy funding during the life of the 5CPA. The Guild and other pharmacy groups argued that the EFC was separate from the 5CPA, and that the shortfall in revenue arising as a result of the application of price disclosure to chemotherapy drugs should be made-up from savings achieved through price disclosure.[10]

3.11 The Department did not agree, but identified funds in the 5CPA as the appropriate source of funding:

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7 The Pharmacy Guild of Australia, *Submission 25*, p. 32.

8 APHS Pharmacy Group, *Submission 31*, p. 7.

9 Department of Health and Ageing, *Submission 35*, p. 13.

10 See Pharmacy Guild of Australia, *Submission* 25, pp. 4, 14; Community Pharmacy Chemotherapy Services Group, *Submission 20*, p. 2.

> There have been no suggestions from any stakeholders that the efficiencies generated for taxpayers by the EFC and EAPD measures are inappropriate. As the only other source of available funding, and the structural model for remuneration for pharmacy services, the Fifth Community Pharmacy Agreement has been identified by the Government as the appropriate source for funding chemotherapy fee changes.[11]

3.12 The committee explored the intention behind the 5CPA and contemporaneous agreements to determine whether the 5CPA was the appropriate source of funding for the supply of chemotherapy drugs.

The 5th Community Pharmacy Agreement Negotiations

3.13 The Department maintained that negotiations around the 5CPA, the Efficient Funding of Chemotherapy Arrangements (EFC), and the Memorandum of Understanding between the Commonwealth and Medicines Australia (MOU) were interlinked, that the agreements were contingent upon one another, and that remuneration to pharmacy related to the supply of chemotherapy drugs should sit within funding for the 5CPA.

3.14 The Department pointed out that the initial 2008 reform proposal, the Intravenous Chemotherapy Supply Program (ICSP), was delayed to enable negotiations about remuneration to pharmacists supplying chemotherapy drugs to occur in the context of the 5CPA. In its submission the Department noted that:

> As part of the Fifth Agreement negotiations, the Pharmacy Guild submitted an "Alternative Funding Model for Chemotherapy". During the agreement negotiations the Commonwealth and the Guild agreed on this alternative funding model, and it formed the basis for the new EFC funding model. Details of the new EFC funding were announced in the 2010–11 Federal Budget as part of the Fifth Community Pharmacy Agreement Budget announcement.[12]

3.15 During the hearing the Department drew attention to the Pharmacy Guild 2010 budget brief, which was sent to Guild members in 2010, shortly after negotiations on the agreements had concluded:[13]

> On the front page, the then president, Mr Sclavos, refers to the memorandum of understanding with Medicines Australia and notes that the guild was privy to the details but was not able to give members a running commentary. In the second column, he goes on to talk about how the savings imposed—in other words, price disclosure and so on—would have an impact on community pharmacy but that that was taken into account. If

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11 Department of Health and Ageing, *Submission 35*, p. 14.

12 Department of Health and Ageing, *Submission 35*, p. 5.

13 The Pharmacy Guild of Australia, *Pharmacy Guild 2010 Budget Brief*, 11 May 2010, http://beta.guild.org.au/uploadedfiles/National/Public/Media_Centre/budget_11May2010.pdf (Accessed 17 April 2013).

> you look at paragraph 20 of the actual pharmacy agreement, 'Additional Programs to Support Patient Services', there is an amount of $277 million subsequently injected into a range of clinical services for patients as a consequence of the impact of price disclosure. Further on in the budget update from the guild, there is a reference to funding for chemotherapy medicines:
>
> > These revised arrangements, negotiated and agreed to by the Guild, will deliver a smaller level of savings than the original 2008 Budget measure, but will ensure continued access to these vital medicines.
> >
> > …
> >
> > It is important that Members know that any failure to reach agreement on the chemotherapy savings would have resulted in the general remuneration across community pharmacy being reduced to capture equivalent savings.
>
> That is giving force to the notion that there was a link. There is a single bucket out of which community pharmacy remuneration is paid and negotiated and agreed. Some of it is normal dispensing fees. Some of it is premium free dispensing. And the efficient funding of chemotherapy model was part and parcel of that. So it was all intimately tied up in these things.[14]

3.16 The Department's written submission noted that chemotherapy drugs were funded in the same way as other PBS drugs before the 5CPA:

> Prior to the Fifth Community Pharmacy Agreement, funding for chemotherapy services was provided through a per-script rate, with a dispensing fee ($6.52) paid per script, no different to any other medicine, along with any mark-up on top of the cost of the drug…
>
> The current funding model for chemotherapy drugs was put in place through the EFC measure. This measure was negotiated in the context of three interlinked measures – the Expanded and Accelerated Price Disclosure measure; EFC, and the Fifth Community Pharmacy Agreement (the Agreement).
>
> The current funding model for chemotherapy emerged from the PBS reforms that commenced in 2007 and negotiations between 2009 and 2010 on the measures above.[15]

Links between PBS Sustainability Measures

3.17 In asserting the separation between chemotherapy funding and the 5CPA the Pharmacy Guild claimed there were a number of areas where the EFC and 5CPA could have been linked together, but were not. These included the text of each of the measures themselves, budget announcements, communications and fact sheets around the initial proposal, information documents for each of the arrangements, and

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14 Mr David Learmonth, Deputy Secretary Department of Health and Ageing, *Committee Hansard*, 28 March 2013, p. 31.

15 Department of Health and Ageing, *Submission 35*, p. 5.

legislative instruments supporting the introduction of the EFC, including any Explanatory Memoranda.[16]

3.18 The committee looked to this range of documents for guidance as to the intentions of the parties during the negotiations for the 5CPA and the EFC. These documents showed that the three agreements were negotiated during the same period and were reached under the broad umbrella of ensuring the PBS remains sustainable. The committee also considered that these documents confirmed that there was always a link between the MOU putting in place EAPD and the 5CPA.

3.19 A Departmental fact sheet on the 5CPA noted that:

> The funding provided for Programs will be supplemented by $277 million in recognition of the income forgone by community pharmacies as a result of the *Further Reforms to PBS Pricing* Budget measure. These transitional funds will be used to enhance and support patient services. [17]

3.20 Income forgone by community pharmacies as a result of this budget measure included reductions in price for PBS drugs as a result of Expanded and Accelerated Price Disclosure (EAPD). The *Further Reforms to PBS Pricing* Budget measure consisted of the package implemented under the Memorandum of Understanding with Medicines Australia that introduced EAPD.[18] During a 2010 hearing about the National Health Act (PBS Reform Bills), the Guild recognised that the 5CPA accommodated measures contained in the MOU:

> Mr Armstrong—… The arrangements for the fifth guild-government agreement, or the Fifth Community Pharmacy Agreement, were negotiated in parallel with the arrangements that were negotiated with Medicines Australia. So to some extent the effect (of EAPD) has been able to be taken into account, but of course those agreement negotiations resulted in a billion dollars worth of savings that are in addition to the savings from these reforms.[19]
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> …The arrangements were negotiated and able to be taken into account in our agreement negotiations. If that were not the case, I do not think we would be supporting the arrangements the way we are. But they were able to be taken into account, so there was a redirection of some funds back into that agreement in recognition of the direct flow-on effect of these changes

16 The Pharmacy Guild of Australia, *Submission 25*, pp. 16–17.

17 Department of Health and Ageing, *Overview of the Fifth Community Pharmacy Agreement*, p. 4 of 7, http://www.health.gov.au/internet/main/publishing.nsf/Content/C3DB799DB360AF0CCA25772000249FA8/$File/5CPA fact sheet.pdf (Accessed 17 April 2013).

18 Department of Health and Ageing, *Portfolio Budget Statements 2010-11*, p. 111.

19 Mr Armstrong, The Pharmacy Guild of Australia, evidence to Senate Community Affairs Legislation Committee, *Inquiry into the National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010: Official Committee Hansard*, 9 November 2010, p. 13.

> on pharmacy mark-ups, which are directly affected by the formula that makes up the reimbursed price.[20]

3.21 These statements are significant because they showed that the Guild was explicitly stating in 2010 that the effects of Expanded and Accelerated Price Disclosure were taken into account in the 5CPA. These effects include the future price reductions in chemotherapy drugs such as Docetaxel. The budget brief released by the Guild, their statements to the committee during 2010, the text of the 5CPA and the Department's statements pointed to a clear connection between EAPD and the 5CPA.

3.22 The Department maintained that all three measures were interlinked. However, as discussed above, the Guild argued that the absence of any reference to the 5CPA in the announcements for the EFC as evidence that at least these two measures were intended to be separate.[21]

3.23 The media announcement contained on the Department's website for the 5CPA announced the 5CPA and MOU together, but does not refer to the EFC.[22] The Department's Portfolio Budget Statements released in May 2010, however, note that the EFC was negotiated in parallel with these agreements:

> The Australian Government's funding arrangements for the provision of chemotherapy medicines announced in the 2008-09 Budget was deferred from 1 September 2009, to allow consideration of the measure in the context of the negotiations with the Pharmacy Guild of Australia for the Fifth Community Pharmacy Agreement. The measure has been revised in line with a proposal received from community pharmacy and other stakeholders.[23]

3.24 In seeking to demonstrate the absence of concrete links between the 5CPA and the EFC, the Guild argued that:

> The Explanatory Memorandum to the National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010, which supported the introduction of the new chemotherapy arrangements contained no reference to the 5th Agreement and referred to the arrangements as a budget initiative.[24]

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20 Mr Armstrong, The Pharmacy Guild of Australia, evidence to Senate Community Affairs Legislation Committee, *Inquiry into the National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010: Official Committee Hansard*, 9 November 2010, p. 16.

21 Pharmacy Guild of Australia, *Submission 25*, pp. 16–17; *Submission 25ss*, 2–6.

22 The Hon Nicola Roxon MP, Minister for Health and Ageing, 'Agreements Ensure Sustainable Access to Medicines', Media Release, 11 May 2010, http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-nr-nr094.htm?OpenDocument&yr=2010&mth=05 (Accessed 15 April 2013).

23 Department of Health and Ageing, *Portfolio Budget Statements 2010–11*, p. 111.

24 Pharmacy Guild of Australia, *Submission 25*, pp. 17.

3.25 However, the committee notes that this in incorrect. The Explanatory Memorandum to the National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010 does refer to the 5CPA and explicitly links the two measures:

> The Bill:
>
> provides a clearer method for listing drugs for supply under section 100 of the Act. This will make clear the application of general PBS provisions such as price disclosure to medicines supplied under those section 100 arrangements;
>
> clarifies and widens the power to make section 100 special arrangements, which will support the introduction of arrangements for the Revised Arrangements for Efficient Funding of Chemotherapy Drugs Budget initiative, and other section 100 programs.[25]
>
> …
>
> The measures set out above are key components of the packages negotiated for Further PBS Pricing Reform, and the Fifth Community Pharmacy Agreement, and miscellaneous amendments related to 2007 PBS Reform.[26]
>
> …
>
> *Revised Arrangements for Efficient Funding of Chemotherapy Drugs*
>
> This measure was announced in the 2008-2009 Budget. Commencement was deferred from 1 September 2009 to allow consideration in the context of negotiations for the Fifth Community Pharmacy Agreement. This Bill does not implement the measure, but makes amendments to section 100 of the Act, and listing arrangements for section 100 medicines, that will support the making of the arrangements for this Program. The measure will now save $75.4 million over the forward estimates period.[27]

3.26 The measures were thus clearly linked in documentation of the time.

Correspondence between the Department and the Pharmacy Guild

3.27 When correspondence between the Guild and the Department recommenced in 2012, the Department's position was consistent with statements made in 2010 around the announcement of the 5CPA, the MOU and the EFC, as well as with its evidence to the current committee inquiry. This is evident in correspondence to the Guild from Mr Learmonth, Deputy Secretary of the Department, on 28 August 2012:

> We appreciate the collaborative and collegiate approach the Guild has taken in working with the Department and with the broader sector to ensure the

25 National Health Act (Pharmaceutical Benefits Scheme) Amendment Bill 2010, *Explanatory Memorandum*, p. 2.

26 National Health Act (Pharmaceutical Benefits Scheme) Amendment Bill 2010, *Explanatory Memorandum* p. 3.

27 National Health Act (Pharmaceutical Benefits Scheme) Amendment Bill 2010, *Explanatory Memorandum*, p. 3.

> successful implementation of the EFC, which commenced on 1 December 2011. As you are aware, the EFC was based largely on the proposal received from the Guild as part of the Fifth Community Pharmacy Agreement negotiations (Fifth Agreement) between the Guild and the Australian Government, signed in May 2010.

3.28 The same policy position is demonstrated in correspondence from Hon Tanya Plibersek MP, Minister for Health, on 22 October 2012:

> Whilst I note your concerns, I also note that Pharmaceutical Benefits Scheme Pricing Reforms, including Expanded and Accelerated Price Disclosure, the Efficient Funding of Chemotherapy (EFC) measure and the Fifth Community Pharmacy Agreement were negotiated concurrently, which allowed all parties to consider the overall impact of all these factors on pharmacy remuneration. I also note that the model for EFC adopted was based largely on your proposal.

3.29 In their supplementary submission, the Guild claimed that the Department had, in the days prior to the signing of the 5CPA, written to them, confirming that there was no connection between the EFC and the 5CPA:

> a matter of days prior the public announcement of the 5th Community Pharmacy Agreement, the Department confirmed in writing that the EFC model had been agreed and was separate from the Agreement.[28]

3.30 In response to a request from the committee, the Guild and the Department both supplied an email that was the basis for the point made by the Guild. Under the subject heading, 'Chemotherapy program in context of 5CPA', a Departmental officer had written:

> I can advise that the revisions to the Chemotherapy program including modifications to the forward estimates, as agreed between the Department and the Guild, has been accepted by Government.
>
> This is (sic) measure remains separate from the Fifth Agreement.[29]

3.31 In a letter to the committee accompanying the above correspondence, the Department provided the following context:

> the Guild had proposed a new mechanism to fund chemotherapy services. The agreement about 5CPA funding included a provision that the Guild's proposal for chemotherapy funding would be properly developed, and that if it turned out to save less than had been proposed, then the difference would be made up by further cuts to general pharmacy remuneration.
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> After this 2009 agreement, and before the 5CPA was finalised in May 2010, further work on the Guild's chemotherapy proposal showed that it would, in fact, save the amount of money that was claimed.

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28 The Pharmacy Guild of Australia, *Submission 25ss*, pp. 3 and 5.

29 The Department of Health and Ageing, Letter to Dr Ian Holland, Secretary Senate Community Affairs Committee, 29 April 2013.

> My email simply advised the Guild of this, and that the Government's budget forward estimates would be amended accordingly. As the claimed saving had been achieved, there was no need to make any further cut to pharmacy remuneration under the 5CPA, which could then be finalised.[30]

3.32 In this context, rather than suggesting that the matters were unrelated, the text indicates that the agreement on chemotherapy funding had been contingent on 5CPA remuneration being available to achieve the desired savings. The text suggests that the agreements are separate documents, not that the matters are unrelated. This is evident also from the email's subject line, and is underlined by the interchange, in the same email thread, between two Guild officials:

> have just received this email from [Departmental official] re Chemo. It is all accepted as the model we put to them in feb.

3.33 This interchange reinforces that the negotiations across the various aspects of pharmaceutical policy were interlinked, and that all the parties knew that the outcomes were conditional on all aspects being agreed.

3.34 The committee considers that the links established between the MOU and the 5CPA, and the references to the 5CPA in the May 2010 Portfolio Budget Statements and the explanatory memorandum for the legislation supporting the introduction of the EFC, corroborated the Department's position that the three measures were always understood to be interlinked.

Committee View

3.35 The committee recognises that the supply of chemotherapy drugs to cancer patients is a complex and intensive exercise, requiring specialised skill and effort on behalf of oncology pharmacists. The committee notes that stakeholders in this inquiry do not dispute the need for adequate funding of these services. That chemotherapy services have to date been funded through long-running, hidden cross-subsidies is similarly agreed to by all parties involved.

3.36 This is not a new issue. These concerns were identified several years ago, prior to the signing of the 5CPA, and it was the Guild that put forward a proposal to address this matter, including price modelling that was accepted by the government at the time. The crux of the current inquiry therefore lay in determining the appropriate source of remuneration to pharmacists to reflect the costs of preparing and supplying chemotherapy infusions.

3.37 It is clear from the committee's evidence that the negotiations and finalisation of the 5CPA took place in the context of PBS sustainability reforms, including the EFC and EAPD measures. The modelling used to determine the costs to pharmacists of preparing chemotherapy drugs was prepared by the Guild in the context of the

30 The Department of Health and Ageing, Letter to Dr Ian Holland, Secretary Senate Community Affairs Committee, 29 April 2013.

5CPA negotiations and EAPD. This modelling was provided to the Department by the Guild in the course of the 5CPA negotiations. The government accepted this modelling, and the costs of supplying chemotherapy drugs, as reflected in the fees contained in the EFC, were part of the known environment in which the 5CPA was agreed. That this was understood by both negotiating parties is made explicitly clear by the Guild's statement to its members at the time that:

> It is important that Members know that any failure to reach agreement on the chemotherapy savings would have resulted in the general remuneration across community pharmacy being reduced to capture equivalent savings.[31]

3.38 The committee considers that the Department's position that funding should occur within the envelope of the 5CPA is consistent with documents from the time, and continues a position that the government has maintained throughout the process. Having reviewed statements provided to the committee by the Guild and the Department, and the statements made by both parties in 2010, the committee accepts that the three measures implemented in 2010 were intended to be linked. The committee recommends the Department and the Guild continue in their negotiations to resolve the funding issue.

3.39 In this regard, the committee notes that, shortly before the committee was due to table this report, the Minister announced a review to determine the correct subsidy for chemotherapy infusions. The review will 'identify options for a long term and sustainable funding model that identifies and appropriately manages all components of chemotherapy dispensing and supply and is not dependent on the cross-subsidisation from the price of chemotherapy medicines for the viability of chemotherapy services', and will report to the Minister for Health by October 2013.[32]

3.40 In addition, the government announced that the May budget will include an additional $29.7 million 'to pay providers an additional $60 for each chemotherapy infusion on an interim basis for six months' between July and December 2013.[33]

Recommendation

3.41 The committee recommends that the government and industry parties, through the review, continue the examination of issues in chemotherapy drug pricing to ensure that existing funds under the Fifth Community Pharmacy Agreement as already agreed are appropriately directed to reflect the costs and

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31 The Pharmacy Guild of Australia, *Pharmacy Guild 2010 Budget Brief*, 11 May 2010, p. 4 of 7, http://beta.guild.org.au/uploadedfiles/National/Public/Media_Centre/budget_11May2010.pdf (Accessed 17 April 2013).

32 Department of Health and Ageing, *Pharmacy, PBS Chemotherapy Medicines Review*, http://www.health.gov.au/chemo-review (Accessed 7 May 2013).

33 The Hon Tanya Plibersek, 'Review to determine correct subsidy for chemotherapy infusions', *Media Release*, 5 May 2013.

benefits of the supply of chemotherapy drugs, and to ensure the ongoing supply of these drugs across all services, particularly in rural and regional areas.

Senator Rachel Siewert

Chair