PBS Reform – National Health Amendment (PBS) Bill 2010
Submission from DHL Supply Chain

Real opportunity to improve the effectiveness and efficiency of the

Pharmaceutical Benefits Scheme (PBS) Supply Chain

In response to the PBS Reform – National Health Amendment Bill 2010 we hereby respectfully submit our response to the submission made by the NPSA in relation to subsidies and cross-subsidies that exist in both the quantum and the method of applying the Community Service Obligation (**CSO**) Funding Pool under the auspices of the 5th Community Pharmacy Agreement (**5th CPA**)

The DHL Supply Chain (**DSC**) Healthcare business (previously known as Exel), was established in Australia in 1998. We are the market leader in the provision of a wide range of Supply Chain solutions for the Healthcare industry locally and abroad. We have a proven capability in warehousing, logistics and the distribution of pharmaceutical, medical and consumer healthcare products across Australia. Our customer base includes a broad cross section of pharmaceutical suppliers, industry leaders as well as new start up generic suppliers. **65%** of the prescription medicines consumed in Australia pass through our facilities as they move through to the consumer in most cases via the Pharmaceutical Wholesalers of which the NPSA represents. The services that DSC provides is a critical part of the Supply Chain, without our services the regular supply of medicines would not be possible; we provide these services without any Commonwealth subsidy.

The 5th CPA negotiated between the Commonwealth and the Pharmacy Guild of Australia has essentially perpetuated the excessive funding arrangements that were put in place in the 4th CPA, thereby missing a significant opportunity for the Commonwealth in the way the PBS distribution is funded. Now more recently the NPSA has suggested that the accelerated reforms that are the subject of the National Health Amendment Bill 2010 would require increased funding for the CSO Funding Pool to offset the decreasing value of PBS medicines as the reforms impact on the average price of PBS medicines over time. It would be a travesty to add further tax payers hard earned contributions to this already over subsidised component of PBS medicine distribution.

Background

There is more than 200 million PBS medicine units distributed throughout Australia every year and the Commonwealth funds the distribution of these medicines via:

- A wholesale margin of 7.0 %, which equates to a 7.52% mark up on the ex manufacturer price of PBS medicines; and
- A CSO Funding Pool established in the 4th CPA and which will grow to $219 million p.a. by July 2011.

The Wholesale margin (net of CSO) is ~ $550.0million p.a, the total Commonwealth distribution budget including the CSO is therefore ~ $750 million and we believe the true cost is closer to $150 to $200 million p.a raising the question on where the remainder of the Commonwealth funding, ~ $500 - $600 million p.a. is being directed. We have included as an attachment a presentation that provides further insight into the real cost of PBS medicine distribution in Australia. The estimates in this presentation fully and pragmatically take into account including importantly the onus of CSO distribution i.e. all of the compliance requirement of the 5th CPA to ensure every Australian has access to PBS medicines wherever they live, namely:

- Distribution to Rural and Remote Community Pharmacy
- Distribution of low volume medicines
- Delivery within 24 hours where required
- The Compliance with TGA / GMP standards within the storage and distribution
- Providing the Commonwealth with real time reporting of PBS medicine distribution as required

The reality is that the current regulated Wholesale Margin and CSO Funding Pool when combined is over 300% more than what is required to provide this service and those obtaining access to these funds should be required to explain how they are being used, it could be argued that this is a gross misuse of tax payer funds. The true cost for the distribution of PBS medicine unit is essentially ~ $0.70 per medicine unit and the current combined contribution by the Commonwealth is $3.00 per medicine unit.

Thursday, 19 August 2010

The $600 million dollar question, or $3 Billion over the life of the 5th CPA, is where does the remaining $2.30 per medicine unit of tax payer funds go?

Other Strategic Considerations

It is clear that the Commonwealth needs to drive strategies that focus on improved efficiency if the growing cost of Healthcare in an ageing population is to be sustainable. The recent changes to the National Health Reforms Bill is an example where making medicines more affordable will contribute toward this objective. A resultant benefit of more affordable medicines is a growth in volume at the expense of the average price of each medicine unit.

A change to the Wholesaler remuneration system (replacing the current 7% margin and CSO) to a system where the Commonwealth pays a unit rate, say $0.70 per medicine unit for the medicine units that the Wholesalers distribute with an added fee for each low volume medicine and a further added fee for medicines delivered to Rural and Remote community pharmacy. These additional fees should be commensurate with the cost of holding low volume medicines and the cost of distribution to Rural and Remote Community Pharmacies. As demonstrated in our attachment, the actual cost per medicine unit distributed on average is not much greater for rural distribution, than for metropolitan distribution, i.e. ~ 2 cents per unit. This could easily be modelled and is a sustainable system as it removes the impact of reducing medicines average unit prices, an objective all Australians would share.

A further objective of the Commonwealth must be to open up competition in the distribution of PBS medicines as competition will ultimately create efficiency. There will be a counter argument that competition will erode the services provided by those engaged in the distribution of PBS Medicines to Community Pharmacies, however this is inconsistent with any other industry where competition has been opened up in a regulated environment. The distribution of PBS medicines has become essentially a regulated environment since the introduction of the CSO. In any case in a more open competitive environment the Commonwealth has the ability to regulate the compliance with the key obligations including those set out in the 5th CPA. The objective must be to reduce the amount of wasted tax payers funds used for the distribution of PBS medicines whilst maintaining the high standards essential in this critical service.

The introduction of the CSO Funding Pool from July 2006 has had a detrimental impact on competition, previously flourishing direct distribution operations have ceased as these services are now unable to compete with the CSO subsidies paid to a select group of National CSO Distributors.

The National CSO Distributors use the combined benefit of the CSO and the wholesale margin to buy pharmacy loyalty through “discounts” underwritten by the Commonwealth’s funding. Much of these discounts are provided to the larger pharmacies and pharmacy groups rather than underwriting the cost of servicing the strategic small rural and remote pharmacies, or for the supposed cost of distribution of low volume medicines a key objective and intent of CSO. In addition the Commonwealth funding for PBS medicines is being used to cross subsidise the National CSO Distributors supply of more than 20,000 other product lines including many non medicine items sold in the front of Pharmacy retail operations. This is a misuse of, and not the intended purpose of the legislated Wholesale Margin and CSO pool.

As with all long term Agreements the negotiation of the 5th CPA was a time to review how these substantial funds can be better used, unfortunately there has been little change in the area of Wholesale distribution funding to either improve competition or claw back the significant misuse of tax payers funds in this area. There are many more effective uses of the CSO Funding Pool worthy of consideration examples include

- Instead of the CSO paid to the Wholesalers direct a pool of funds, in lieu of CSO paid directly to Rural and Remote (R & R) Pharmacy. This would then be paid by the Pharmacy to the Wholesalers, to recover the true costs of distribution to R & R pharmacies on a per delivery basis as a delivery fee. This would foster efficient Supply Chain activity by both the Wholesaler and the Community Pharmacy
- This would incentivise Community Pharmacy by creating more efficient ordering behaviour
- Wholesale tenders to occur for single State based suppliers, per State reducing current cross subsidies. There are many areas where duplication is unnecessary and a waste of Commonwealth funding. Ultimately the most cost efficient supply model, will aggregate volumes where possible. Doing this at a State level, still allows for competition amongst distributors across Australia.

The 5th CPA as with the 4th CPA provides for a fixed CSO allocation of the Funding Pool, this can mean that if 50% of PBS medicines were more effectively distributed by other means then the participating National CSO distributors would still receive the total CSO funding pool, for only 50% of the work involved. The CSO should be paid by medicine unit distributed (only) if the volume distributed by National CSO distributors fall then so should the subsidy.

There is no need to increase the CSO or any other Wholesale subsidisation at this stage as requested by the NPSA, clearly this is over subscribed now and the reality is that the Commonwealth should use the opportunity to claw back funding where it is not being directed to its intended use.

We recommend a unit rate for all PBS medicines units distributed with a further subsidy only for those medicines to R & R areas and low volumes medicines; we believe the fee should be $0.70 per medicine unit.

We would welcome the opportunity to present a Supply Chain perspective on how the Commonwealth's support for PBS medicine distribution could more fairly reflect the true cost to provide this service releasing close to $3 billion over the 5 years life of a CPA to other more deserving areas of the Health budget.

Yours sincerely

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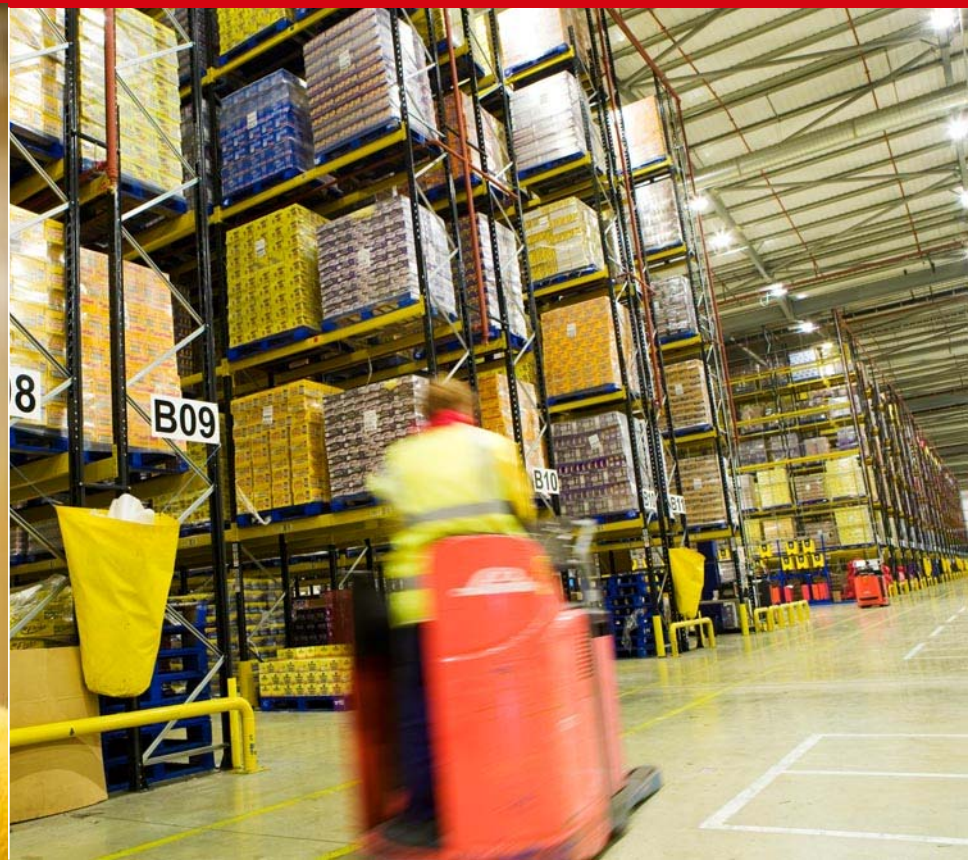
PBS Distribution & the CSO Funding Pool

Michael Ison, Saul Resnick
20 August 2010



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Established market share, credibility & reputation

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2003

Integrated Supply Chain Services

2006

2009+

- **70% of Pharmaceutical logistics market**
- **# 1 in Pharma, Consumer, Medical Devices and Animal Health**
- **Deliver over 30,000 cold chain units each day**

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Supply Chain Perspective - Cost to Serve model

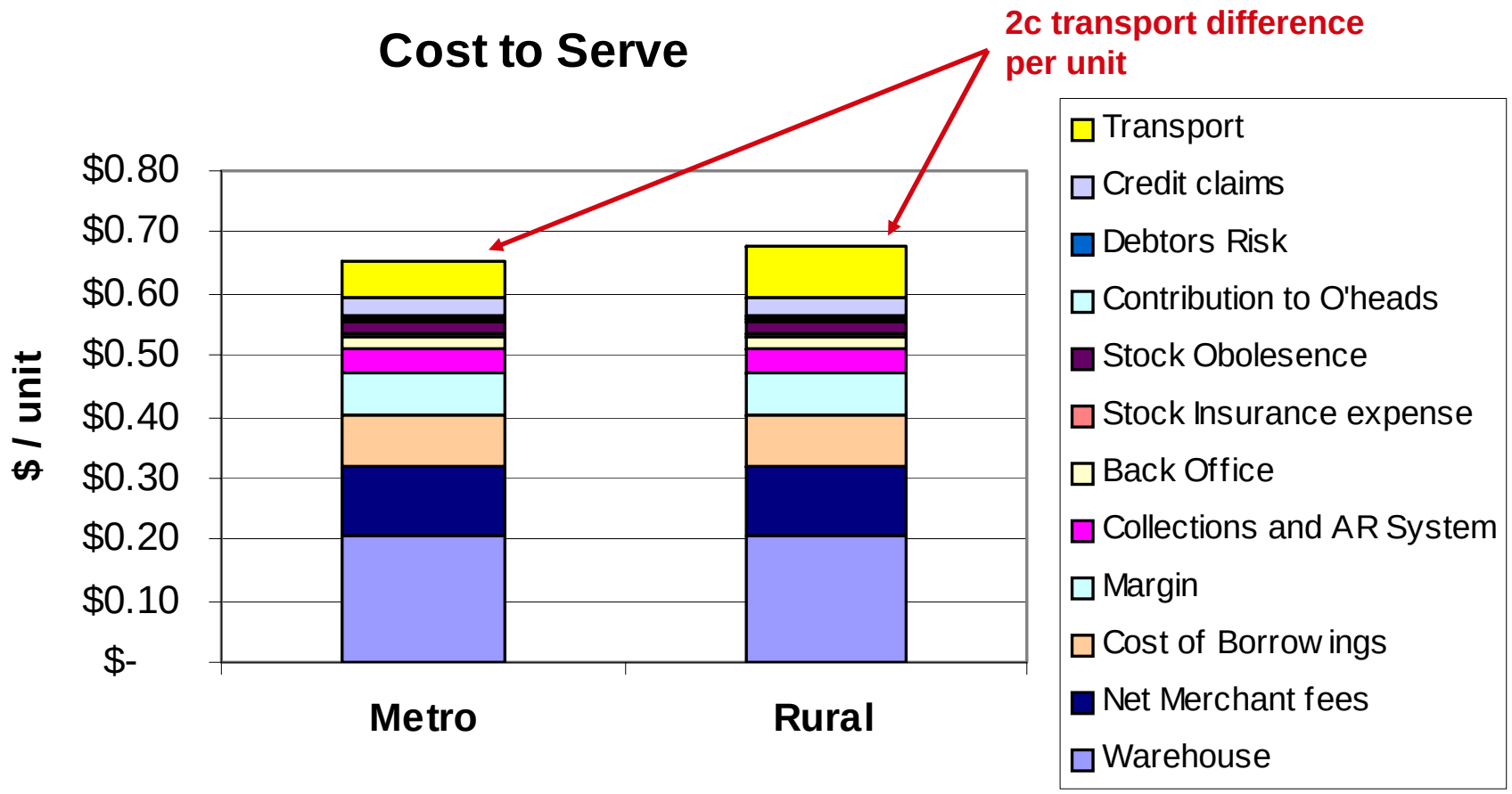
- A pure play cost to serve model is the most cost effective way to profile true cost of distribution vs a % of sales methodology.

Sydney to Dubbo transport rate ~$10

- PANAMAX $ 3.50
- PROGRAF $ 950.00
- VFEND $ 2,500.00

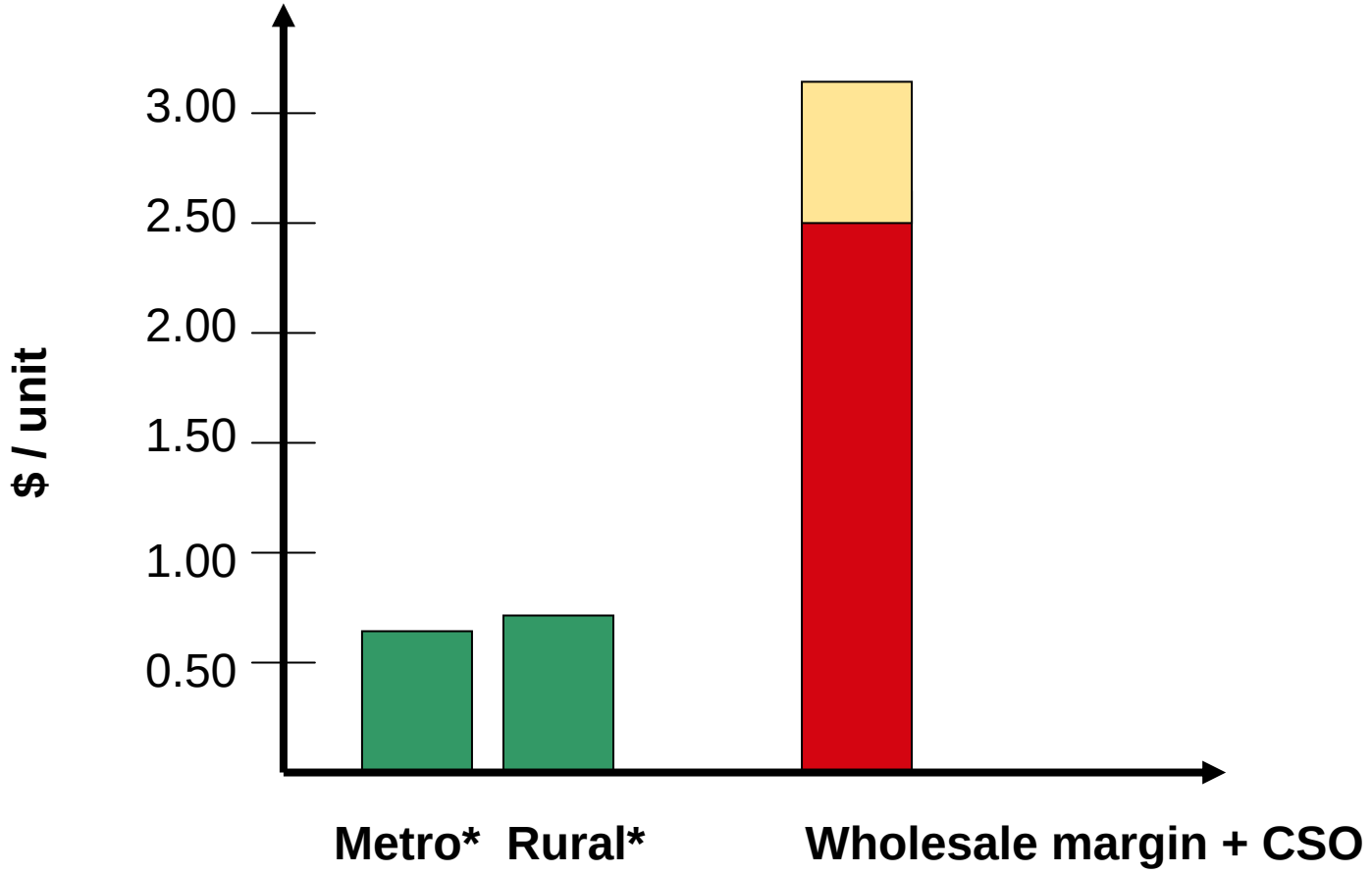
Transport cost is the same

True Cost to Serve



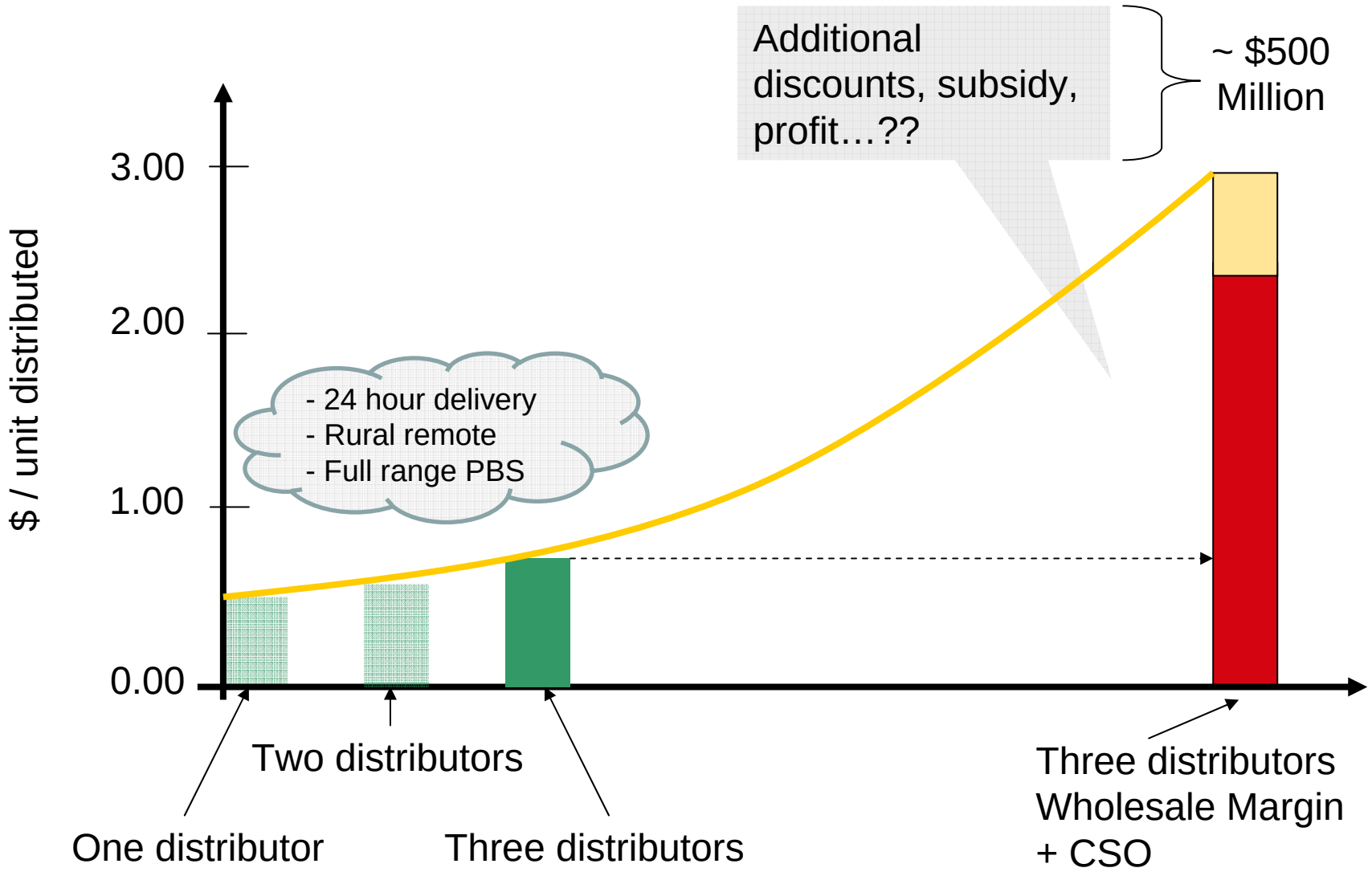
True Cost to Serve

True cost to serve versus existing government allocated cost

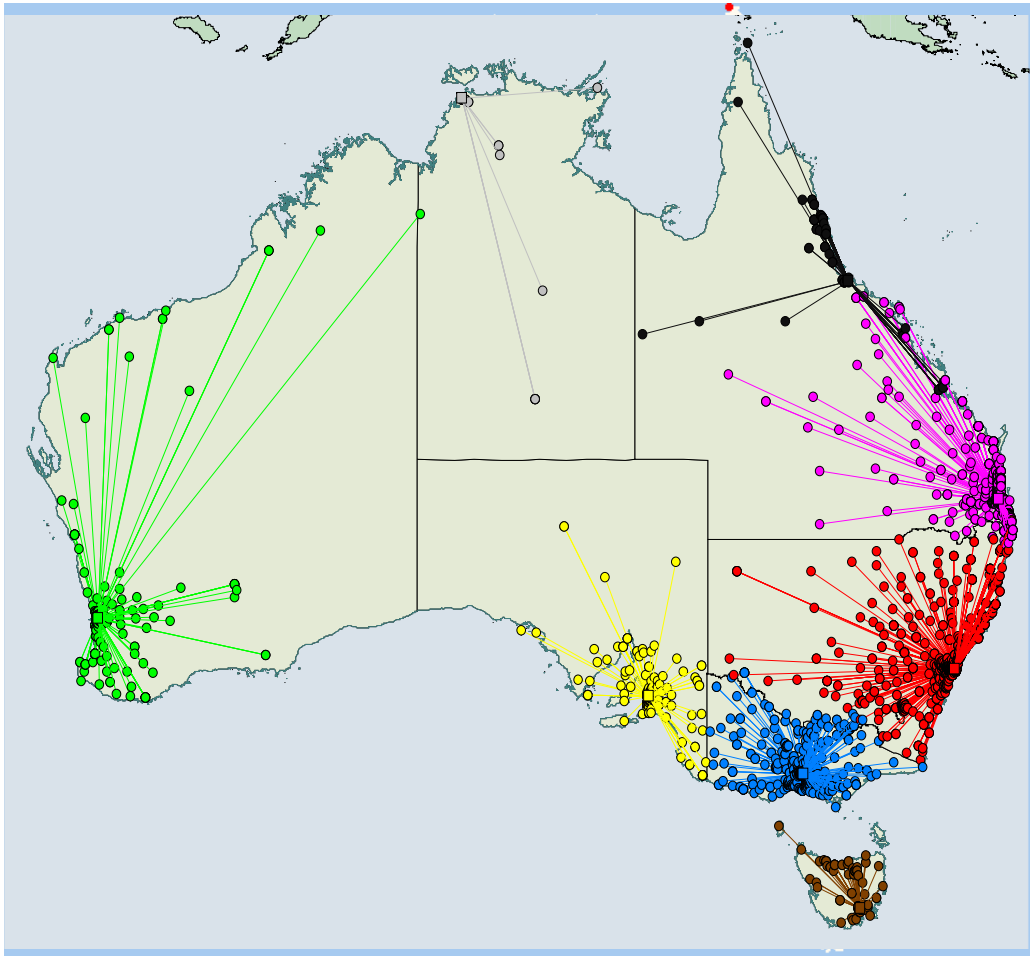


** Based on 3 distributors*

Cost to Serve Continuum



Rural and Remote Australia

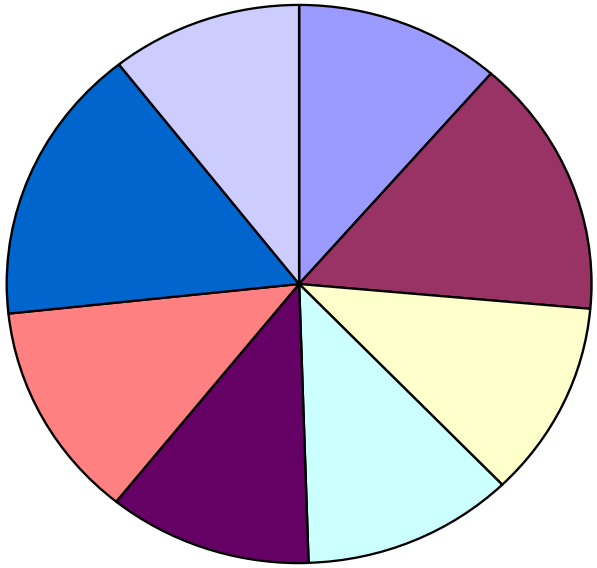


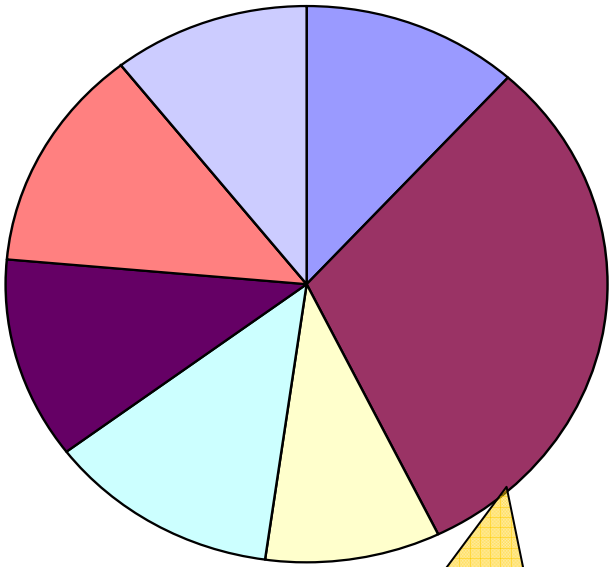
- Manufacturers place stock into wholesaler warehouses (free into store)

People to Pharmacy Ratios

- People served per metro pharmacy is very similar across the country

Metro
People / Pharmacy





- Western Australia
- Northern Territory
- South Australia
- Queensland
- New South Wales
- Victoria
- Australian Capital Territories
- Tasmania

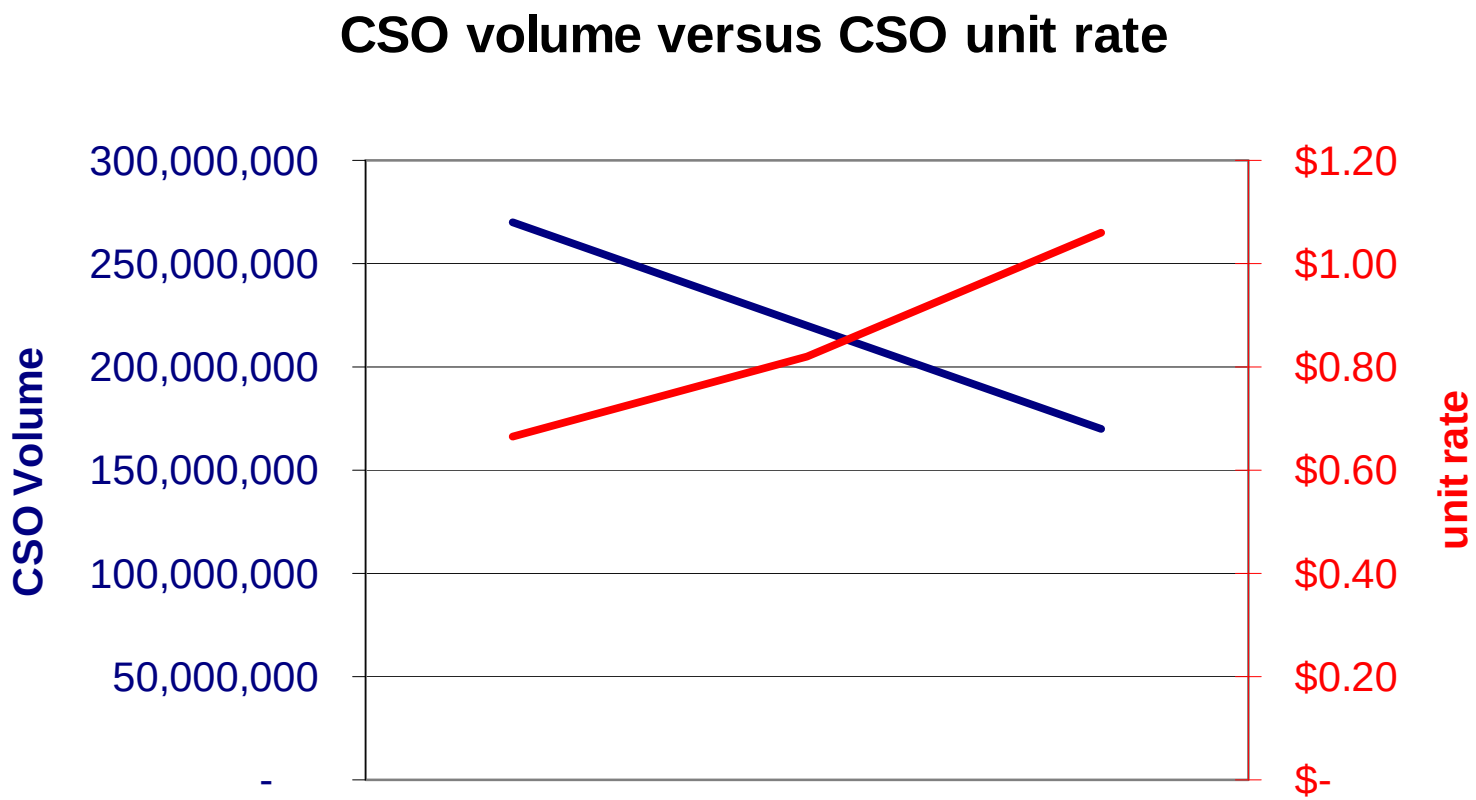
Rural
People / Pharmacy

NT Pharmacies serve almost 3 times more people than pharmacies in NSW

Observations on the CSO

- CSO is being used to cross subsidise at two levels
  - Less expensive PBS medicines
  - Non PBS products sold at pharmacy eg OTC
- Evidence that CSO is being used to offer bigger discounts to higher volume purchasers and buying groups
- Discounts do not accurately provide relevance to lower volume medicines
- Wholesalers incentivised to provide discounts in nearby R&R areas, to achieve hurdles (e.g. Galston NSW 2159, transport is $0.02 per unit)
- 39% of pharmacies surveyed (total 1,223), feel prices have gone up since 3 major manufacturers stopped going direct
- 56% of Pharmacies surveyed did not know about CSO
- Volume taken from the overall scripts delivered for direct or exclusive distribution, do not reduce the overall CSO pool...

Volume to units distributed



CSO distribution via wholesaler	non-CSO distribution (Exclusive & Direct)	CSO fund	Rate per unit
270,000,000	-	$ 180,000,000	$ 0.67
220,000,000	50,000,000	$ 180,000,000	$ 0.82
170,000,000	100,000,000	$ 180,000,000	$ 1.06

5th Community Pharmacy Agreement

Down stream efficiency unlikely if CSO remains unchanged

Arrangements to balance the impact need review

- The Wholesale margin and CSO is largely given to pharmacy
- The CSO restricts new entrants and alternate models (and it is growing)
- Realign subsidy for Rural and Remote & Low volume distribution only

Consider strategies to drive efficiency in the down stream supply chain:

- Pay CSO to the appropriate community pharmacy (not the Wholesaler)
- Allow Wholesalers to charge a fee for each delivery service provided
- Do not reward community pharmacy for poor stocking behaviour

"Commonwealth has a choice to address inequalities in the 5th CPA or adopt the status quo

THANK YOU FOR YOUR ATTENTION