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Your Pharmacy Partner

9 April 2013

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Committee Members

Re: Supply of chemotherapy drugs such as Docetaxel

Thank you for the opportunity to present to the Committee on 28 March 2013. Achieving a sustainable chemotherapy system is an issue of great importance to the healthcare industry, as is ensuring continued access to world class cancer care for all Australians in a timely, safe and cost effective manner.

As per my commitment at the hearing, I'd like to present additional information for the Committee's consideration and to address certain details of other submissions and hearing evidence.

1. Timetable of activity

Provided with this letter is a supplementary document detailing interactions with the Department of Health & Ageing, which are limited to those that APHS has either been directly involved in or are sufficiently aware of. These interactions relate to the financial impact pharmacies and hospitals faced as a result of Docetaxel's price reduction on 1 December 2012, this being the price reduction of greatest significance and magnitude and the tipping point for sustainability of funding in the sector.

This timetable excludes 2009 dialogue regarding ICSP and presentation of the 'Alternate Model', which other submissions and attendees recognised as incorporating clear data regarding the sector's reliance on 'discounts' available on a small number of molecules to maintain overall viability. They also noted that the 'Alternate Model' confirmed price disclosure would deliver savings that actually created an unsustainable model at some point in the future and a requirement for partial reinvestment of the savings was needed in response to this.

As some providers have stated in their submissions, there was a very clear understanding that DoHA were in agreement with this position at the time, but quite correctly could not create a reinvestment model until it was clear what the level of saving and required reinvestment was. It would have been inappropriate to implement a reinvestment model when pharmacies and hospitals were continuing to receive the benefit of the existing discounts.

2. Additional information relating to the independent report prepared for CPCSG

The CPCSG engaged Pitcher Partners to independently review price disclosure impacts on the funding of chemotherapy items under EFC, and the cost of supply associated with these items. The cost information previously provided by members of the CPCSG to DoHA on DoHA's templates in November and December 2012 was the starting point for this review, which produced a final report prepared specifically for inclusion in the CPCSG submission to the inquiry.

A high level overview of the report was presented at the forum convened by Professionals for Safe Cancer Treatment in Canberra on 20 March 2013, which was attended by representatives of DoHA.

Following this forum, DoHA representatives raised some queries with Pitcher Partners. I attach as Appendix 1 the additional information provided by Pitcher Partners in response to DoHA's queries, which I request is treated as commercial in confidence. As members of the CPCSG are either competitors or potential competitors, all information provided is confidential and only presented back to members, or a wider audience, in a de-identified format to avoid disadvantaging any member. The document attached reduces de-identification of pharmacy operators to a degree, therefore we respectfully request that it remains confidential. Its circulation within the CPCSG has been limited to those members affected, unlike the initial report contained in the CPCSG submission that all members have seen and is now in the public domain via this inquiry.

This additional report confirmed that the weighted average cost for preparation of an infusion exceeded $180, and that across the 12 sites examined in detail, with different supply models, client bases, and clinical involvement, only 2 locations presented a materially lower supply cost of approximately $150 per infusion while others were closer to $200.

We consider this adds validity to our view that a funding model providing an appropriate level of compounding funding, dispensing funding, and "final mile" clinical service funding, will deliver an equitable outcome for government and the sector. As DoHA presented in their submission, current funding (including all remuneration aspects) is approximately $91 per infusion. This creates a material deficiency in revenue compared to supply costs across all sites reported in the Pitcher Partners report.

3. Continuation of service provision

It has been disappointing, both professionally and personally, to see criticism of pharmacy and hospital operators in both media and submissions to this inquiry. This includes accusations that patients are being used as a negotiating tool and operators have made threats to withdraw services.

The DoHA Inquiry submission confirms there was no noticeable change in the volume of chemotherapy scripts processed after December, and they are not aware of any reduction in services to date.

I would not expect there would be any material change to the number of scripts processed, or treatments provided, since December. As health professionals, we have sought to draw attention to this funding issue over an extended period of time. We have done all within our power to avoid creating alarm for patients or creating disadvantage to a patient's care.

On 30 November 2012, we were reassured by the Pharmacy Guild that productive discussions were underway with the Government. They also requested we maintain all current services, with an expectation of a solution being delivered and backdated to 1 December 2012.

As far as we are aware, all pharmacy and hospital operators have continued service. However, as the months continue the losses grow and it is an inevitable commercial reality that individual pharmacy operators will have to make that extremely difficult decision at some point; do I introduce my own fees to survive (in most cases breaching contracts and therefore threatening their business), do I walk away from chemotherapy to try to maintain viability of the rest of my business (which in some cases will also breach contracts and threaten their business regardless), or do I continue indefinitely in the hope that a solution will be implemented before bankruptcy occurs and a is backdated to allow me to climb back out of the growing hole. For hospital operators, similar questions arise as to whether to absorb costs against other profitable areas of the hospital where able to, to cap patient treatments or restrict treatment of certain cancers, or to reduce the number of patients currently treated.

I've been extremely proud of the level of commitment to patient care across the sector, and that continued care has been prioritised above the financial challenges all operators hoped would remain short term. As others have stated, the collective losses absorbed in the sector exceed $1 million per week. It would be a serious misgiving for anyone to assume the 'holding on' that is currently occurring is an empty threat or a way of abusing patients' concerns to engender a positive financial outcome.

4. Quality of service

APHS have experience in provision of chemotherapy services in both private and public settings, and find the comments made at the hearing by Ms Sally Crossing (Cancer Voices) to be entirely inconsistent with our experiences.

The attached presentation on the TRACC study included a review of public versus private care, from page 58 onwards, which does not reflect a lesser outcome for patient survivorship when receiving treatment in the private setting.

As an experienced private oncology provider, we haven't witnessed patients who have found themselves unaware of a high personal cost as part of their treatment. Our experience is that private hospitals diligently follow processes regarding informing patients and obtaining what is known as "informed financial consent" prior to treatment commencing, and in circumstances where patients are unable to have their medications funded via the PBS they are aware of this before commencing treatment.

I certainly wouldn't dispute that individual patients may have had a negative experience in their cancer treatment, which can occur irrespective of whether the setting is in a public or private hospital. However, to suggest that patients would be better off in public care, and to assume that the public system has the capacity to treat the 60% of patients currently treated privately (and that the total cost to the government to provide these treatments would not exceed the cost of funding chemotherapy items on the PBS in a sustainable manner) is of grave concern.

5. Delivering a solution

We hold significant concern regarding the closing statement in the DoHA submission, which says they continue to work in good faith with the Pharmacy Guild to reach a speedy resolution. For everyone outside of DoHA and the Pharmacy Guild, there appears to be a stand-off and a stand-still for at least the last two months, centred on how a resolution would be funded.

The Pharmacy Guild has publicly stated that funding will not come from 5CPA funding, and should be a reinvestment of savings delivered by price disclosure on these items, while stating that the Government intend to use 5CPA funding to pay for the resolution. This, combined with DoHA representatives being unable to suggest any timetable for a resolution during questioning at the hearing, leaves the sector wondering whether they can hold on long enough for a solution, or whether, as some have privately questioned, operators must cease or cap services, or a pharmacy provider go broke, before a solution will be delivered.

If it is the case that a solution will only be delivered when a centre closes, or can't access chemotherapy for its patients, it will absolutely and unacceptably be at the cost of patient care. There would be a very real risk that for at least some of those patients impacted, the ramifications of interruption to their care would be reduced survivorship.

Yours sincerely

Stuart Giles
Managing Partner and Chairman
APHS Pharmacy Group