National Health Amendment (Simplified Price Disclosure) Bill 2013

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Date introduced: 21 November 2013
House: House of Representatives
Portfolio: Health
Commencement: On Royal Assent.

Links: The links to the Bill, its Explanatory Memorandum and second reading speech can be found on the Bill’s home page, or through http://www.aph.gov.au/Parliamentary_Business/Bills_Legislation

When Bills have been passed and have received Royal Assent, they become Acts, which can be found at the ComLaw website at http://www.comlaw.gov.au/.
Purpose of the Bill

The purpose of the National Health Amendment (Simplified Price Disclosure) Bill 2013 (the Bill) is to amend the National Health Act 1953 (the Act)¹ to simplify the operation of the current price disclosure arrangements. Specifically the Bill will:

- reduce the length of each price disclosure cycle from 18 months to 12 months
- ensure that there is only one ongoing price disclosure cycle, as opposed to the current arrangement of having three cycles per year
- provide that 1 April or 1 October are to be price disclosure reduction days (with the option of prescribing other days)
- retain the current price disclosure arrangements which prevent the Government from reducing the price of a medicine on the PBS unless the weighted average price is at least ten per cent lower than the PBS price and
- provide for transitional arrangements with regards to existing price disclosure cycles.²

Background

History of the PBS

Since 1948, the Pharmaceutical Benefits Scheme (PBS) has aimed to provide Australians with affordable access to medicines.³ Under the PBS, the Government subsidises the cost of some medicines. These medicines are listed on the PBS Schedule, which is managed by the Department of Health and administered by the Department of Human Services.⁴

The PBS forms part of the Government’s National Medicines Policy,⁵ which was developed to ‘meet medication and related service needs, so that both optimal health outcomes and economic objectives are achieved’.⁶ The central objectives of the National Medicines Policy are:

- timely access to the medicines that Australians need, at a cost individuals and the community can afford
- medicines that meet appropriate standards of quality, safety and efficacy
- quality use of medicines and
- maintaining a responsible and viable medicines industry.⁷

In 2012–13, around 197 million PBS-subsidised prescriptions were dispensed at a cost of over $8.8 billion,⁸ representing nearly 17 per cent of the Health and Ageing portfolio budget of $51.2 billion.⁹ Although the Government manages the price of each medicine on the PBS, the total cost of the PBS remains uncapped. Over the ten years to 2004–05, the cost of the PBS grew by nearly 13 per cent each year.¹⁰

Listing items on the PBS

The rationale for the PBS Schedule is to ensure the health of all Australians is maintained in a way that is cost effective. The process for listing is as follows:

An application to have an item listed on the PBS can be made for any medicine for any use for which it is registered on the Australian Register of Therapeutic Goods at the time of listing.

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⁴. Ibid.
The Pharmaceutical Benefits Advisory Committee (PBAC) is an independent statutory committee that meets three times a year to assess applications for listing on the PBS based on the clinical benefit and cost-effectiveness compared with other treatments or products for the same condition or use. It is assisted by the PBAC secretariat and teams of expert drug evaluators.

The PBAC may reject an application or make recommendations regarding a medicine’s uses and any conditions or restrictions on those uses and the Minister of Health can only approve the subsidy of a medicine in line with that independent recommendation.

The Pharmaceutical Benefits Pricing Authority (PBPA) is a non-statutory committee that meets three times a year following PBAC meetings. It may recommend either a ceiling price or price range for an item that has been approved by the PBAC following negotiation.

The decision to subsidise an item is considered by Cabinet if the net cost to the PBS is greater than $20 million per year, and then determined by the Minister for Health. The Government also exercises a number of controls to manage the overall cost of the scheme.

Once an item is listed on the PBS, the Government sets a wholesale price for the drug. When a consumer purchases the drug at a pharmacy, they are required to pay a co-payment (up to $36.90 for most PBS medicines or $6.00 by those persons who have a concession card). If the wholesale cost is not met by the consumer, the Government pays the pharmacist the remainder. The co-payment is intended to keep the PBS scheme viable. The amount of the co-payment is adjusted on 1 January each year in line with the Consumer Price Index (CPI).

**Patented and generic drugs**

According to the Grattan Institute:

Drug pricing is complex. Developing truly new drugs can be a long and expensive undertaking. The journey from ‘bench to bedside’ involves many hurdles, with promising inventions in the laboratory often failing to succeed when tested on the population. Drugs must also be approved for safety and effectiveness, adding further delays and costs.

To recover these costs, discoveries can be patented. Patents effectively give an exclusive licence to manufacture, and allow the manufacturer to charge higher prices for the 20-year patent period. Because these 20 years include the approval process, drugs will not be on the market for the whole time they are under patent.

After the patent has expired, other companies can use the intellectual property behind the drug and bring identical ‘generic’ copies (as opposed to the ‘patented’ version) to market. The patent-holder might also offer a generic version of the drug.

**Introduction of price disclosure**

In 2007, the Howard Government made significant changes to the PBS by enacting the *National Health Amendment (Pharmaceutical Benefits) Act 2007* (*2007 Amending Act*). The effect of the *2007 Amending Act* was to create two categories of drugs listed on the PBS Schedule:

- Formulary 1 (F1) which comprises drugs with only a single brand (usually where the patent over the drug has yet to expire) and

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13. Ibid.
• Formulary 2 (F2) comprising drugs with multiple brands and single brand drugs that are in a Therapeutic Group with a drug that has multiple brands.17

The purpose of the divide was to ensure that the Government received price reductions when generic medicines were listed on the PBS Schedule.18 A generic drug contains the same active ingredient as the original patented drug but is marketed under another name and is normally cheaper, as there are no licence fees payable to a patent holder.19

Of concern for the Government was that pharmacies may have received significant discounts with regards to off-patent medicines when they purchased bulk orders of generic drugs directly from manufacturers. As a result, the Government considered that it had been ‘paying too much for many multiple brand medicines where there is a competitive market operating’.20 In order to counter this, the Government introduced a 12.5 per cent price reduction on the cost of particular medicines when the first generic version of the medicine was listed on the PBS. This reduction applied to all brands of that medicine listed under Formulary 2. However further reductions were not imposed once other brands were listed.

From 1 August 2008 to 1 January 2011, additional price reductions applied. Formulary 2 was split into two sub-formularies, being F2A and F2T, with staged price cuts of two per cent per annum for three years applied to F2A products and a one-off 25 per cent price cut applied to F2T products.21

As part of these reforms, the Government introduced price disclosure requirements so that:

... the responsible persons for some multiple-brand medicines are required to provide information to the Department of Health & Ageing, including their revenue for supply of those brands of medicine to wholesalers and approved pharmacists, and the volume of sales. Price disclosure information provided to the Department will be used to determine whether there will be a price reduction.22

These requirements only applied to new brands of medicines listed on the PBS Schedule on or after 1 August 2007, and did not apply to generic medicines listed on F2T before 1 July 2011. The data cycles under which the information was collected would take either 23 or 27 months to complete, depending on the start date.23

**Expanded and accelerated price disclosure**

Implementation of the 2007 reforms was ‘fraught with both administrative complexity and legal challenge’.24 From the introduction of PBS reform until December 2009, a total of 38 drugs were subject to price disclosure. Of these, only six were subject to price reduction.25

For the products that were subject to reduction, the range of price reduction was considerable from 14.57 per cent to 71.80 per cent. The Generic Medicines Industry Association (GMiA) estimates that this has generated savings of...
$30 million per annum. In the context of an almost $8.5 billion dollar program (per annum), questions could be asked about the benefits of the policy for government, tax payers and the industry. 26

In 2010, the Government announced it would be extending the 2007 PBS reforms. 27 The National Health Amendment (Pharmaceutical Benefits Scheme) Act 2010 (2010 Amending Act) established the Expanded and Accelerated Price Disclosure Program. 28 The amendments introduced two further statutory price reductions and extended the operation of the price disclosure arrangements. 29 This meant that the arrangements applied to all medicines listed on F2 (rather than merely those on F2A) 30 and the introduction of a new brand was no longer required to trigger price disclosure. 31 The reforms also resulted in data collection cycles being reduced to no less than 18 months.

As noted in the Department of Health and Ageing annual report:

The price disclosure reforms of 2010 have resulted in further price deductions for many PBS medicines. In the first year of the 2010 reforms, $1.9 billion in savings were achieved over the forward estimates period. Price changes in 2012-13 and beyond will reduce the forward estimates by a further $2 billion, with a total of around $4 billion in savings since these reforms began in 2010. 32

**Simplified price disclosure**

In August 2013, as part of its Economic Statement, the former Labor Government announced that it intended to streamline the existing price disclosure arrangements by way of a new Simplified Price Disclosure (SPD) measure. 33 However, no Bill was introduced before the 43rd Parliament was prorogued.

The SPD in this Bill will replace the current Expanded and Accelerated Price Disclosure arrangements (EAPD) and reduce the length of each price disclosure cycle. 34

The Explanatory Memorandum describes the operation of the SPD as follows:

SPD would streamline the operation of the current price disclosure arrangements. All medicines would be merged into one ongoing cycle rather than having several different cycles over the year. The changes would allow price reductions to occur sooner, and more frequently, after medicines become subject to market competition. This would be achieved by reducing the length of each price disclosure cycle from 18 months to 12 months. The first SPD reduction would occur on 1 October 2014. 35

The Department of Health has prepared a table which outlines the changes between the proposed and existing arrangements, which is reproduced in Appendix 1 of this Bills Digest.

**Committee consideration**

**Senate Selection of Bills Committee**

On 4 December 2013, the Senate Selection of Bills Committee determined that the Bill not be referred to Committee for inquiry and report. 36

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27. A Bills Digest was prepared by the Parliamentary Library which discusses these reforms: R de Boer and S Scully, National Health Amendment (Pharmaceutical Benefits Scheme) Bill 2010, op. cit.
30. Ibid., p. 2.
34. Explanatory Memorandum, p. 1.
35. Ibid.


**Senate Standing Committee for the Scrutiny of Bills**

The Senate Standing Committee for the Scrutiny of Bills had no comment to make with respect to this Bill.  

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**Parliamentary Joint Committee on Human Rights**

As required under Part 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011* (Cth), the Government has assessed the Bill’s compatibility with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of that Act.  

The Government considers that the Bill is compatible and that it advances the protection of human rights.

In particular, the Government states that the Bill advances the right of all Australians to enjoy the highest attainable standard of physical and mental health:  

> The PBS assists with advancement of this human right by providing subsidised access to medicines for Australians. The proposed amendments also improve access to medicines, because consumers will pay less for some PBS medicines as a result of these changes.

The Parliamentary Joint Committee on Human Rights considered that the Bill does not give rise to any human rights concerns.

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**Policy position of non-government parties**

As part of the August 2013 Economic Statement, the then Labor Government referred to savings achieved as a result of reductions in payments under the PBS, ‘which are expected to be $388 million lower in 2013–14 ($2.0 billion over the four years to 2016–17)’. Senator Wong, the then Finance Minister, indicated that these savings were a result of the price disclosure amendments proposed in this Bill.  

That being the case, Labor supports the Bill.

However, the question for Labor is how the saving arising from the Bill will be spent. The Shadow Minister for Health, Catherine King, moved an opposition amendment which provided that the revenue raised by the Bill should remain within the health portfolio.

> Price disclosure does deliver savings and is one of the ways we can reduce the pressure on budgets. But it is critical that this money stays in the health portfolio and is invested in critical health infrastructure and the PBS and is also invested in medical research to ensure that facilities with young researchers are able to work on cures and new medicines for some of the world’s most challenging diseases. We also need to ensure that these savings will be used to fund the new medicines coming through the PBAC process and to support other health priorities in this important portfolio.

While the Government did not support this amendment, the Health Minister, Peter Dutton, indicated in his second reading speech that the savings were already factored into the health budget.

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38. Explanatory Memorandum, p. 2.

39. Ibid.


41. Explanatory Memorandum, p. 2.


46. Ibid.

Position of major interest groups

This new measure has attracted both support and criticism from stakeholders.

The Pharmacy Guild

The Pharmacy Guild (the Guild) has been highly critical of the introduction of SPD. The Guild is reported to have claimed that ‘it will be difficult for some community pharmacies to stay afloat, and that will cost jobs and jeopardise traditional pharmacy services such as home-delivered medications to the elderly’. 48

Consumers Health Forum

Consumers groups such as the Consumers Health Forum (CHF) of Australia, Choice and the Australian Council of Social Service have been campaigning against the high cost of prescription medicines in Australia. 49 With regards to the changes proposed by the Bill, Consumers Health Forum chief executive Carol Bennett applauded the measure stating that it ‘will further close the gap in what Australians pay for medicines compared to other Western countries. It will make room for more new drugs to be listed and for health consumers to get more affordable and effective treatments sooner’. 50

National Pharmaceutical Services Association

In August 2013, the National Pharmaceutical Services Association (NPSA) released a statement saying that it had joined ‘the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia in calling on the Federal Government to immediately increase pharmacy remuneration in response to recent changes to the price disclosure regime for PBS medicines’. 51 The President of the NPSA, Patrick Davies, commented that ‘pharmacists and wholesalers alike would feel significant impact and the industry would be under increasing pressure with additional financial strain’. 52 He also expressed disappointment with the lack of consultation regarding the policy change. 53

Medicines Australia

When the SPD was first announced in the August Economic Statement by the former Government, Medicines Australia also expressed disappointment over the lack of consultation. 54 Dr Brendan Shaw, Medicines Australia Chief Executive, made the following comments:

Previous price disclosure arrangements agreed by industry have been delivering savings to the Government leading to a series of downward revisions of PBS spending estimates since their introduction.

Price disclosure arrangements have always been subject to extensive consultation between Government and industry to ensure that a viable industry is maintained and patient’s access to medicines is not compromised. 55

Financial implications

The Explanatory Memorandum estimates that this measure will deliver savings of $835 million to the Federal Budget, commencing 1 October 2014. 56

Key issues

Burden on pharmacies?

According to Dr Stephen Duckett of the Grattan Institute:

52. Ibid.
53. Ibid.
55. Ibid.
Although $1bn annual savings sounds like a big deal—and it is—those costs to government and consumers are revenues to pharmacy manufacturers or pharmacies. They can be expected to protest vociferously against any loss of income.\(^ {57}\)

In introducing this Bill, the Health Minister criticised the former Government with regards to the timing of these amendments:

The former government announced these changes on the second of August, only hours before the start of the caretaker period and without consultation.

The Pharmacy Guild had a formal agreement with the previous government through the Fifth Community Pharmacy Agreement. Medicines Australia had an agreement through their memorandum of understanding. Neither of these parties was consulted in any way despite these changes having a huge impact on their agreements.

Because there was no opportunity for negotiation or discussion, pharmacies in particular were not able to factor these changes into their business plans for the future.\(^ {58}\)

He further stated that ‘this Government would have handled the approach and delivery of this policy in a very different manner’.\(^ {59}\) However, the Government does not appear to have consulted with either consumer or industry groups in re-introducing this Bill, although the Minister indicated that such consultation would occur ‘in the implementation of the new Simplified Price Disclosure arrangements’.\(^ {60}\)

In a media release, the Guild’s National President, Kos Sclavos, said that ‘the unexpected change would leave each community pharmacy $90,000 out of pocket in 2014–15, when added to existing price change arrangements’.\(^ {61}\)

The Guild commented on what this might mean for community pharmacies:

The changes may force some pharmacies to close their doors or slash important services for the elderly, very young or chronically ill, with the risk particularly high for the more than 1000 pharmacies in rural and regional areas, and for the 410 Australian towns which have just one pharmacy.\(^ {62}\)

However, the Guild has been criticised by programs such as the ABC’s Fact Check as having exaggerated the effect these changes would have:

The impact of the accelerated reduction is unlikely to be evenly distributed among pharmacies.

Those who have planned ahead and place less reliance on “trading terms” income from discounted generic medicines will feel less impact.

Professional Pharmacists Australia says owners who "over-leveraged themselves as they predicted that mark-up margins would continue" for up to six years are the most likely to sack employees and reduce staffing costs.

It says "a good owner would have developed strategies to mitigate these changes" although "there is a level of unfairness that arises with this sudden decision in light of the fact that planning for such changes is a medium term issue".

Terry White Chemists told ABC Fact Check "[s]maller independent and transactional pharmacies are likely to feel more pressure from these changes" than Terry White, which "has long understood that relying on dispensary profits was unsustainable and as a result now derives its revenue from a broad base".\(^ {63}\)


\(^{59}\) Ibid.

\(^{60}\) Ibid.

\(^{61}\) The Pharmacy Guild of Australia, Pharmacy jobs, services to go after shock Government decision, media release, 13 August 2013, accessed 17 January 2014.

\(^{62}\) Ibid.
While the lack of consultation with regards to these changes and the haste in which they have come about is a significant concern for some stakeholders, the ABC is right in identifying that ‘successive governments have been seeking better value for taxpayers by moving to faster price disclosure since 2007’. When announcing the original price disclosure arrangements back in 2006, Tony Abbott, then Health Minister for the Howard Government suggested that pharmacies may have to change their business model:

But their business model built these discounts in and if we’re going to take these discounts out and make them available to taxpayers, we have to provide a certain amount of compensation, which is what we’ve done.

As part of the original arrangements, the Howard Government provided a compensation package to assist pharmacists and pharmaceutical wholesalers to adjust to the reforms. In 2010, the Rudd Government and the Pharmacy Guild entered into the Fifth Community Pharmacy Agreement, which provided significant benefits to community pharmacies:

The Fifth Agreement provides $15.4 billion over the life of the Agreement for around 5000 community pharmacies for dispensing PBS medicines, providing pharmacy programs and services, and for the Community Services Obligation arrangements with pharmaceutical wholesalers. A commitment to maintaining location rules for approved pharmacies is also provided.

The Guild has commented that it would be seeking increase on the $15.4 billion paid by the Rudd Government when the Agreement is renegotiated in 2015. This compensation would be in the form of an ‘adjustment to dispensing remuneration’ and it is unclear how much the Guild would be seeking. It would appear unlikely that the Government intends to compensate pharmacies as a result of the changes.

Benefit to consumers?

In his second reading speech, the Minister commented that there would not be a direct correlation between the savings achieved by these amendments and the costs paid by consumers:

I should note that Simplified Price Disclosure is not designed to increase the magnitude of reductions to PBS prices. Rather, it is about applying price deductions sooner after a drug becomes subject to market competition, and more frequently, so the PBS price follows market prices more closely.

The Explanatory Memorandum states that:

... these savings are already factored into the forward estimates for the PBS and Repatriation Pharmaceutical Benefits Scheme (RPBS). Not implementing the SPD policy would require the Government to find the savings from other programmes.

While consumers will not benefit directly from the savings arising out of these measures, they will receive the benefit of paying less for some PBS medicines due to the quicker adjustment period when drug patents expire.

The Grattan Institute has recently released a report looking at the Government’s purchasing policy for pharmaceuticals. The report followed earlier research by the Institute, which found that Australians pay higher prices for pharmaceuticals than those in other countries. In particular, the authors cited the following example:

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64. Ibid.
68. Ibid.
69. The Minister indicated in his second reading speech that the current fiscal environment made the savings necessary, though did state that consultation with pharmacy and industry bodies would occur at the implementation stage: P Dutton, 'Second reading speech: National Health Amendment (Simplified Price Disclosure) Bill 2013', op. cit., pp. 977-978.
70. Ibid., p. 977.
Atorvastatin (formerly sold only under the brand name Lipitor) is a drug that lowers cholesterol. It is one of the most commonly prescribed drugs, with nearly 10 million scripts issued each year.

On 1 December the ex-manufacturer price of a box of 30 40mg pills falls from $38.69 to $19.32. This sounds like a big drop, but the ex-manufacturer price in the UK is the equivalent of $2.84. In New Zealand it is only $2.01 cents.

For this drug alone, the massive premium paid in Australia costs taxpayers tens of millions of dollars a year. Many Australians are paying for these high prices twice—once through their taxes and then again at the pharmacy.

After pharmacy mark-ups the December price reduction will save patients without a concession about $7 per box of pills. But if we had the UK’s wholesale prices, the saving would be up to almost $19 greater, and almost $20 more with New Zealand’s wholesale prices.  

Dr Stephen Duckett, one of the authors of the report and the Director of the health program at the Grattan Institute has stated that the amendments proposed by this Bill are a ’step in the right direction’, but has argued that the Government should instead adopt a system known as benchmarking:

Grattan Institute’s 2013 report, Australia’s bad drug deal, proposed another way to reduce the cost of pharmaceuticals on the PBS. It suggested an independent drug pricing body with a fixed budget and medical expertise. It also recommended sharp cuts in the price of new generic medicines entering the market.

Most importantly, the new body would look at the prices paid elsewhere to determine what the PBS should pay. Many countries look overseas to help set prices. Twenty-five out of 27 EU member countries, along with Canada, New Zealand and Japan, use some form of benchmarking. The UK is often used in these comparisons, with 11 countries using it as a benchmark.

The model proposed in Australia’s bad drug deal would have an independent pricing authority set a price (based on an international benchmark) and allow many drug companies to sell at that price.

This model would still allow choice for consumers, just as the current system does – any manufacturer would still be free to sell the drug.

**Main provisions**

**Moving the relevant day**

Section 84AF of the Act empowers the Minister to determine, by legislative instrument, that a person is the responsible person for a brand of a pharmaceutical. Section 99ADC of the Act requires the responsible person to provide information prescribed by the regulations in relation to the supply of the brand of the pharmaceutical item in the manner and form and at the times prescribed by the regulations. These are called the **price disclosure requirements**. They apply in respect of a listed brand of a pharmaceutical item that has a drug on F2.

Using the information disclosed under the price disclosure requirements, the Minister may, by legislative instrument, determine the weighted average disclosed price of a brand of a pharmaceutical item. The method

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74. S Duckett et al, *Poor pricing progress: price disclosure isn’t the answer to high drug prices*, op. cit., p. 5.


76. P Breadon and S Duckett, *Poor pricing progress: price disclosure isn’t the answer to high drug prices*, op. cit., p. 4.


78. *National Health Act*, section 99ADD.

for calculating **weighted average disclosed price** is contained in regulation 37G of the National Health (Pharmaceutical Benefits) Regulations 1960 (the Regulations).80

Where the weighted average disclosed price is at least ten per cent less than the price currently listed on the PBS Schedule the Government adjusts the PBS price.81 Under the current arrangements the **relevant day** is the last day of the period in respect of which the weighted average disclosed price of the brand of pharmaceutical item has been determined (subsection 99ADH(1)). Item 1 of the Bill amends subsection 99ADH(1) of the Act to repeal and replace the definition of **relevant day** to mean the day **after** the end of the period in respect of which the weighted average disclosed price of the brand is determined. According to the Department of Health, ‘this amendment will allow other price reductions that would be due on that day to be taken into account before the PBS and market prices are compared’.82 The practical effect ‘is to preserve the 10 per cent buffer afforded in the existing arrangements for companies to respond to market forces’.83

### Price reduction days

**Item 2** of the Bill repeals and replaces subsection 99ADH(2) of the Act, which sets out when a price reduction based on information provided under the price disclosure requirements can occur.

Currently paragraph 99ADH(1)(aa) of the Act provides that the Minister has the power to determine, by legislative instrument, when a **reduction day** will occur in relation to a brand of a pharmaceutical item.84 The day must be prescribed under the Regulations. Existing regulation 37K of the Regulations provides that the reduction days are 1 April, 1 August or 1 December in any year.

Under **proposed subsection 99ADH(2)** of the Act, a **reduction day** must either be 1 April or 1 October, or any other day prescribed by the Minister under the Regulations.

According to the Explanatory Memorandum:

> The ability to prescribe reduction days will be retained in subsection 99ADH(2), and the actual reduction day for a medicine (for example, 1 October 2014) will continue to be determined by the Minister under paragraph 99ADH(1)(aa) of the Act.85

Essentially, this amendment decreases the number of data collection cycles from three to one.86 The number of reduction days reduces to two and the length of the data collection period undertaken by drug companies has decreased from 12 months to six months (shortening the length of a normal data cycle from 18 months to 12 months).87

The Department of Health has flagged that in some cases there will need to be additional cycles:

> However, reductions sometimes cannot go ahead on the intended day. For example, for the 2013 Main Cycle, reductions needed to be split across two dates. Most reductions occurred on 1 April 2013, but some were delayed until 1 August 2013.

> It is proposed that the amended National Health (Pharmaceutical Benefits) Regulations 1960 retain 1 August and 1 December as possible reduction days. These days could be used, if required, so that any delayed reductions occur as close as possible to the intended 1 April or 1 October day.88

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83. Explanatory Memorandum, National Health Amendment (Simplified Price Disclosure) Bill 2013, op. cit., p. 3.
84. The *Acts Interpretation Act 1901* states that if a provision of an Act refers to a Minister by using the expression “the Minister” without specifying which Minister is referred to then the reference is a reference to the Minister who administers the provision in respect of the relevant matter. As the PBS is administered by the Department of Health, it is therefore the Minister of Health that the Act refers to.
85. Explanatory Memorandum, National Health Amendment (Simplified Price Disclosure) Bill 2013, op. cit., p. 4.
86. A comparison of these changes is set out at *Appendix 1*.
87. *Appendix 2* sets out a table which shows diagram ‘how cycles under the current arrangements and SPD would look if compared across the same timeline’.
**Application provisions**

Item 3 of the Bill provides ‘that the SPD amendments apply to a data period which ends on or after 1 February 2014’. The first SPD reduction will therefore occur on 1 October 2014.

**Concluding comments**

While the Minister has stated that the savings achieved by this Bill will go back into the Health portfolio, it is not clear whether the savings will directly lead to reduced medicine prices for consumers or the listing of additional items on the PBS.

There is also a concern that these amendments will have a significant impact on community pharmacies, particularly those that are independent or in rural and regional areas, who had not factored such changes into their forward financial planning.

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89. Explanatory Memorandum, National Health Amendment (Simplified Price Disclosure) Bill 2013, op. cit., p. 4.

90. Ibid., p. 1.
Appendix 1
Comparison of proposed and existing arrangements

<table>
<thead>
<tr>
<th></th>
<th>Existing arrangements</th>
<th>New arrangements</th>
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<tr>
<td><strong>Number of regular cycles</strong></td>
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<td>1</td>
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<tr>
<td><strong>Price disclosure reduction days per year</strong></td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td><strong>Length of regular cycles</strong></td>
<td>18 months</td>
<td>12 months</td>
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<tr>
<td><strong>Data collection period for price calculations</strong></td>
<td>≥ 12 months</td>
<td>≥ 6 months</td>
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<tr>
<td><strong>Price reporting, calculation, notification, dispute resolution period</strong></td>
<td>6 months</td>
<td>6 months</td>
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<tr>
<td><strong>Reporting period – data batches</strong></td>
<td>Every 6 months or as specified</td>
<td>Every 6 months or as specified</td>
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<tr>
<td><strong>Report due six weeks after</strong></td>
<td>31 March &amp; 30 Sept</td>
<td>31 March &amp; 30 Sept</td>
</tr>
<tr>
<td><strong>≥ 10% price difference test</strong></td>
<td>Yes</td>
<td>Yes</td>
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This table was prepared by the Department of Health as part of a stakeholder information session.91

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## Appendix 2

### EAPD to SPD cycles

<table>
<thead>
<tr>
<th>Drug</th>
<th>Current EAPD Cycle</th>
<th>Current Reduction Day</th>
<th>SPD Reduction Day</th>
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</thead>
<tbody>
<tr>
<td>Atorvastatin</td>
<td>Formerly 2013 Supplementary B (currently 2015 Main Cycle)</td>
<td>1 April 2015</td>
<td>1 October 2014</td>
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<tr>
<td>Aspirin</td>
<td>2014 Main Cycle</td>
<td>1 April 2014 (remains)</td>
<td>1 October 2014</td>
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<td>Candesartan</td>
<td>2014 Supplementary B Cycle</td>
<td>1 December 2014</td>
<td>1 October 2014</td>
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<tr>
<td>Zolmitriptan</td>
<td>2015 Main Cycle</td>
<td>1 April 2015</td>
<td>1 October 2014</td>
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<tr>
<td>Riluzole</td>
<td>2014 Supplementary A Cycle</td>
<td>1 August 2014 (remains)</td>
<td>1 April 2015</td>
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<tr>
<td>Nevirapine</td>
<td>2014 Supplementary A Cycle</td>
<td>1 August 2014 (remains)</td>
<td>1 April 2015</td>
</tr>
</tbody>
</table>

This table was prepared by the Department of Health as part of a stakeholder information session.\(^{92}\)

\(^{92}\) Ibid.
National Health Amendment (Simplified Price Disclosure) Bill 2013

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