PBS reform — a missed opportunity?

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Abstract

The Pharmaceutical Benefits Scheme (PBS) reform package was announced in 2006 and was designed to save the government significant expenditure on the PBS through mandatory price cuts and price disclosure arrangements for multi-brand products. Perhaps most significantly, the formulary was spilt in two with no linkages between the formularies on either price or therapeutic outcome. This article examines the potential impact of these changes on the PBS and pharmaceutical policy in Australia more broadly.

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What is known about the topic?

The Pharmaceutical Benefits Scheme (PBS) reform package was announced in 2006 and the first round of mandatory price cuts were imposed on 1 August 2008. The government expects savings of around $580 million over the next 4 years as a result of this package.

What does this paper add?

This paper provides an analysis of the reforms and examines whether the fundamental architecture of the PBS and the objectives of the National Medicines Policy have been preserved or undermined by these changes.

What are the implications for practitioners?

An understanding of the PBS and recent policy developments by consumers and practitioners alike will enhance the sustainability of the PBS.

THE INTRODUCTION OF the PBS reform package in 2006 was heralded as an opportunity for the government to save up to $3 billion over the next ten years and $580 million over the next four years[1] As a result of the changes that were part of the reform* package, the existing formulary was split and the pharmaceutical industry has been forced to accept significant price reductions for some products.

As part of the 2008–09 Budget, the new Rudd government also introduced cost-recovery arrangements to the listings of medicines on the PBS. Although first announced in 2005, it was widely considered to be "off the agenda" as the Australian Labor Party had vehemently opposed its introduction while in opposition as it was considered to undermine the independence of the Pharmaceutical Benefits Advisory Committee (PBAC).[2] In support of the measure, the Minister for Health and Ageing, the Hon Nicola Roxon MP, said that it was not "unreasonable" for the pharmaceutical industry to contribute towards the operation of the PBS.[3]

Clearly, it is too early to tell whether the reforms will generate the anticipated savings or if cost-recovery arrangements have any impact on the operation of the PBS. The Draft National Health (Pharmaceutical Benefits — charges) Regulations 2008 Bill is yet to be passed by the Senate, despite being referred twice to the Senate Committee on Community Affairs. This article examines implementation to date of the PBS reform package and the recent changes to pharmaceutical policy in Australia, such as the introduction of cost recovery to PBAC processes.

* The term "reform" has been adopted in this article as it reflects the terminology used by government.

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PBS reform package

When the previous federal Minister for Health and Ageing, the Hon Tony Abbott MP announced the package of reforms to the PBS in 2006, it was

designed to address two issues: the first, overpricing to government (and taxpayers) of generic medicines; and, secondly, the impact of reference pricing in a system of mandatory price cuts for new generic medicines being listed on the PBS.[4†] The key objective of the reforms was to generate costs savings but the expected savings are small in the context of annual PBS expenditure.[5‡]

A key feature of the PBS reform package was the splitting of a single national formulary into two separate formularies, Formulary 1 (F1) and Formulary 2 (F2), with different pricing strategies for each. Medicines listed on F1 are single brands (only one medicine of its type listed on the PBS) and typically will include on-patent drugs and often the first drug of its type to be listed on the PBS. For medicines in the same reference pricing group, the standard pricing arrangements apply. Products in the F2 formulary typically include medicines that are interchangeable at the patient level and where generics are available. Two subformularies have been created (Formulary 2A and Formulary 2T) with different pricing arrangements. Price disclosure arrangements apply for products listed on F2.

Despite the intention to retain reference pricing, there is to be no price linkage between the two formularies, which would seem to undermine this intention.[1] The splitting of the formulary effectively shields most patented products from any price cuts that would have previously flowed from off-patent, cost-minimised products (usually generics). It will ensure that the government will continue to pay high, or higher, prices for products that are not deemed interchangeable at the patient level.[6] Furthermore, it has been suggested that this will encourage the pharmaceutical companies to focus their efforts on demonstrating that their products are not interchangeable at the patient level rather than addressing more clinically useful questions.[7]

The government imposed mandatory price cuts on drugs listed on F2 on 1 August 2008. Products on F2A received a 2% cut which will be applied each year until 2010. A 25% cut was applied to all products on F2T.

In addition, pharmaceutical manufacturers are now required to disclose the "actual market price" as a condition of listing on the PBS on F2. This is designed to ensure that the government reaps the benefits of discounting arrangements between pharmacists and wholesalers. The Pharmacy Guild (the Guild) has signalled its support for these arrangements.[8]

Each formulary has different commencement and implementation dates for price disclosure arrangements. For example, price disclosure arrangements for F2A began on 1 August 2007 but will not impact price until 1 August 2009. For F2T, price disclosure arrangements apply from 1 January 2011 but will not impact price until 1 August 2012. In both instances, price disclosure arrangements will only be applied if the weighted average disclosed price is 10% more than what is currently being paid.

Price disclosure arrangements are triggered when a new brand of a drug already listed on the PBS is listed. It should be noted that in circumstances where the 12.5%[§] and 2% price reduction policy does not apply, the initial listing price of the new brand will be the same as those already listed on the PBS (not dissimilar to current arrangements) but the supplier will be required to disclose to the Department of Health and Ageing (DoHA) the actual price at which this drug is sold to wholesalers and/or pharmacies.

DoHA will then invite other suppliers of the same medicine to disclose their prices. It is important to note that participation in this process is voluntary and the DoHA can not compel any manufacturer to disclose their pricing arrangements. This has the potential to be "gamed" by other suppliers as it may be inferred

† This policy refers to the 12.5% policy introduced in April 2005 — a price cut that was triggered when a generic entered the market.

‡ The latest figures show PBS expenditure at $6.4 billion per annum (June 2007) and anticipate it to be around $7 billion for 2007–08. When the reforms were announced, PBS expenditure was about $6.2 billion. On average, the expected savings are $145 million per annum.

§ The 12.5% reduction policy was introduced in 2005. In short, when the first alternative brand of a medicine is listed on the PBS, a mandatory 12.5% price reduction is applied to all medicines in that reference pricing group.

that those suppliers who do not disclose their price are already supplying the product below the listed PBS price and new suppliers may price accordingly.

If this information is provided, it will form the basis for the calculations of the weighted average price and possibly trigger further price reductions. If the price reduction is less than 10% of the PBS ex-supplier price, the price reduction will not apply. If the reduction is greater than 10%, the weighted average disclosed price will be the subsidised price, rather than the disclosed price.

Although there has been little published analysis of the price disclosure arrangements, it has been suggested that implementation will be "challenging" for government.[9] It has been acknowledged that discounting is part of the pharmaceutical wholesaler business model.[9]

Implementation of PBS reforms

Before the price cuts being imposed on 1 August 2008, there was concern that the price cuts would lead to significant stock shortages as pharmacists and wholesalers would seek to discharge higher priced stock before the lower prices commenced.[10] To lessen the impact of the price cuts and ensure supply, the Department of Health and Ageing wrote to pharmaceutical companies in early May 2008 and asked them to bring forward the price reduction.[11] The pharmaceutical industry heeded the call of the government and imposed the price changes early. It was suggested that this saved the government from significant embarrassment.[12] The cooperation between the government, wholesalers and the pharmaceutical industry ensured that patients were not left without adequate supplies of pharmaceuticals.[12,13]

Although this perhaps could be viewed as a triumph for stakeholder relations, it highlights the lack of adequate consultation regarding implementation of these changes. It has been suggested that wholesalers have largely been excluded from discussions about the implementation of PBS reforms.[11,13] In contrast, the (previous) government had negotiated transition arrangements with the Pharmacy Guild of Australia to ensure stock levels would be maintained.[14] No such arrangements were made by the previous government with pharmaceutical wholesalers. It should be noted that the transition arrangements resulted in an additional payment of $1.50 being provided to pharmacists for products dispensed that are "substitutable, premium free medicine" (these are usually, but not always, generic medicines[15]), which, in turn, will undermine savings achieved through this measure.

In addition to the uncertainty about stock levels, there is widespread concern among the generic manufacturers and wholesalers about future impacts. From the generic industry's point of view, the reforms could have encouraged greater generic uptake by prescribers or improved incentives for consumers to purchase generic medicines. (Personal communication, Di Ford, former Executive Director, Generic Medicines Industry Association, 2008.) In addition, the government dramatically reduced the funding available for a generic medicines awareness campaign in the 2008–09 budget, from $20 million to $5 million.[16]

Generic medicines have the potential to offer significant savings to government and consumers as they are usually priced much lower than their patented equivalent. In Australia, however, generic penetration is relatively low (around 28% of dispensed prescriptions)[¶] and the price of generic medicines to government, before the reforms, was comparatively high. It is inevitable that this has resulted in higher overall expenditure on pharmaceuticals. There are numerous reasons why generic medicines are not widely used in Australia, and consumer awareness is often cited as one of them. Unlike the United Kingdom, generic prescribing is not mandatory in Australia.

The generic medicines industry has expressed concern about the impact of the price cuts on the operation of its business, and most were predicting a decline in revenue.[17,18] It has been estimated that the PBS reform cost one generic

¶ This is a widely accepted figure and often quoted in newspaper articles and by the pharmaceutical industry.

manufacturer, Sigma Pharmaceuticals, as much as $8 million in the first half of 2008.[19] Another, Alphapharm, has reduced its workforce in Australia, citing the impact of the reform package.[20] Despite this, it has been suggested that the generic medicines industry will ultimately benefit from the changes as generic volumes increase.[9] An increase in generic volumes has been noted since the introduction of the reforms.[19]

Pharmaceutical wholesalers are also predicting a decline in revenue.[17] The reforms may also lead to further industry consolidation.[9] Pharmaceutical wholesalers receive a proportion of the value of each product sold, and once the mandatory price reductions and price disclosure arrangements are fully implemented, the margins for pharmaceutical wholesalers will be reduced. It should be noted that pharmaceutical wholesalers that supply predominantly rural and remote areas are eligible for additional funding (which will also undermine the savings achievable by this measure).

The decreased revenue of both generic manufacturers and pharmaceutical wholesalers, in the short term, may not necessarily render generic manufacturers and wholesalers unprofitable but it does present challenges for the industry in Australia. Alternatively, it could be argued that they have received significant benefits from the PBS for many years and are now entering a period of correction.

These reforms were introduced on the premise that generic medicines in Australia were overpriced. It is too early to tell whether the reforms will deliver the expected saving of $580 million (over 4 years) or significantly reduce the price of generics in the long term, as this may simply be a correction of higher prices rather than continuous downward pressure through reference pricing. Despite this, the government is committed to a $1.1 billion compensation package for pharmacists to be paid until 2011. In addition to the $1.50 payment noted previously, pharmacists also receive a 40c payment for products dispensed through PBS Online (a program developed by the government to reduce the administrative burden of the PBS). These payments will be paid irrespective of whether the savings are achieved. Furthermore, the Pharmacy Guild may seek to enshrine these compensation arrangements in the next Community Pharmacy Agreement (CPA). The current CPA is due to expire in 2010 and if the increased dispensing fee provided as a part of these reforms is included in the next CPA, it will ensure that pharmacists continue to receive a significant proportion of PBS expenditure (currently around 30%).

It has been suggested there may be other unintended benefits for pharmacists as a result of the reforms. If originator manufacturers dropped their brand price premium for products listed on F2 when the price cuts were introduced, pharmacists could still receive the $1.50 payment without substituting a generic.[21] While there is no evidence to suggest that this is happening, it may have serious implications for generic usage in Australia. This possibility reflects the nature of the pharmaceutical industry in Australia and the overlap between the "originator" and "generic" pharmaceutical industries.

Price disclosure

Perhaps one of the least reported aspects of PBS reform has been price disclosure. In place since August 2007, there has been little public discussion about its implementation or the extent of savings achieved by the measure. As at January 2009 there were 27 items subject to price disclosure and 47 items exempt. This perhaps is due, in part, to the procedural rule that specifies that different administrations of the same active ingredient are not subject to price disclosure arrangements.[22] For example, if a drug in a tablet form was subject to price disclosure arrangements, the same product in a liquid form preparation would not be. Presumably this is to ensure access to low volume products or products with paediatric indications.

The price disclosure guidelines on the PBS website seek to explain a complex set of guidelines and procedures. In short, sales data must

be collected by the manufacturer (described in the legislation and guidelines as the "responsible person") on a monthly basis and submitted every 3 months. All other information such as further discounts, charge backs and incentives is submitted on an annual basis.[23] Calculations are made on an annual basis with the price reduction being applied with a 6-month delay. The price disclosure arrangements apply only to brands that are subject to price disclosure arrangements, not necessarily all brands supplied by the manufacturer or all brands on the PBS. This raises questions about the extent of the savings that can be achieved and whether the government will have a comprehensive understanding of the arrangements between pharmaceutical wholesalers and pharmacists.

Furthermore, if a brand is subject to price reduction as a result of price disclosure, it will be removed from the therapeutic group and the reduced price will not "flow on" to other brands in the therapeutic group. This is in contrast to the previous arrangements for reference pricing, whereby any reductions in price applied to the entire therapeutic group. The removal of brands that have been subject to price reduction will have significant implications for reference pricing and the potential savings to government. For example, the first round of price reductions announced in February 2009 detailed reductions that ranged from 15% to 64%.[24] If these reductions were to be applied to the entire therapeutic group this would generate considerable savings. Despite these concerns, the Guild estimates that these reductions will save the government around $13 million per year.[24] It should be noted that the Guild has not publicly released the modelling on which these assumptions are based. Furthermore, the government has not yet released any expected savings from this price reduction.

When the PBS reform package was announced, it was argued by government that the "fundamentals of the PBS" would not change as a result. One of these fundamentals is reference pricing and the concept of purchasing health outcomes. While reference pricing has not been dismantled, it could be argued that it has been compromised. The reference pricing will now only operate within therapeutic groups. Weighted average monthly treatment cost and the 12.5% reduction policy with the listing of a new brand will continue to apply within therapeutic groups with no flow-on effect in any circumstances. In comparison to the previous arrangements, these are severely limiting constraints. Furthermore, each new brand that is listed on F2 will be subject to price disclosure arrangements as well as a 12.5% cut, which could act as a disincentive to the pharmaceutical industry to list new brands at considerably lower prices, as volume can not be guaranteed (or at least encouraged) through incentives to consumers or pharmacists. This, in combination with the de-linking of F1 and F2, raises serious questions about the extent of the savings that can be achieved and the manner in which reference pricing can now be used as a tool to put downward pressure on prices. The 6-month delay from notification to the price reduction taking effect will also compromise savings. No explanation has been given for this delay.

Single brand combinations are also exempt from price disclosure. However, price disclosure arrangements apply in any of their component drugs. This is administratively complex and may also limit the extent of the savings able to be achieved by this measure.

The price reduction associated with price disclosure is of concern to the pharmaceutical industry as it argues that this artificially reduces the price of the comparator when making a submission to the PBAC.[25] This is refuted by the Australian Government Department of Health and Ageing who argue that the PBAC are well placed to determine the price of the comparator and assess the therapeutic value of a drug.[25] This issue is yet to be resolved but highlights the tensions in an administratively complex system with competing stakeholder objectives.

There is no doubt the pricing of generic medicines in Australia represents a complex policy challenge for government. The arrangements that

have been implemented are administratively complicated and are unlikely to achieve significant savings in the long term.

Cost recovery for listing of medicines on the PBS

The announcement of the introduction of cost recovery arrangements in the 2008–09 Federal Budget took many pharmaceutical industry observers, and the pharmaceutical industry, by surprise. This is supported by many submissions and evidence provided at the Senate Committee on Community Affairs inquiry into the Draft National Health (Pharmaceutical Benefits — charges) Regulations 2008 Bill.[26]

Given the comments made by Ms Roxon in her capacity as Opposition spokeswoman for Health when the Bill was first introduced by the Howard government, it was assumed by many industry observers that the cost-recovery measure was "off the agenda". There does not appear to have been any consultation with the pharmaceutical industry before the Budget announcement in which it was made clear that government would pursue the introduction of these arrangements.[26]

In the context of a $6 billion (and rising) program, the anticipated savings of $9.4 million in 2008–09 (unlikely to be fully realised as the Bill has not yet passed Parliament and will need to be re-introduced into the Senate) and $14 million in 2009–10 are negligible. The government argues that as the pharmaceutical industry benefits greatly from its products being listed on the PBS it should pay towards some of the costs associated with its operation, in accordance with the *Cost Recovery Guidelines* adopted by the Australian Government in 2002.

The submissions and hearings before the Senate Community Affairs Committee (the Committee) established to review the legislation challenged this assumption. The majority of submissions argued that the PBS did not fit the criteria for cost recovery as the benefit of access to wide-ranging prescription medications was in the public interest.[27,28] Quite apart from the applicability of the cost-recovery guidelines, cost-recovery arrangements lend themselves to the perception that the independence of the PBAC may be compromised as there is a financial benefit associated with the listing process.

The government has assured the Parliament and the Committee that the PBAC will not receive any revenue from the collection of fees and will remain removed from the fee-setting process.[26,29] Furthermore, the fees collected will be returned to consolidated revenue and will not be used directly in the administration of the PBS or the operation of the PBAC. This raises the question of whether these arrangements can realistically be considered a cost-recovery mechanism or merely the imposition of an evaluation fee. By contrast, the Therapeutic Goods Administration (TGA) operates on full cost-recovery principles and the fees paid for the evaluation of products are used to fund the entire operation of the TGA.

Some commentators suggested that the money raised from cost recovery should be used to fund specific medicines or used for specific health programs.[26] (pp. 4, 5) One witness before the Committee even suggested that this money could be used to ensure the sustainability of the PBS.[26] (pp. 4, 5) This is unlikely, as the anticipated revenue for cost recovery is around $14 million–$22 million per annum. There are many products on the PBS that cost the government hundreds of millions of dollars on an annual basis and this will do little to offset expenditure (atorvastatin alone cost the government around $221 million in 2007–08).

The government was severely criticised for not releasing the detail of the legislation to the Committee and the Senate to enable further scrutiny.** It was on this issue that the Bill was defeated in the Senate. As the regulations were released on the day the legislation was debated in the Senate, they were referred to the Committee for consideration. The Committee tabled its report on the regulation on 2 October 2008 and recommended passage of the legislation. In a

** This was noted in both Final Reports of the Senate Community Affairs Committee and in Senate debate of the legislation prior to being referred to Committee for a second time.

dissenting report, Coalition senators did not support the introduction of cost recovery guidelines and noted the lack of a compelling argument.

The benefits of cost recovery are unclear. Submissions to the Committee from the pharmaceutical industry have indicated that it will add significant costs to the preparation of a submission to the PBAC. It has been suggested that this may be passed on to patients (and ultimately taxpayers) through higher prices, a possibility acknowledged by the Department of Health and Ageing when the bill was first introduced.[††]

Another concern expressed by both the Committee and stakeholders was the circumstances in which a waiver would apply. Concern was expressed that pharmaceuticals only used in small patient groups or within limited indications would not seek listing on the PBS because of the additional costs (for example pharmaceuticals used in palliative care). In response, the regulations were amended to reflect that a waiver could be applied if it is in "the public interest and payment of the fee would make the application financially unviable".[30] This amendment must be carefully monitored to ensure that it is not "gamed" by the pharmaceutical industry. The waiver may well encourage "salami-slicing" of pharmaceutical products. For example, to qualify for a waiver, a narrow indication with a limited population group may be sought for the initial listing of a product. This may encourage the pharmaceutical industry to seek narrow indications at a higher price rather than broader indications at a lower price.

Future challenges

The cost of the PBS has long been of concern to governments as expenditure has increased at an average nominal growth rate of 12% per annum between 1995 and 2004.[4] This growth has since slowed and the projected PBS growth rate for 2008–09 is around 5%.[31] However, as Australians now have the second longest life expectancy in the world, and pharmaceutical use increases with age, there is a growing burden of chronic disease as well as an increasing number of expensive drugs being listed on the PBS.

Since the late 1980s, one of the fundamentals of the PBS has been the assessment of value for money as an essential criterion for listing. The economic evaluation framework together with the use of reference pricing has meant, conceptually at least, that through the PBS, the Australian Government has been purchasing health outcomes, not drugs. The prices paid for pharmaceuticals have been comparably lower than in many OECD countries, particularly the US. However, it is not true across the board as many new products, particularly biologics, are more expensive than in the United States.[32] It could be argued then to the pharmaceutical industry that economic evaluation need not be a threat to the pricing of pharmaceuticals in Australia.

While the PBS reforms signal a shift in the approach to the pricing of pharmaceuticals at the time of listing, they also have a significant impact on economic evaluation. Medicines which offer a similar therapeutic outcome are no longer automatically linked on price. The imposition of a price cut, while perhaps of benefit to government, is not based on any assessment, economic or otherwise. This undermines principles of reference pricing and it is no longer possible to say that products are priced according to health outcomes.

As noted above, when these reforms were introduced, the government was principally concerned about over-pricing of generics in order to achieve savings. The one-off price cuts may generate short-term savings but will not lead to fundamental changes in the long term. It is not clear how the price disclosure arrangements will address this. Price disclosure arrangements are notoriously fraught and often circumvented,[§§] and, moreover, there is a significant time lag

†† Refer to Community Affairs Legal Committee Estimates Discussion on 1 June 2005 between Senator Lyn Alison and Ms Judy Blazow.

§§ Refer to Kwon[33] for a description of what happened in Korea when the government introduced a "no margin" policy and significantly reduced the reimbursement level for drugs. In short, the policy encouraged collusion among pharmaceutical manufacturers which resulted in higher prices for consumers.

between disclosure of the price and the imposition of any subsequent cut. Furthermore, price reductions will apply only if the average disclosed price is 10% higher than the existing price to government. Markets are inherently dynamic and it is unreasonable to expect that the market conditions applying at the time of price disclosure will necessarily persist at the time the price cut takes effect. There is also evidence to suggest price disclosure arrangements may encourage collusion.[33]

The expected savings are predicated on the mandatory price cuts and price disclosure arrangements and thus there is no guarantee that there will be any savings as a result, either in the short or long term. Furthermore, the costs associated with the administration of such a system may also offset any savings. It has been argued that these savings to the PBS will create "headroom" and allow for new, more expensive drugs to be listed. As the PBS is an uncapped program it is difficult to see how this might be the case. Furthermore, the legislative requirements for listing are unchanged and the government has not given any indication that these settings may be revised.

There are many challenges ahead for pharmaceutical policy in Australia. Maintaining the objectives of access, equity and affordability, as articulated in the National Medicines Policy (NMP), poses a challenge for the government, consumers and the pharmaceutical industry alike. On balance, these reforms do little to advance this. When the reforms were announced, it was estimated that consumers would save $2.76 per script, which, while beneficial, is hardly substantial.[34] The 2007–08 Mid Year Economic and Financial Outlook notes that the government will save $88 million as a result of the price cut applied to simvastatin alone, yet this is offset by the $46 million that will be paid to pharmacists to implement PBS Online (a part of the reform package).

Amid concerns about rising pharmaceutical expenditure, it is interesting to note that prescription charges to consumers were abolished in Wales in 2007.[35] Scotland is also following suit.[36] The yearly growth rate for prescription volume in Wales has stabilised at around 5% for the past 5 years and there has been no discernible change as a result of free prescriptions.[35] In Australia, the application of copayments has been used to limit expenditure on the PBS, with varying success, as detailed by Sweeny in this issue (*page 215*). In debates about pharmaceutical policy, there has been little consideration of individual affordability. Perhaps one of the unintended impacts of PBS reform will be that for the estimated 400 products that are now priced below the general copayment, consumers will not necessarily reap the benefits of price reductions, as pricing of these products is at the discretion of the pharmacist.

Concluding remarks

In an era of a large number of patent expiries there are unprecedented opportunities for government to achieve savings through price reductions and the maintenance (or restoration) of reference pricing. As noted by the Office of Fair Trading in the United Kingdom, there are clear benefits in adopting a "value-based approach"[37] to the pricing of pharmaceuticals. However, to realise significant savings, the government may need to move away from a fee-for-service model and consider alternative models for pharmacists' remuneration. In the present model, pharmacists are able to determine prices for products under the level of the copayment as they attract no reimbursement to pharmacy. This may provide an incentive to charge prices approximating the copayment. When this occurs, savings are essentially captured by the retailers.

Pharmaceutical policy in Australia has undergone significant change over the past 2 years, and yet these changes have not advanced the objectives of the NMP. Instead the reforms have added complexity to what was already a complex system and there has been an undermining of the implied principle of purchasing "health outcomes not drugs". Mandatory price cuts will reduce expenditure in the short term but the savings will be eroded, perhaps many times over, in the long term as reference pricing is weakened.[38]

Cost-recovery arrangements were introduced under the guise of budgetary savings, but these are minimal in the context of overall PBS government expenditure. It appears that the overarching policy objectives for the PBS and pharmaceutical policy are focussed on cost containment and cost recovery rather than the objectives articulated in the NMP. The Minister for Health and Ageing has noted that the PBS is "suffering a little from reform fatigue",[39] but it is perhaps more reform — and reform which advances the NMP objectives of access, equity and affordability — that is needed to ensure that the fundamentals of the PBS are preserved into the future.

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Competing interests

The author declares that she has no competing interests.

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