Consumers Health Forum of Australia

Ms Deborah Monk
Director, Compliance
Medicines Australia
16 Napier Close
DEAKIN ACT 2600

Dear Ms Monk

Code of Conduct Review and Consultation on the MA Transparency Model

The Consumers Health Forum of Australia (CHF) welcomes Medicines Australia (MA)'s ongoing engagement with stakeholders on the *Review of Medicines Australia Code & Proposed Transparency Model,* and take this opportunity to provide comment on the these significant documents.

CHF is the national peak body representing the interests of Australian healthcare consumers. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems. As such, CHF and its members have a strong interest in the ethical promotion of therapeutic goods.

CHF has welcomed and supported MA's work in this area, recognising that MA has taken leadership on this issue that extends beyond the usual remit of its work. As highlighted through our previous submissions to reviews of the Code, CHF has long advocated for individual level disclosure of payments made by companies to healthcare professionals and we have supported and commended the work of the Transparency Working Group (TWG) and MA in developing the Discussion Paper last year.

We are obviously disappointed to note that the proposed amendments to the code and transparency model as discussed in recent briefings, fail to live up to consumer expectations. Some of the issues that CHF has with the provisions are as detailed below.

Alignment to the "Activity-based" EFPIA model

CHF is disappointed with MA's preference of the European model of self-regulation. CHF continues to support full disclosure of all payments over the $10 threshold for recording and reporting of payments. This would capture items of low monetary value, such as lunches at a healthcare professional's office, which, when one-off may not be a significant amount, but when aggregated over a period of a year could total a substantial figure. More important than the actual monetary threshold however, is the capturing of data that reflects how often health practitioners and industry interact.

A $120 threshold proposed under the current provisions will fail to record and report a majority of industry-health practitioner interactions, and thus will continue to facilitate influencing of prescribing behaviour under the radar.

Obtaining Consent for Reporting

CHF notes that the provision of individual level disclosure hinges on Industry obtaining consent from health practitioners. While we acknowledge MA's and pharmaceutical companies' obligations to comply with privacy legislation, we do not believe that this is a significant inhibitor to effective transparency.

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The consent for disclosure should be embedded in any contract where there is a transfer of value between health practitioners and industry. A robust and effective code is undermined where practitioners can obtain gifts or payments without any commitment to ensure transparency and disclosure of these arrangements.

We note that practitioners could choose to withdraw their consent at any point, even after having granted initial permission to disclose. CHF argues that in such a circumstance, it is only reasonable that the practitioner should be obliged (through the terms of the original agreement) to repay the value of the gift or payment to the company which provided it. This would allow privacy laws to be adhered to, while ensuring that no benefit accrues without disclosure.

Moreover, without a financial disincentive, the complex reporting, checking and follow through iteration proposed by MA, will only provide incentives for practitioners to opt for the non-disclosure option, rendering the entire individual level disclosure intent of the system meaningless.

Repository of Recorded Disclosure

CHF is also disappointed to note that in the first phase of implementation, MA is proposing that the reports on disclosure be listed on each industry member's website. This would imply that a consumer will have to essentially look through reports hosted on all of MA's member websites before they can completely unravel the relationship between their health practitioner and industry. Clearly, this is an inappropriate way to assist transparency.

A central database, that can collate disclosure data linked to individual practitioners (through identifiers such as the AHPRA UID numbers) is a critical component of the transparency model, and we are disappointed that this has not been more extensively explored.

Conclusion

Overall, while CHF recognises that some issues are beyond the direct control of MA and require the involvement of other stakeholders, we would encourage MA to consider these issues such that it can continue to play a leadership role.

We congratulate Medicines Australia's initiative to authorise their code of conduct through the ACCC, which sets a benchmark for accountability within the Australian medicines industry.

We recognise and applaud the leadership MA has taken across the industry in this aspect. However we note the challenges the Code faces in operating in a system where there are several different self-regulated codes, often with no authorisation, in different parts of the therapeutic goods industry. CHF thus continues to advocate for the establishment of a single, rigorous code of conduct for all pharmaceutical and therapeutic goods industries, for all members and non-members of industry associations alike.

If you would like to discuss these comments in greater detail, please contact CHF Policy Officer, Priyanka Rai.

Yours sincerely

Adam Stankevicius
Chief Executive Officer

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