

# Are Australia's drugs too cheap for our own good?

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The Pharmaceutical Benefits Advisory Committee (PBAC) plays an important role in controlling the drugs that are available at subsidised prices under the Pharmaceutical Benefits Scheme (PBS). In brief, the Committee provides advice on whether a new drug is sufficiently cost-effective to merit its being added to the PBS. Listing is important to the drug manufacturers, because it has a beneficial effect on sales volume. They are therefore often prepared to offer lower prices than would otherwise be the case if availability were determined solely by the marketplace.

On 31 December 2000, the Federal government dismissed all members of the PBAC, and appointed Lloyd Samson as the new chairperson. He is not considered to be an apologist for the pharmaceuticals industry, but does appear to favour a more collaborative relationship between government and industry. Some people believe this may be inappropriate, since there are good reasons why tension should exist between the buyer and the seller. Perhaps of more concern may be the appointment of Pat Clear to the Committee: he has been a paid consultant for the industry for many years.

The changes to membership attracted the attention of both the popular and the professional media. On the one hand, some commentators saw it as an action that was long overdue, and as an appropriate response to the economic nonsense of old-fashioned welfarism which stifles innovation and punishes the Australian economy. On the other, it was seen as a payoff to the rich by a small government of economic rationalists, and a further dismantling of Medicare and rejection of the principles on which it is founded.

I will make just three points, as an introduction to the invited papers on the PBS that are presented below. The papers are worth reading by anyone interested in our health care system, and not just in the PBS.

My first point is that the media interest was international. Indeed, there were probably more comments on this aspect of the Australian health care system than on any other in living memory.

I was in Bulgaria when the story broke. A senior doctor in the Ministry of Health heard the news before me, and simply said "Where will Bulgaria be in future, now that the glorious fight that Australians have fought for health over drug company profits is over?" The point was reinforced a few days later, when I met up with a highly respected medical academic in Manila. "Welcome back" he said. "And why have you given up the fight against big business? We were relying on you to continue to show how drug prices and use should be controlled".

Much of this may be hyperbole and good-natured banter, but there is a bitter edge. Many health care professionals overseas who know almost nothing about our health care system are convinced (rightly or wrongly) that we are good at managing drug costs and utilisation.

The majority of the most respected health journals had commentaries of one kind or another. For example, The Lancet ran an article (Loff and Cordner, 2001) in which the authors saw more risk than opportunity in the government's moving "... to reduce controls on the pharmaceutical industry". The British Medical Journal had an article by Zinn (2001) that was much less equivocal: he reported widespread anger among health professionals, not simply because the PBAC members had been spilled, but also because a "former (drug) industry lobbyist" had been appointed to the "drug watchdog."

In general, there is an informed international and national view that we have done quite well. Several authors including Kanavos, Trueman, and Bosilevac (2000) have noted that other countries are beginning to take similar approaches. As Rosalie Viney puts it in this issue of the AHR, "... Australia has been a world-leader" by using "... an internationally unique process for listing new pharmaceuticals for subsidised access, based on cost-effectiveness." Andrew Dalton says Australia's system "... is recognised internationally as being the best approach" and he reproduces statistics from the Industry Commission which show drug prices in Australia are typically from 5% to 45% less expensive than those in other similar countries. Roy Harvey refers to Australia's reputation as having a first class national drug program. Kenneth Hartigan-Go says that Australia's approach "... serves as a model and a stimulus for less fortunate countries like The Philippines, and indeed most countries in the world."

One more anecdote is worth reporting. A colleague has just returned from a meeting organised by the World Trade Organisation and the World Health Organisation, titled "A workshop on differential pricing and financing of essential drugs." It was directed at trying to make drugs more affordable in low income countries. The Australian approach was the only existing scheme to be given serious consideration, as a starting point for reforms that might be suited to the poorer world.

My second point is that the actions were entirely predictable in terms of broad policy, however clumsily they might have been applied in this case. It would have looked better if the decision had not been preceded by a meeting between the Prime Minister and representatives of the pharmaceutical industry at which the main agenda item was what to do with the PBAC's membership. It might have been wise to avoid the claim (made by the ABC's Four Corners program and by others) that the government was lying about the purpose of the meeting. It was probably a mistake to hold the meeting in the Prime Minister's own electorate, given that so many of the drug manufacturers have offices there. Convenience was not a good enough reason.

This said, the action was consistent with trends that have been well documented over the years. For example, the AHR published a paper by Hans Lofgren (1998) in which he argued that the issue was "... not whether, but how best to manage the winding back of state controls and welfare benefits in favour of regulation through the market mechanism."

He noted the main arguments in favour of reduced control, which have been propounded by the drugs manufacturers ever since governments began to interfere in Menzies' time: that a freer market will increase Australia's international competitiveness, facilitate growth of pharmaceutical manufacturing in Australia (and hence create employment and reduce imports), and generally lead to "... more efficient use of resources" (Australian Pharmaceutical Manufacturers' Association, 1995).

Both Labor and Coalition governments have acted as if these arguments are at least partly plausible since 1993, and there have been two common interpretations of their motives. One is that they genuinely believe Australia would benefit by a freer marketplace for pharmaceuticals. The other is that they believe it is politically important to buy off such a wealthy and influential industry.

Regardless of motives, we need to understand whether this latest action represents an initial step towards less welfare and more market, or just a fit of pique (since the PBAC was obviously creating an increasing amount of difficulty for the government). After all, the government has argued it has no desire to give the PBAC any different riding instructions. Rather, the government merely wishes to ensure there are what it perceives to be more balanced inputs to the Committee's unchanged terms of reference.

The arguments against reduced control seem strong to me. There is no evidence to show that a free market in drugs leads to increased cost-effectiveness. Nor is there much logic in the claim that increased profits for drug companies result in a net economic benefit to Australia. There is no country in the world where the pharmaceutical industry has taken the initiative with regard to the use of measures of cost-benefit for the community as the basis for drugs development, production, distribution, marketing, and pricing. It would be illogical for them to do so. Their primary responsibility is to shareholders, and it is impossible to maximise profits by concentrating on the maximisation of community benefits if only because the consumers with the most money tend not to be the people with the greatest need for drug therapy.

It is worth illustrating this point. Nowhere is it more apparent than in developing countries where the costs of anti-retroviral treatments for HIV-AIDS have remained far out of reach. Only relentless political pressure, public humiliation, and the entry of generic manufacturers has forced major pharmaceutical manufacturers to drop their prices. In doing so, they have revealed that the marginal costs of production may be less than 10% of the current selling prices. Still, this has not stopped 39 drug companies from taking the South African government to court for daring to introduce legislation to constrain drug prices. Two of the government instruments being tested in court are used in Australia-generic substitution and tight price controls.

While making final checks on this paper, I heard on the news that the drug companies have just withdrawn their suit against the South African government. It is too soon to know why, or whether this is good news. I doubt, however, that the companies' dominant concern was the health of the poor in Africa.

Sadly, there are other recent examples that suggest governments are willing to damage the health care system in the interests of for-profit players. One was the decision to transfer over \$2 billion a year of public funds to the private insurance sector - and hence mainly to private hospitals and private medical specialists - where it buys far less health care because the private insurance sector is less efficient and less equitable. The for-profit care providers were the main proponents of this policy and are the only clear winners.

My last point is about the selection of authors. All have an academic bent, they do not manufacture drugs, and none have operational responsibilities for financing or delivery of health care. Their views are similar, and this might be expected from their backgrounds.

Most of the AHR's papers are unsolicited, but we do from time to time invite papers on a topical issue. In this case, we were unable to find a more heterogeneous mix of people who were willing to respond. Perhaps people with different views are too busy doing more useful things. At times, however, I start to suspect that those who complain about excessive exposure of views they dislike may simply be people who have no defensible views of their own.

It seems to me that Viney, Harvey, and Dalton have presented well-balanced arguments. They describe weaknesses in current methods, in addition to the strengths. Their conclusions are similar: that the PBS deserves support from all health care professionals, not because it is perfect but because it is taking us in the right direction - and showing the way ahead for other components of our health care system. If you disagree, space is available in the AHR to express different views. You are also welcome to agree.

## References

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