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Pharmaceutical benefits provide a stable framework within which consumers, prescribers, suppliers, pharmacists and other actors undertake transactions. The state in effect delivers a good that enhances individual autonomy. A major reason for the legitimacy enjoyed by pharmaceutical benefits in both Australia and Sweden is that these programs have strong attributes of universalism (rather than targeting). Sweden’s predominantly public health system allows greater scope for pharmaceutical policy innovation. Australia’s Pharmaceutical Benefits Scheme (PBS), while historically resilient and effective, is now wedged precariously between traditional considerations of equity and public health on the one hand, and constant pressure for increased marketisation on the other.

Introduction

In this article I compare pharmaceutical benefits in Australia and Sweden, addressing the following central questions. Why have public subsidies of the cost of prescription drugs proven to be effective, robust and popular in both countries? To what extent have these programs been modified in recent years in response to developments in the pharmaceutical market and broader changes in social policy? And what is the likelihood of retaining effective social protection with respect to drug costs when the global pharmaceutical industry is launching a stream of increasingly expensive products?

Pharmaceutical benefits in many countries are among the most entrenched and widely supported of the social programs first introduced in the 1940s and 1950s. They typify a kind of intervention that governments are able to undertake effectively with strong popular support (Rothstein 1998: 77-79). The relationship between policy measures (the subsidy) and outcomes (relatively equitable access) is incontrovertible. Governments, through procedures requiring relatively straightforward and inexpensive
administration, ensure financial security with respect to the cost of prescription drugs, thereby enhancing citizens’ individual autonomy. Significantly, in providing pharmaceutical benefits the state does not intrude into individuals’ personal circumstances. These are regulatory (as distinct from strongly interventionist) programs that provide a relatively stable and predictable framework within which consumers, prescribers, suppliers, pharmacists and other actors can make choices and undertake transactions. Stigmatisation is wholly absent in the Swedish system; and in the case of Australia’s Pharmaceutical Benefits Scheme (PBS) is confined to an extent that is uncommon within the country’s predominantly selective welfare system. (It is striking, for instance, that the PBS has precluded demand for private insurance in this domain.)

Australia and Sweden have different welfare state traditions. Australia exemplifies the low taxing, residualist model, while Sweden is the archetypal universal welfare state premised on high levels of taxation. But targeted and universalist programs can be found in both countries. Some of Australia’s major social programs — Medicare being the primary example — provide support for all permanent residents. Conversely, a range of selective programs can be found in Sweden, including social assistance and housing allowances, and these have been shown consistently to enjoy least popular support (Rothstein 1998: 167). Rising drug prices and other market developments will impel governments to adjust subsidy programs, but the security that pharmaceutical benefits afford to all citizens makes them less vulnerable to change than most other social programs.

**The prescription drug sector in Australia and Sweden**

To some extent, governments regulate each step of the medicinal drug development, production and distribution chain. While the antecedents of contemporary controls go back centuries — the Swedish government commenced regulation of drug prices in 1688 (SOU 1998: 50: 37) — the modern rationale for state intervention largely reflects the identification of various pharmaceutical market ‘failures’, notably information asymmetries affecting the relationship between suppliers, prescribers and consumers (Schweitzer 1997).

The Australian and Swedish pharmaceutical sectors are regulated along similar lines and are subject to the same pressures from the globalisation of R&D, production and marketing. The Swedish Medical Products Agency and Australia’s Therapeutic Goods Administration (TGA) perform equivalent functions. Comparable standards are applied in the assessment of product safety and efficacy, and a similar range of products has been approved in both countries. Both agencies take an active role in the process of international regulatory harmonisation — Sweden for example harmonising its regulation with European Union requirements.
The Swedish pharmaceutical sector as a whole was largely state controlled for much of the post-war period. In the 1960s, the government acquired ownership of two drug manufacturing firms and state ownership was further extended by the Social Democrats until a change of government in 1976. Following industry restructuring and privatisation, Astra and Pharmacia emerged in the 1980s as major research-based firms with large exports. Both companies in recent years have been swept up in a global wave of mergers, with head offices transferred overseas, and range within the group of major global drug firms.

By contrast, the Australian drug market in the post-war period was supplied by the local branches of foreign multinational companies. R&D, innovation and the fostering of export-oriented firms were of little concern to governments until a change of policy direction initiated by Labor’s Industry Minister John Button in the mid-1980s (Löfgren 1997). The differences between the two countries are reflected in the relatively high prices received historically by drug manufacturers in Sweden, by comparison with relatively low Australian prices. Price differentials between some OECD countries are still significant, but the trend is for such differences to diminish, paralleling the international harmonisation of safety and marketing regulation. Within the European Union drug prices are tending towards convergence (SOU 2000: 86, 69). Such developments have reinforced supplier claims that global integration is making current PBS pricing arrangements unviable.

There are also stark differences between the two countries in the structure of retail distribution and the profile of their drug manufacturing industries. In Australia, ‘community pharmacies’ operate as small businesses regulated by State and Federal authorities, relying on the PBS for most of their income. In Sweden, retail distribution since 1971 has been the monopoly of a state-owned corporation, Apoteket AB. This agency is responsible for the delivery to consumers of pharmaceutical benefits, a function intertwined with other roles such as the public dissemination of drug information. Until recently, Apoteket AB also had regulatory responsibilities, but the task of negotiating prices with suppliers has now been transferred to another agency. Economic liberals have long been critical of the state pharmacy monopoly, and the non-socialist Coalition government of 1991-94 initiated steps towards privatisation that were subsequently halted by the Social Democrats. A commission of inquiry in 1998 recommended deregulatory measures that included competition with private retailers (SOU 1998: 28). However, in March 1999, the government decided to retain the state monopoly with only minor adjustments. This decision reflected entrenched support for Apoteket AB, an institution that is virtually emblematic of the Swedish welfare state. (The Swedish Social Democratic government in other areas like electricity and telecommunications, and in postal and taxi services, has pursued privatisation and competition policies resolutely.)

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In terms of safety and efficacy regulation, the trend throughout the OECD until the 1980s was for state controls, exercised at arms length from suppliers, to become increasingly stringent. Higher priority is now given to business interests (particularly in countries with large pharmaceutical industries, such as the UK and the USA) with a preference for co- and self-regulation premised on ‘partnerships’ across the public and private sectors. Pharmaceutical benefits in both Australia and Sweden are integrated within these broader regulatory systems; equity and welfare objectives are intertwined with policy aims such as industry development and the ‘rational use’ of prescription drugs among consumers generally. In Australia, the PBS does not ‘simply’ ensure equity of access, but delivers a degree of market power that sustains a capacity to monitor and influence the use of prescription drugs across the population. Conversely, product safety and efficacy controls administered by the TGA cannot be entirely separated from the PBS which, in effect, provides for a second tier of safety controls. The role of Apoteket AB in Sweden is comparable. This is a commercial services provider, generating substantial government revenue, but at the same time a crucial element of the drug regulation system, remaining suffused by a public interest ethos.

The impossibility of entirely disentangling welfare from other policy objectives has made pharmaceutical benefits more entrenched than would otherwise be the case. This is particularly accentuated in the case of the PBS; if a subsidy were made available only to the very poor, or were to encompass only a narrow range of core medicines, this would have not only equity and budgetary implications but would lessen the capacity of the Department of Health to pursue the ‘quality use of medicines’ among Australian consumers.

**Pharmaceutical benefits**

Pharmaceutical benefits were introduced in Australia and Sweden in the 1950s along with child and family welfare programs, sickness insurance and various housing and education measures (Hunter 1963; Olsson 1993; Sloan 1995). The purpose was to ensure access to appropriate prescription medicines irrespective of the patient’s financial circumstances. The result was that price signals, for a period of several decades, ceased to be a significant determinant of the behaviour of prescribers and consumers.

Recent policy adjustments in both countries have been driven, first and foremost, by the rising cost of prescription drugs. On the supply side, the research-based industry is making available a stream of new, increasingly expensive drugs, many designed to enhance quality of life rather than treat recognised illnesses. On the demand side, an ageing population ensures automatic expansion of the market for many drugs.
Governments’ response has been to impose some constraints on the conditions for, or level of, subsidies, or to exclude particular products altogether. The much publicised potency drug Viagra, for example, is not currently listed on the PBS despite intensive lobbying (including unsuccessful legal action) by its manufacturer, Pfizer.

Decisions over which drugs to subsidise, and under what conditions, are fraught with controversy. This has recently been highlighted in Australia by the debate that followed the introduction of restrictions on subsidies for cholesterol-lowering drugs. Scientific and economic experts have a major influence on such decisions, but social and political judgements are an inescapable aspect of the process and in both Australia and Sweden it is the Health Minister or Cabinet that make final decisions on drug subsidies.

**Australia**

For more than 50 years, the PBS has provided equity of access to prescription drugs, minimising the risk of financial hardship ensuing from pharmaceutical expenses in cases of illness or injury (in most instances). The program was designed under Labor in the 1940s, implemented by the Menzies Government, and subsequently expanded to provide free or low cost access to most prescription drugs to all Australian residents (Hunter 1963; Sloan 1995).

PBS listing of a product means that the government agrees to subsidise its cost to the consumer (if priced above the level of the co-payment). The ‘PBS Schedule’ in 2001 encompasses ‘593 drug substances (generic drugs), available in 1,469 forms and strengths (items) and marketed as 2,351 different drug products (brands)’ (Department of Health and Aged Care 2001). This is considered by most commentators to be sufficiently comprehensive for the appropriate treatment of the vast majority of medical conditions. There is also a private market for non PBS-listed approved prescription drugs, but the PBS accounts for approximately 80% of total prescription drug sales and the private market is only rarely commercially viable. This gives government substantial purchasing (‘monopsony’) power which has been employed to extract relatively low prices from drug suppliers. For decades this price depressing effect has been the central cause of tension between drug suppliers and the government. The international industry claims that total annual savings to Australian consumers currently are in the order of $860 million (Pharmaceutical Research and Manufacturers of America 2001).

Australian consumers generally pay a proportion of the cost of prescription drugs. The subsidy to general patients is the amount (in 2001) exceeding $21.90 per prescription item, while concession cardholders pay $3.50. The co-payment is removed for concessional beneficiaries when total eligible expenditure has reached $182.00
within a calendar year. For general consumers, the co-payment decreases to $3.50 when expenditure has reached $669.70 (Department of Health and Aged Care 2001).

In total, co-payment increases have been substantial in the past two decades, with general consumers now paying the full cost of many drugs. Concessional benefits consequently make up the bulk of government PBS expenditure, representing in 1999-2000 some 80% of the total PBS expenditure of $3,488 million (Department of Health and Aged Care 2001). The program in this respect is highly targeted, consistent with the residualist philosophy of Australian welfare policy. However, the distinction between universalism and targeting is not as clear-cut as expenditure data alone may suggest. PBS listing requires a price acceptable to the government, with the effect, directly or indirectly, of depressing prices to a lower level than would apply in the absence of the scheme. Lower prices benefit consumers and tax payers generally, irrespective of whether they actually receive the subsidy for any particular prescription. Moreover, all consumers pay a relatively small maximum amount per prescription, and are also protected by safety net provisions from large expenses.

Suppliers have historically wavered between two perspectives on the PBS. On the one hand, subsidisation has delivered market growth and predictability. But on the other, the industry has always resented the scheme’s price-depressing effect. The listing process has been subject to a great deal of argument, with suppliers seeking faster, cheaper and more transparent decisions, with greater consideration given to the views of business. From the late 1980s, administration of the PBS became increasingly sensitive to the industry viewpoint, as part of the broader attempt to provide an industry-friendly environment to encourage investment and exports. Indeed, both Labor and Coalition governments have been bending over backwards to consult with the industry on PBS and other regulatory matters. At the same time, rising PBS expenditure and the aim of cost-effective and appropriate drug use have led to measures that have made the listing process more complex, notably with the introduction of mandatory economic analyses. Since 1993 suppliers must demonstrate, as a condition for PBS listing, that new drugs meet acceptable cost-effectiveness criteria. Rigorous assessment including economic analysis as a condition for subsidisation is in line with international trends, but this aspect of the PBS process continues to generate complaints from the drug companies.

It is difficult to say with any certainty whether the PBS changes of the past decade have made the program unambiguously more or less industry-friendly (or at least until the end of 2000: see the postscript below). The stridency of industry criticism would seem less to reflect real alterations to the PBS than the ever-growing economic and political bargaining power of suppliers. All in all, the PBS retains strong popular support, particularly among low-income groups and the elderly but also among
pharmacists and health professionals. The entrenched status of the program is captured by the Australian National Audit Office (1998: Part 2: 4):

industry and consumer representatives provided a generally favourable impression of the PBS ... but there were some strong criticisms of certain aspects of the listing process from certain sections of the industry ... There appeared, however, to be a general view that the PBS was fundamentally a good scheme. This was summarised by a CEO of one major multinational company in these terms: 'broadly speaking the current system of subsidies for pharmaceuticals works well; the health of all Australians is good compared to other countries where in many cases it is mainly the rich who have access to medicines.'

Finally, it is important to understand that the PBS operates separately from both the general health care system and from industry policy, notably the Pharmaceutical Industry Investment Program (PIIP) administered by the Department of Industry, Science and Resources to compensate some firms for the price-depressing effects of the PBS. Health policy is of course primarily the responsibility of State governments. Consequently decisions with respect to pharmaceutical benefits are made in relative isolation from broader health policy considerations and priorities. The drug industry argues that the costs and benefits of medicines should be assessed in the total context of health services delivery, believing such a move would often provide a rationale for higher prices (Clear 1999). This would indeed be a rational approach also from a consumer or public health perspective, but such integration cannot readily be accomplished within a health system fragmented between two levels of government and public and private providers.

Sweden

Pharmaceutical benefits were first considered in the Swedish parliament during the Second World War, paralleling similar proposals in Australia. The issue was intertwined with questions of ownership of pharmacies and the drug manufacturing industry, and pharmaceutical benefits did not eventuate until 1955 (SOU 1998: 50: 31). In that year pharmaceutical benefits were introduced as an offshoot of a comprehensive insurance system providing earnings-related cash benefits in case of sickness and other social programs, such as maternity benefits (Olsson 1993: 130-31).

From the mid-1950s, again paralleling developments in Australia, Swedish consumers had free or almost free access to a wide range of pharmaceuticals. In 1996 there was an extension of the number of conditions for which free drugs were made available. A radically different system was introduced in 1997, designed as a safety net arrangement, with higher consumer co-payments. Consumers now paid the full or a

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a diminishing proportion of the cost of prescription drugs, with four staggered expenditure steps. The subsidy is related to the total cost of reimbursable products purchased in a period of twelve months following the first purchase. Unanticipated budget overruns led to further increases in consumer payments in 1999. In that year, consumers paid the first SEK900 (approximately $177) of the cost of one or several prescriptions, after which staggered subsidies took effect. When a total expense of SEK4,300 (around $843) had been reached, the consumer was eligible to receive free prescriptions for the rest of the twelve month period (SOU 2000: 86). By Swedish standards, the changes of 1997 and 1999 represented noticeable entitlement cuts and attracted considerable public, especially media, attention.

Beyond adjustments to benefit entitlements, the 1997 reform entailed planning for the devolution of management responsibility for pharmaceutical benefits from the central government to the 24 county councils that administer hospitals and other health services. Until 2001, pharmaceutical costs incurred by these regional administrations were reimbursed by the national government. A new funding system was then to be introduced, with the cost of prescription pharmaceuticals becoming an integrated component of the general budget of regional health services providers. The rationale was to provide incentives for the monitoring and guidance by regional drug committees of the prescribing habits within health provider units and among individual doctors. Previously, medicinal drugs, funded by the central government, could have been considered a free good from the perspective of doctors and hospitals.

In contrast to the PBS, there is no specific mechanism, in either the pre- or post-1997 system, for determining product subsidy eligibility, other than the requirement that an acceptable price must be negotiated with the government (and the basic condition that subsidised prescriptions must be for the purpose of treating an illness). Swedish pharmaceutical benefits have thus been more directly susceptible to cost increases flowing from the introduction of new products than is the case with the PBS, which subjects each new product to an intricate assessment process.

Swedish pharmaceutical benefits are less universalist than the PBS in that they have allowed scope for complementary ‘private insurance’ arrangements by way of collective bargaining in the labour market. Relatively privileged occupational groups of state employees and white-collar workers have negotiated free prescription drugs (and health care) shielding them from adjustments to co-payment arrangements. To that extent, increased consumer costs for the purpose of containing government expenditure have a more direct impact on lower-income groups.

The changes of the late 1990s did not deliver the expected stability; and the whole pharmaceutical benefits system was again the focus of a major inquiry in 1999-2000.
Escalating cost increases brought on to its agenda issues such as the challenge posed by ‘lifestyle’ drugs, the possible restriction of doctors’ free prescription rights and the more extensive use of generics. The inquiry’s report, presented in September 2000, proposed the retention of a simplified safety net system with individuals in a twelve month period paying the full cost of prescriptions up to SEK1,800 (approximately $353), and a ceiling of SEK900 jointly for children in a family. Thereafter a charge of SEK40 (approximately $8.00) per prescription would apply (with another safety net ceiling taking effect later). The inquiry also proposed new procedures — along the lines of the PBS listing process, including cost-effectiveness analysis — for assessing whether drugs should be subsidised at all (SOU 2000: 86). Thus, significant adjustments to Swedish pharmaceutical benefits can be expected in the next few years. Protection against high pharmaceutical costs is not at risk, but consumers are indeed expected to respond to price signals and to carry some of the cost of prescription drugs.

All in all, Swedish pharmaceutical benefits have been subjected to considerable change in the past five or so years. By comparison, PBS arrangements have been quite stable. Part of an explanation for this difference (Australia’s federal system being another factor) is the political consensus in Sweden in support of a universalist welfare state, making it highly unlikely that changes to pharmaceutical benefits would weaken protection for middle and low-income households. In Australia, on the contrary, there is apprehension that any restructuring of the PBS would seek to target benefits to the very poor or limit subsidisation to a smaller range of drugs. This potential for political conflict in itself creates obstacles to policy innovation.

Conclusion

In both Australia and Sweden, government expenditure on pharmaceutical benefits is likely to continue to increase, with (more or less) incremental program adjustments to contain such increases. A ‘roll back’ of the welfare state in this domain is unlikely; all stakeholders, including the multinational pharmaceutical industry, accept government subsidies as indispensable. How is this strong support for pharmaceutical benefits to be explained? First, there are taken-for-granted ethical reasons for access to affordable and appropriate medicinal drugs in the case of ill health or injury, irrespective of financial resources. Secondly, in both countries the direct and indirect beneficiaries of pharmaceutical benefits encompass the entire population. Substantial entitlement cutbacks would be politically hazardous, and have not been seriously proposed in either country. And third, pharmaceutical benefits — particularly Australia’s PBS — are intertwined with other regulatory arrangements and contribute to broader policy objectives.

The Swedish system is decidedly universalist, delivering greatest benefits to those
incuring the greatest drug costs, irrespective of financial circumstances. The direct benefits of the PBS, by contrast, are now targeted predominantly to low-income households. However, as emphasised, the effect of the PBS is to deliver lower drug prices to all citizens than would be the case in the absence of this program. Moreover, all consumers pay a relatively small maximum amount per prescription, and are protected by safety net provisions from large expenses. These universalist attributes would seem to be a major reason for the entrenched status of the PBS and the absence of private insurance in this area.

A final comparative point relates to constraints and opportunities for policy innovation. Total health expenditure is around 8.5% of GDP in both Australia and Sweden, but with a significantly higher private share in Australia and consequently a lesser public capacity to shape health sector developments. Equitable access to, and the rational use of, medicinal drugs require extensive government intervention. In Australia, the Commonwealth’s capacity to undertake such interventions is weakened by two main factors: the strength of private interests within the health system (private hospitals, insurers, doctors, etc.), and the federal system of government which separates responsibilities for services delivery and funding. The PBS has been remarkably stable for 50 years, but the program is now wedged precariously between contending social and economic pressures, with limited scope for consensus-based innovation. Having to contend with strong industry and neo-liberal lobbying for extended market exchange and private insurance, those advocating social equity and rational drug use have been forced into a position of defending current PBS arrangements. The Swedish public system, on the other hand, has proven able to accommodate innovation more readily; for example, through administrative devolution designed to achieve a rational integration of the use of pharmaceuticals within the broader health system. It would seem that institutional change is more easily introduced within the Swedish unitary, public system, where there is less need to accommodate private interests. In combination with the state monopoly in the retail pharmacy sector, the public health system allows greater scope for experiments and innovations in response to the challenges flowing from developments in the pharmaceutical market. In Australia a proposal to devolve responsibility for pharmaceutical benefits to the States would most likely be seen as a means of weakening regulatory capacity and thus as a threat to social equity. Consequently, the structural features of the PBS appear largely frozen.

**Postscript: PBS developments in 2000-01**

Conflict between governments seeking to contain social policy expenditure and the ‘welfare lobby’ is a familiar feature of the Australian political landscape. When it comes to pharmaceutical benefits, however, this tension is turned on its head. Here the strongest advocacy for judicious and cost-effective use of public resources is
found among core supporters of the PBS. The Howard Government, however, has been plainly reluctant to uphold and extend regulatory controls, developed by the Department of Health and Aged Care over many years, to contain rising subsidy costs. This is well illustrated by Health Minister Michael Wooldridge’s decision in 2000 to disregard, for the first time in PBS history, advice from the Pharmaceutical Benefits Advisory Committee (PBAC) that a new drug (Celebrex) be PBS listed with particular conditions (requiring the price to be halved after the issuing of a certain number of prescriptions). Instead, Minister Wooldridge accepted a higher than recommended price, with no cap on the number of scripts issued at that price (Davies 2001). In the subsequent nine months to 30 April 2001, the taxpayer cost of Celebrex reached approximately $140 million, compared to original projections of around $40 million for the first full year (Australian Senate 2001). The Government, it would seem, has taken on board the industry’s view that the PBS must be made more accommodating to the pharmaceutical industry’s demands for higher prices.

Tensions over the PBS, building up over many years, came to a head on 31 December 2000 with the legislative reconfiguration of the PBAC and its Economics and Drug Utilisation sub-committees. Composed largely of medical experts and pharmacologists, the PBAC has responsibility for making recommendations regarding the inclusion of new drugs on the PBS. Such advice has enormous commercial, budgetary and public health implications. The Minister’s sudden and unexpected move to reconstitute the PBAC, and to appoint for the first time a de facto industry representative on the committee, marked the culmination of a long-standing campaign by the multinational drug companies against expert ‘value for money’ assessments (Henry and Birkett 2001). In a confidential background paper prepared by the Australian Pharmaceutical Manufacturers Association (APMA) for a meeting in November 2000 between the Prime Minister and APMA members located within John Howard’s electoral district, the industry stressed that it was ‘greatly concerned about membership of PBAC particularly the public hostile attitude of some members and staff to industry’ (APMA 2001). Moreover, the PBAC had recently been subjected to unprecedented legal threats and actions by firms aggrieved by recommendations not to subsidise particular products (for example Viagra).

These events have generated strong misgiving about the Government’s intentions. The dismissed Chairs of the PBAC and its Economic Sub-Committee presented the following interpretation:

A possible explanation is that [the Government] was under pressure from the international pharmaceutical manufacturers lobbying to have their products listed at higher prices on the PBS. Perhaps the PBAC is viewed as being too demanding, making recommendations that result
in prices that set 'undesirable' international precedents? (Henry and Birkett 2001: 209)

Thus the ostensible paradox of PBS advocates defending systematic cost-effectiveness controls more strongly than a conservative government is not difficult to explain. In general terms, the choice faced by governments in responding to escalating drug prices is between rigorously applied cost-effectiveness (value-for-money) assessments, in combination with effective guidance and monitoring of doctors' prescribing habits, or a winding-back of government market intervention. The first response requires that regulatory constraints on the pharmaceutical industry be generally upheld and extended, with respect to marketing (to prescribers and consumers), pricing arrangements (including encouragement of cheaper generic drugs), and subsidy eligibility assessments. This kind of response requires regulation premised on arms-length relationships with the industry. However, the philosophy now enjoying bipartisan political support is that of 'partnerships' between regulators and industry, which predisposes governments to respond favourably to industry lobbying (such as the demand that the PBAC be restructured).

PBS costs are indeed increasing unsustainably; budget expenditure in 2000-01 is estimated to reach $4,255 billion, an increase of around 22% on the previous year (Australian Senate 2001). This cost blowout is largely explained by the listing of several new products — notably Zyban (for smoking addiction) and the above-mentioned Celebrex (for arthritis) — and the escalating cost of several cholesterol-lowering drugs. Increases of this magnitude raise doubts about the viability of the PBS, and various stakeholders within the pharmaceutical policy domain are now exploring options for adjustments to the PBS. Industry lobbyists, and those wedded to the model of private health, are looking at increased consumer payments and private health insurance, perhaps in combination with a means test for the very poor. Changes in this direction would chip away at the universalist character of the PBS, and bring pharmaceutical benefits more in line with the private-public divide of hospitals and schools. Thus the former Liberal Health Minister Professor Peter Baume has recently proposed subsidisation for only a small range of life-saving drugs, with consumers paying the full cost of many currently PBS listed drugs (Birnbauer and Gray 2001).

Social equity and public health with respect to pharmaceuticals are threatened by an industry that is extraordinarily cohesive and well organised at both national and international levels. The APMA speaks effectively on behalf of the whole research-based drug industry, with a capacity to enunciate clear policy objectives. A former APMA executive director, Pat Clear — the very same individual appointed to the PBAC by Minister Wooldridge in 2001 — has made plain the industry's strategic objective:
There must be a recognition that good healthcare has a price. Without a price, there is no value. The Australian attitude that healthcare must be free has taken four decades to evolve, and may take another generation to change. (Clear 1998: 5)

In attempting to realise this objective, the APMA is backed strongly by overseas and international drug industry bodies. The association organising research-based drug companies in the USA, Pharmaceutical Research and Manufacturers of America (PhRMA), has recently included Australia on a ‘watchlist’ of countries considered hostile to multinational pharmaceutical industry profitability. The primary reason for this is the price depressing effects of the PBS, said to unfairly subsidise Australian taxpayers at the expenses of the multinational pharmaceutical industry (Pharmaceutical Research and Manufacturers of America 2001).

Any Australian government will find itself squeezed between the imperative of reining in PBS cost increases, industry demands for ‘world parity prices’, and consumer and health professional expectations of equitable access to appropriate prescription drugs. The events of the past year, however, signal ominously a shift of priorities in favour of ensuring an increasingly ‘business-friendly’ regulatory environment.

Endnote


References


