Australia's PBS: the wrong looking glass

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The Government should change its frame pf reference for viewing the Pharmaceutical Benefits Scheme, argues Ian McAuley. That could well lead to genuine savings.

Until recently, most war combatants' deaths have not been from the immediate trauma of arrows and bullets but from disease. That largely changed during the conflicts of 1939-1945 with the use of sulphonamides ('sulpha' drugs) and penicillin — the wonder drugs of the era. Because infectious diseases were also the major civilian causes of early death, in the post-war years there was a huge political demand to make these expensive drugs widely available.

In Australia the Curtin Government, anticipating the post-war demand for pharmaceuticals, passed the *Pharmaceutical Benefits Act* in 1944, which provided for free Commonwealth-approved prescription medicines. The Pharmaceutical Benefits Scheme (PBS) would not materialise for another four years, however. The Australian Branch of the British Medical Association successfully challenged the Act on the basis that the Commonwealth had no constitutional power to spend money on medicines. Not until after a referendum, further legal challenges by the British Medical Association, a campaign of non-compliance by the medical profession and further legislation, was the PBS finally established in 1949.

Later in 1949 Labor lost office to the Menzies Government. Although the Liberal Party was not enamoured by national health schemes, they dared not dismantle the PBS, and were quick to claim it for themselves. The PBS was, and still is, very popular with the Australian electorate.

Over 56 years it has grown. In its first year Commonwealth expenditure on the approved 139 PBS drugs was £149,000; in 2005 prices that's only about $5.8 million, or around 75 cents a head. This year the PBS is budgeted to cost $5.8 billion — a thousand-fold increase — or around $290 a head. Projections by the Commonwealth Treasury (in the Commonwealth's *Intergenerational Report*) suggest that by 2041 PBS expenditure could rise to around $3000 a head.

There are many reasons for this growth. The conquest of infectious diseases resulted in our living long enough to be assailed by other diseases — particularly heart diseases and cancer. Lifestyles changed and people's expectations of medical care changed; pharmaceutical therapy extended from preserving life to improving people's conditions and to family planning. Apart from the medical-induced growth in life expectancy, our population aged as immigration slowed. Following the Thalidomide disaster in the 1960s new regulations resulted in more extensive and expensive trials before new drugs could be brought to market, and following the Vioxx problems, the cost of new drug development could rise further. As the price of the original antibiotic wonder drugs fell away, new and much more expensive wonder drugs have come onto the market.

Here come the co-payments

For ten years the Menzies Government sustained the PBS as a free system before introducing a five-shilling co-payment in 1960 — around $5 in 2005 prices. Significant co-payments first appeared in 1986, when the general patient contribution was raised to $10.00, equating to about $20.00 in 2005 prices, and it remained at about the same real level until this year when it rose to $28.60.

The Commonwealth is clearly worried about the cost of the PBS. In an attempt to curb budgetary outlays it has not only increased co-payments, it has also introduced a patient contribution for brand-name prescriptions where a generic equivalent drug is available, and it is generally tightening prescribing guidelines. The Commonwealth sees reining-in PBS outlays as an important policy objective, most recently articulated in the 2005 Budget:

"In particular, expenses for the Pharmaceutical Benefits Scheme increased by 11 per cent in 2003-04, reflecting higher general demand for health services — an effect that will be compounded through demographic change. The increase in PBS patient co-payments, the mandatory 12.5 per cent price reduction for generic drugs as well as the raising of the Medicare Safety Net thresholds are directed to returning healthcare to a sustainable footing so that future generations can also enjoy high quality health services." (Budget Paper #1.)

Is there cause for concern? I won't provide a categorical answer to that question; rather my intention is to present different perspectives on the PBS because the Commonwealth's perspective is particularly narrow.

Re-framing

Responses to questions of public policy are influenced by the way in which those questions are framed. For example, if the problem of terrorism is cast in a military frame we tend to direct our attention to military solutions; if the question is cast in a social frame we tend to think about how the conditions that give rise to terrorism could be changed.

To quote George Lakoff of the progressive Rockridge Institute think-tank:

"Frames are mental structures that shape the way we see the world. As a result they shape the goals we seek, the plans we make, the way we act and what counts as good or bad outcomes of our actions. In politics our frames shape our social policies and the institutions we form to carry out those policies." George Lakoff, *Don't think of an elephant: know your values and frame the debate*, Chelsea Green 2004.

In relation to the PBS the Commonwealth's frame is a budgetary one and it is about one component of health-care costs only. Such a frame channels one to the conclusion "we must do something to rein in the cost of the PBS". There are other frames, however, which can lead us to more productive ways to think about the PBS.

First frame — what's the problem if we do spend more on the PBS?

Since 1949 our consumption patterns have changed dramatically. We are spending much more on travel, wine, sound recordings and many other goods, but we don't see this as problematic; rather, many would see this as the success of technologies and of marketing.

Similarly, there is no reason for seeing rising expenditure on pharmaceuticals as problematic. Pharmaceuticals are subject to rigorous cost-benefit analysis by the Commonwealth's Pharmaceutical Benefits Advisory Committee (PBAC) — an exemplar of the process of scrutiny for public value. No pharmaceutical makes it onto the PBS unless its benefits exceed its cost.

This is not to say that all drug use is beneficial; there is inappropriate prescribing, hoarding and other improper use of pharmaceuticals. And there are cases where non-pharmaceutical treatments would be more cost-effective than pharmaceuticals. But this is a case for extending the cost-benefit approach of the PBS to other therapies rather than suggesting the PBS is too costly.

Also, the Commonwealth's tables in the *Intergenerational Report* are simply projections of current trends. Projections are not predictions. Using Treasury's growth factors we could drive their projections to absurdity, showing that by around the year 2200 our entire national income will be devoted to the PBS! Most products go through phases of rapid market growth followed by a long-term levelling; there is no reason to expect pharmaceuticals to be any different.

Some of the recent growth in PBS expenditure results from once-off factors, such as liberalisation of the income limits for self-funded retirees to qualify for a Seniors Health Care Card, increased use of private hospitals (which use the PBS for patients' medications), and the tendency for public hospitals to discharge people earlier, resulting in their substituting PBS medications for hospital medications. These last two factors remind us that changes in program outlays can result from re-classifications of expenditure or from cost-shifting.

Second frame — there's more to economics than the Budget

Outlays on the PBS should not be confused with our national expenditure on pharmaceuticals. The PBS pays for part of some prescription medications. It does not pay for:

- pharmaceuticals used in public hospitals
- private prescription medications (approved pharmaceuticals but not subsidised under the PBS)
- prescription pharmaceuticals with a retail price below the co-payment threshold
- non-prescription pharmaceuticals available only in pharmacies (Schedule 2) and those available only from a pharmacist (Schedule 3)
- medications more freely available, such as analgesics and other products sold in supermarkets

In fact, the Commonwealth covers only *half* of Australians' expenditure on pharmaceuticals — a point one would miss if guided by publications such as the *Intergenerational Report*.

Treasury officials and their political masters are narrowly focused on budgetary outlays. If they were concerned with national expenditure on pharmaceuticals they would consider all expenditure — not just the Commonwealth's budgetary outlays. At the cost of pointing out what should be obvious, but which escapes the attention of the Commonwealth, consumers' outlays on health care come both from their taxes and their own pockets in direct transactions.

The Commonwealth appears to be callously indifferent to consumers' direct expenditures. For Schedule 2 and Schedule 3 pharmaceuticals, and for prescription pharmaceuticals priced below the $28.60 co-payment, consumers are forced into a highly protected and uncompetitive market. The retail pharmacy industry has been largely bypassed by national competition policy; it bears more resemblance to the high-cost tariff-protected industries of the 1950s than to any industry one may expect to find in a first-world country. It is protected by restrictions on price advertising, location restrictions and by ownership restrictions. (For an excellent description of pharmacists' practices see Nicola Ballenden's *Consuming Interest* articles, *Protected species: the community pharmacist*, Autumn 2005 and *The pharmacy: why it can't stay a closed shop*, Winter 2005.)

If the Commonwealth was really concerned with the nation's pharmaceutical bill it would bring to bear the force of competition policy on the retail end. The Commonwealth's failure to do so confirms that its concern is a narrow bookkeeping one rather than a wider economic concern with the nation's pharmaceutical bill.

If all the Commonwealth cares about is its budgetary outlay, while leaving other outlays to a high-cost distorted market, it's an abrogation of economic responsibility. Cost-shifting is not sound economic management. At best it simply shifts the burden of payment, from the collective to the individual. At worst it results in serious distortions with costly consequences. Research by Professor Jeff Richardson of Monash University shows that when people are faced with difficulty in paying for pharmaceuticals they make unwise choices. They will pay for drugs with clear and immediate benefits, such as pain killers, but they are likely to forgo paying for drugs with unseen and unfelt effects, such as anti-hypertensive medications. The consequences of such decisions can be costly.

As health economists point out there are good reasons for publicly funded health-care schemes. There are also good reasons to have some co-payments, and even more compelling reasons to bring to bear the discipline of market competition in those sectors where the consumer is not supported by public programs. But there is no excuse for policy neglect. A recent *Economist* editorial on health care criticised the narrow budgetary obsession of governments:

"Rather than focusing on how the money is raised, reformers should worry about how it is spent. Health-care expenditure is rocketing not just because demand is rising but also because health care markets work badly." *The Economist*, 7 August, 2005.

Third frame — think about health care, not drugs.

For the last twenty years Australian governments have been talking about policy reform. Previously public budgets were concerned with inputs, but the essence of the reforms has been to allocate funding to programs, which in turn should be centred on outputs and outcomes.

At least that's the rhetoric. In health care we find government programs, Commonwealth and State, are still organised on input lines. The three dominant programs — the PBS, Medicare and hospitals — are all concerned with inputs into health care.

It made sense in 1949 to have a specific pharmaceutical program. Politically there was no way in which the Commonwealth could establish a comprehensive national healthcare scheme such as the UK's system; another quarter century would pass before Medibank and

Medicare came to fruition. Also there were good technical reasons for separating pharmacy from primary care. Medical practitioners made house calls, pharmacists worked in mini-factories preparing many medications from basic ingredients with mortar and pestle.

In 2005 it still makes sense to have an evaluative mechanism such as PBAC and to use the Commonwealth's strong purchasing power to counter the power of the multinational pharmaceutical firms. But sustaining a pharmaceutical program separated from other aspects of primary care makes no sense. We are living with the legacy of a program structure that is long past its use-by date.

There have been proposals to bring all health-care programs under one tier of government — Commonwealth or State. Few would dispute the desirability of consolidation. Yet simply bringing programs under one tier would not, in itself, achieve integration. The two main Commonwealth programs, Medicare and the PBS, operate under different criteria and with radically different regimes of co-payments.

While governments should be concerned about total health-care expenditure there is no reason why they should be particularly concerned about the components of this expenditure. In Australia, as in other countries, pharmaceutical treatments are displacing other forms of treatment; in many cases they provide a low-cost substitute for hospitalisation and they often have the economic benefit of allowing people who would otherwise be incapacitated or in need of constant care to lead independent, productive lives. It is natural that pharmaceutical expenditure should rise faster than other aspects of health expenditure.

If the Commonwealth could live by its own ‘reform’ rhetoric it would not bother with a PBS program. Rather, its concern would be on health care as a whole. It may subdivide its health-care responsibilities into programs but these subdivisions would be along consumer lines. It may use age/demographic divisions — children, youth, aged — or it may divide among people’s conditions — acute, chronic, occasional.

In this article I am not advocating a specific system design; rather my intention is to point out that at present we do not have a consumer-based system because the Commonwealth’s frame is still concerned with inputs rather than outputs and with budgetary costs rather than economic resource allocation. In fact we don’t even have a health-care system, simply a fragmented set of input-based programs. While we have such a structure the possibility of serious policy concern with the costs and benefits of health care will be overshadowed by alarmist budgetary projections such as those in the *Intergenerational Report*.