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*How do decisions on the listing of
pharmaceuticals influence health and health
services in Australia?*

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First, it is necessary to examine some relevant Australian assumptions about health.

What are health outcomes?

What are often called 'health outcomes' are actually 'illness outcomes'. Many medical practitioners, trained to detect and treat episodes of illness, often become interested in people only when they become ill and generally lose interest in them once they become well again. Health outcomes encompass more than survival rates – unless they include some assessment of functional capacity, the societal consequences of disabling chronic or congenital conditions such as schizophrenia, rheumatoid arthritis or cerebral palsy will be underestimated¹. So other measures – disability adjusted life years (DALYS), potential years of life lost (PYLLS) and quality adjusted life years (QALYS) have been developed to allow consideration of relevant aspects of illness apart from survival. Health outcomes should also address quality of life (QOL) for which many scales of measurement have been, and continue to be, developed.

The quantity of existence has increased during the 20th century, the average life span in Australia increasing from about 57 years in 1900² to 75.4 at birth for boys and 81.1 years at birth for girls in 1996³. Quality of life has not kept pace with quantity⁴. Infectious diseases have been replaced in Australia by degenerative and chronic diseases, many of which require drug therapy for symptom relief and/or for modification of the main features of the illness (see below).

How Australia has become healthier

Attitudes

Some Australians seem to believe, mistakenly, that drugs alone will fix most things that are wrong with them.

Dependence on pharmaceuticals rests on complex human assumptions and reflects complicated human needs. There is a wish, sometimes unstated, by many humans to live indefinitely. This is the underlying basis of some medical research programs (eg the 'war against heart disease' or the 'war against cancer') and is a distressing but logical result of extreme Cartesian thinking which regards the human as a machine, the parts of which only have to be repaired for it to run forever. There is a reluctance on the part of some, among them some registered carers, to

discuss or to face the realities of universal human mortality and the consequence of those realities⁵.

The system which underpins much drug treatment is a variant of the older system of allopathy, the ‘treatment of disease by ... inducing an opposite condition’⁶. It defines many drugs by what they are against. So there are antiarrhythmics, antiemetics, antinauseants, contraceptives, antibiotics, anaesthetics, analgesics, antimycotics, antidiarrhoeals, antispasmodics, antacids, antihypertensives, beta adrenergic blocking agents, calcium channel inhibitors, antiangina agents, anticoagulants, fibrinolytic agents, antianxiety agents, antipsychotic agents, antidepressants, anticonvulsants, anti-inflammatory agents, antirheumatoid agents, antithyroid agents, antiseptics, antineoplastic agents, antisera, antivenoms, antitussives, decongestants, antihistamines, antiallergy preparations, anticholinergic drugs, spermicides, antidotes. All are defined by what they oppose. The names of the groups indicate a way of thinking, as some of the groups could easily be described differently.

History of improved outcomes

The greatest contributions to good quality increases in human longevity came in the 20th century, not from drug therapy nor from conventional ‘medical service’ arrangements, but from the application of public health measures⁷. For example, the mortality from tuberculosis was diminishing dramatically long before there was any specific treatment available for that infectious disease⁸ (see Figure 1).

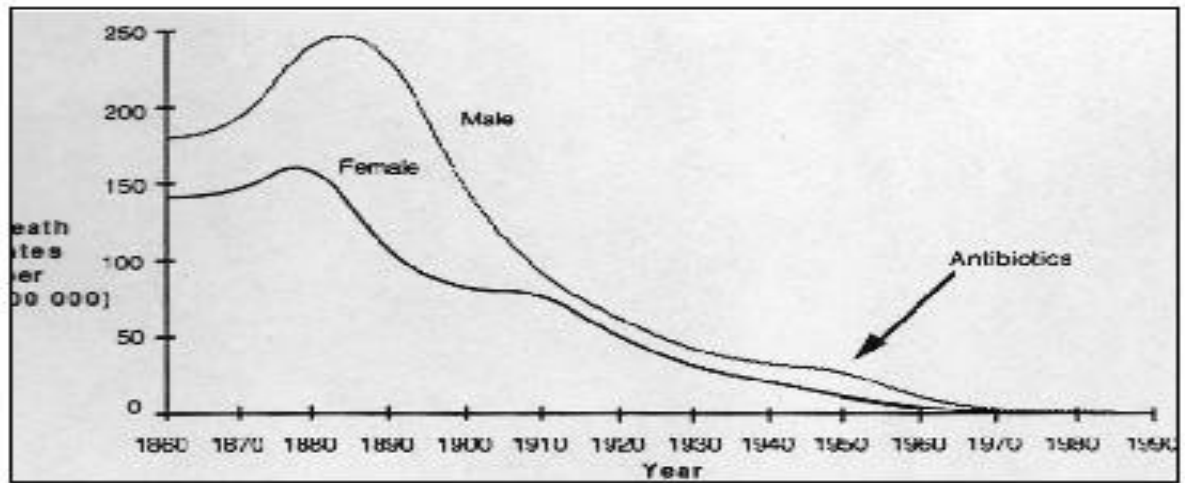


Figure 1. Tuberculosis, Australia - age-adjusted mortality rates per 100 000 population per year, 1860-1988

The same is true of many other infectious illnesses. Much of the increase in longevity in the early years of the 20th century was due to a reduced burden of infectious diseases. Many developing countries today would derive greater benefit in terms of extra years of quality life gained from the application of principles of sewerage, drainage, rubbish removal, water provision and purification, immunisation, personal hygiene, better family planning and improved nutrition than they would from the treatment of disease once established, and particularly more than they would get from an investment in increasingly expensive tertiary care medical services. It may be cheaper, for example, for some industrialising nations to evacuate sick people than it would be to provide and maintain expensive services locally. Much of the extra benefit that would accrue would be to the very young and there would be a flow-on need for extra food, extra housing, extra services, extra schools and extra paid employment to cater for those who had not died prematurely, to some of which provision the survivors would be able to contribute.

The major increases in quality of life were in place by the mid-20th century. Since then, drugs and better technology have each played an increasing part in extending life yet further^{9,10} – but quality, since about 1960, has not kept pace with quantity of life¹¹.

What drug therapy has done (apart from conferring important symptom relief and so improving quality of life) is to confer *extra* benefit, over and above that gained from earlier public health measures. In an increasing number of instances (eg, insulin, antibiotics, specific vitamin treatment or specific hormone therapy) drug therapy has been of great importance to individuals for whom it has altered health outcomes. The public has learned to trust and depend upon drugs, and there is often a belief that a ‘magic bullet’ will be available¹² for every ill with a consequential tendency to devalue personal responsibility for health in favour of the use of drugs to overcome the often predictable effects of personal lifestyle choices.

Drugs and health outcomes

Many drugs prolong and improve life by altering the course of illnesses^{13,14}. It was not possible to make this claim until relatively recently. Before this, drugs were mainly used to improve the quality of life – specifically for comfort and for symptom relief – but pharmaceutical drugs have been used increasingly during the 20th century to alter the natural history of some illnesses.

However, a recent assessment of the major medical advances of the last millennium¹⁵ listed just three of the ten advances as being drug-related – the discovery of anaesthetics, the development of chemotherapy (drug treatment) and the development of the contraceptive pill. One of these epochal events occurred in the 19th, while only two occurred in the 20th century. Another publication¹⁶ suggests that only four of the ten major medical discoveries of the past thousand years have been made in the 20th century – and then in the first half of that century.

Selected examples of major effective chemotherapy include the use of drugs for hypertension (see below), antibiotics to treat infectious disease¹⁷, drugs for viral disease¹⁸, use of diuretics¹⁹, vaccines to prevent infectious disease^{41,42,43,44,45,46}, addition of fluoride to drinking water to prevent dental caries^{20,21}, insulin for diabetes^{22,23}, aspirin as a preventive²⁴, drug therapy to minimise or prevent osteoporosis^{25,26}, other hormone²⁷, mineral and vitamin²⁸ replacements for specific proven deficiencies, drugs for congestive cardiac failure²⁹ (although doubt was thrown on the role of digitalis by Mulrow et al³⁰), drugs for convulsive disorder³¹, and many more. The Pharmaceutical Benefits Advisory Committee seeks evidence of efficacy, among other things,

before recommending the listing of any drug as a benefit. Therefore, one would expect all listed drugs to be 'efficacious'.

Drugs either confer some basic advance (eg, insulin or Salk vaccine³²) or give marginal advantage (eg, a new diuretic which allegedly causes less tubular potassium loss) or are similar to drugs already listed. These latter are sometimes referred to as 'me too' drugs³³. Most pharmaceutical companies will promote that company's products as being a major advance, but such promotion is not always justified.

An example of effective chemotherapy is the treatment of hypertension. Drug treatment has been shown to improve health outcomes in people with hypertension,^{34,35,36,37,38,39,40,93}. Those having drug therapy have fewer vascular catastrophes, and the effect is related quantitatively to the initial level of the blood pressure. So people with the highest original levels of blood pressure get the most dramatic benefits from drug therapy and have the highest incidence of vascular disasters if left untreated. Those with lower levels of diastolic hypertension get less, but still significant, relief from drug therapy and have fewer, but still an excess of vascular disasters if untreated. Conversely, cessation of treatment or non-compliance results – in subsequent elevation of blood pressure and a return of untoward outcomes.

A different class of effective chemotherapy is the use of vaccines to prevent infectious disease. Smallpox has been eliminated world wide as a result of vaccination⁴¹ – the first disease to be eradicated totally. Bulbar poliomyelitis is not now seen in communities using effective immunisation⁴², (Figures 2 and 3) nor are the consequences of rubella in pregnancy.

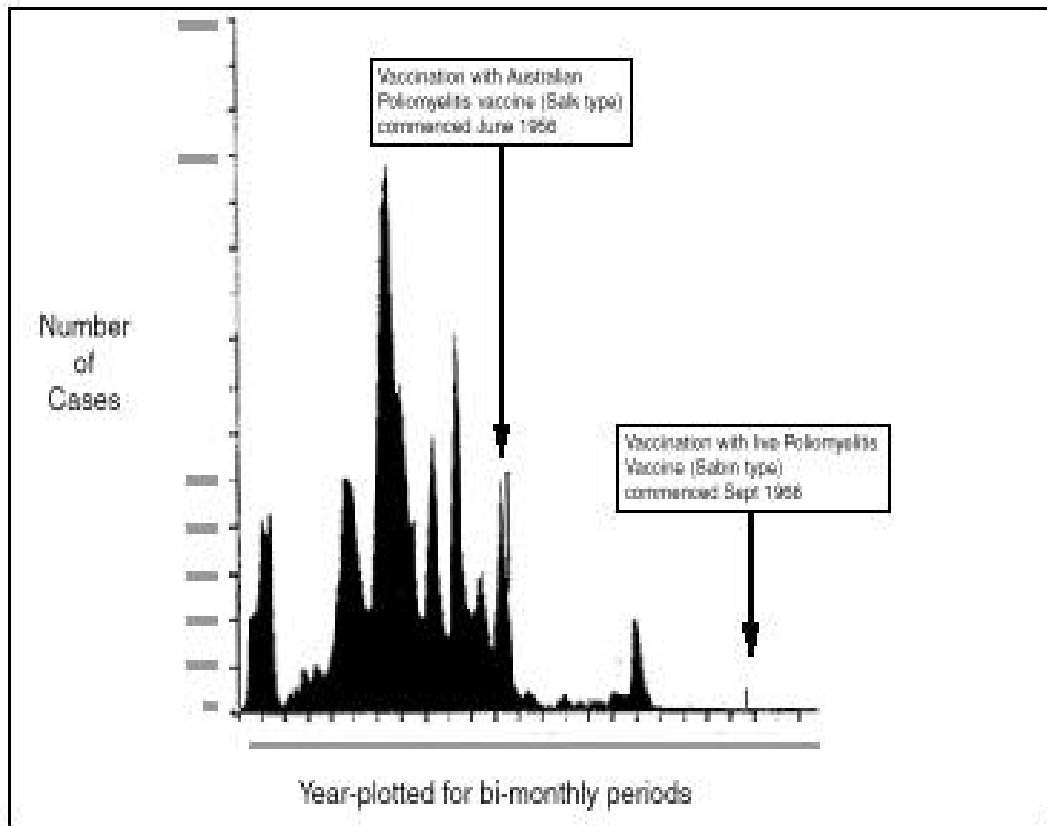


Figure 2. The impact of polio vaccine on the incidence of poliomyelitis in Australia

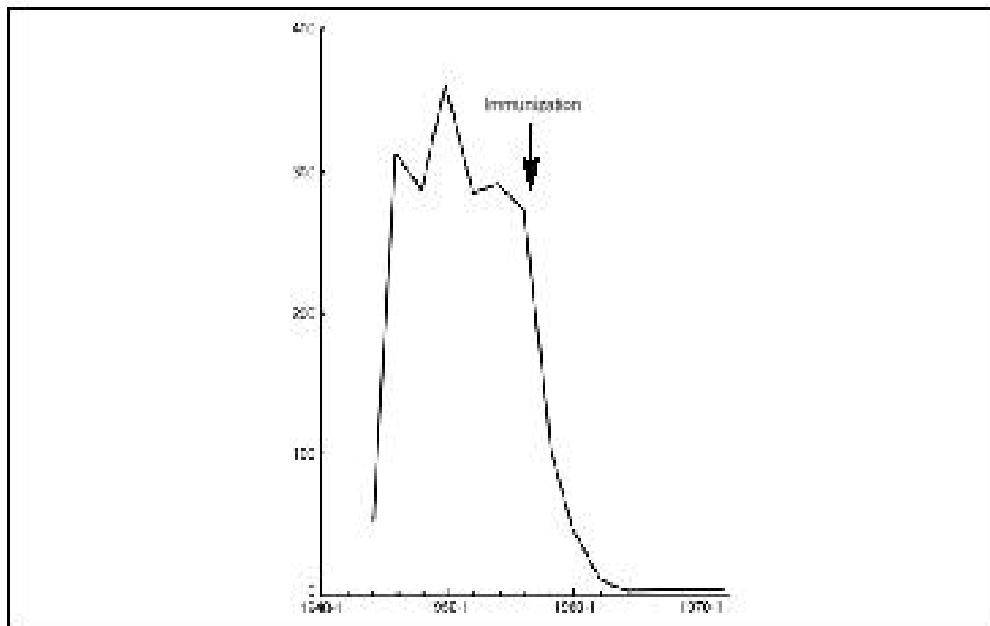


Figure 3. Poliomyelitis: mean annual notification rates (per million persons under 15); England and Wales

The clinical complications of diphtheria have gone⁴³; tetanus is almost gone and the incidence of pertussis has reduced markedly in Australia since the introduction of Hib immunisation⁴⁴.

Measles vaccine is effective⁴⁵ as is rubella immunisation of young women and immunisation for hepatitis B⁴⁶. Vaccine development is being pursued for diseases such as AIDS and malaria and vaccines are available for specific use in those exposed, or likely to be exposed, to other diseases.

Some chemotherapy for cancer is effective (although some forms of chemotherapy also affect adversely the quality of life of those taking the therapy⁴⁷).

The Pharmaceutical Benefits Scheme (PBS)

Pharmaceutical benefits were first made available federally for war veterans in 1919 under the Repatriation Pharmaceutical Benefits Scheme and later for all people under the *Pharmaceuticals Benefits Act (1944)*, disallowed subsequently by the High Court of Australia⁴⁸.

The Commonwealth of Australia unequivocally acquired power to provide pharmaceuticals to all its population when an amendment in 1946 inserted placitum XXiiiA into s51 of the Constitution⁴⁹. Before then, the provision of pharmaceuticals had been constitutionally a matter for State governments. The provision of pharmaceuticals remains the responsibility of States in those institutions such as public hospitals which are run by the States. The States also have responsibility for the registration of the medical and dental practitioners who prescribe drugs for patients and the pharmacists who dispense the drugs and later claim repayment from the Commonwealth.

From 1 June 1948 drugs in the British Pharmacopoeia were made available to pensioners in Australia and 139 drugs described as 'life saving and disease preventing'⁵⁰ were made available for other Australians. In August 1999 the Pharmaceutical Benefits Scheme (PBS) applied to Australian citizens and to visitors from the United Kingdom, Ireland, New Zealand, Malta, Italy, Sweden, the Netherlands and Finland⁵¹. It covered '565 drug substances, available in 1385 forms and strengths and marketed as 2058 different drug products. Restrictions applied to 672 of the items, 270 of which required an authority prescription.'⁵² Some drugs available under sections of the National Health Act are the subject of special arrangements; some emergency drugs are available for doctors' bags and some drugs have other special conditions for

availability. The situation now is a far departure from the situation applying at the time of introduction of the PBS, many of the extensions being the result of promises made before elections.

Each quarter the relevant Commonwealth Department prints a new list of drugs for which subsidy is available⁵¹. Those drugs are then dispensed by a registered pharmacist at a low⁵³ negotiated price and money is later recovered from the Health Insurance Commission by the pharmacist. While it is possible for a practitioner to prescribe any other drug not on the list of subsidised drugs⁵⁴, the patients pay any premium amount over the negotiated price of the designated substance. In addition, the extra expenditure does not count in computations under the safety net arrangements (see below). Non-prescription drugs are slated to be liable to GST⁵⁵ from 1 July 2000. About 70 per cent of Australians have used a therapeutic drug in any two-week period⁵⁶, increasing with age, more in women, half of the drugs on prescription – of which 75 per cent qualify for benefits under the PBS⁵⁷. Some commercial organisations (eg MIMS^{58,59}) publish compendia with descriptions of all medications available, including details of their availability under one or more pharmaceutical benefit schemes.

The full process for the listing of any substance is shown graphically in Figures 4⁶⁰ and 5⁶¹.

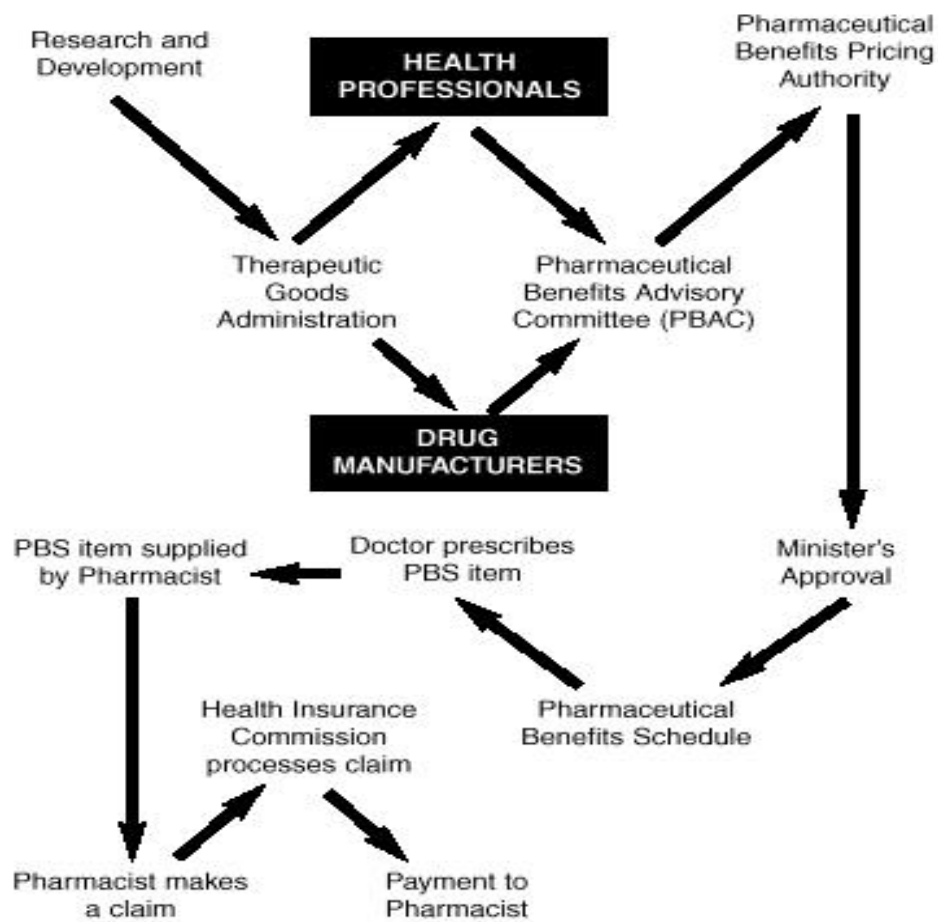


Figure 4. The Birth of a Pharmaceutical Benefit⁶⁰

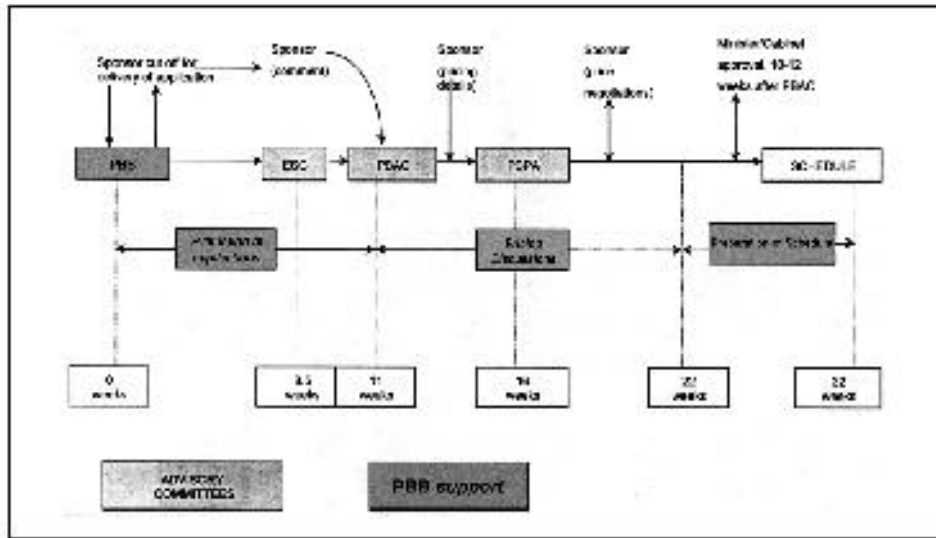


Figure 5. Steps in the listing process

The number of prescriptions by type of service is shown in Figure 6. This demonstrates that most prescriptions are concessional, that the next most frequent category is ‘under co-payment’, and that other categories account for only small percentages of prescriptions.

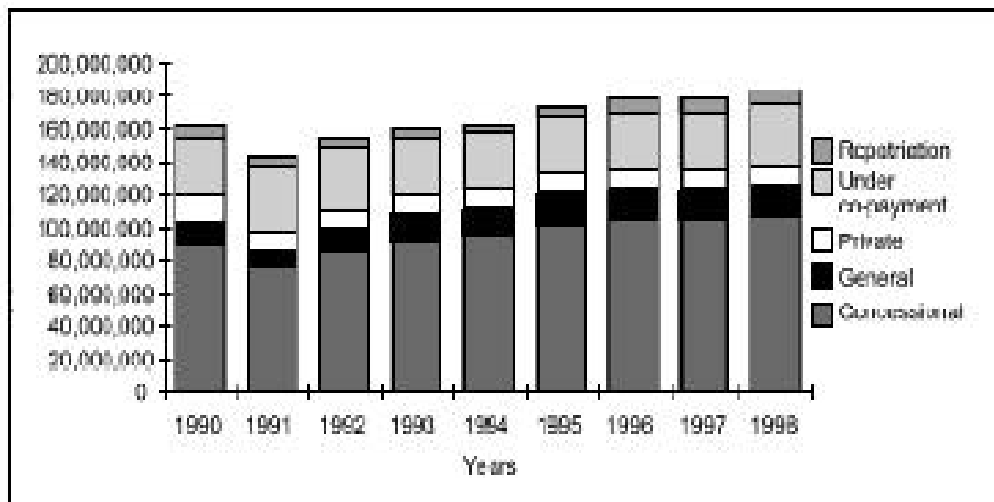


Figure 6. Number of prescriptions by type of service⁶¹

The effect of PBS listing on drug use

Evidence that PBS listing leads to more frequent use falls within the purview of the Health Insurance Commission and the Department of Health and Aged Services ('The Department'). The Secretary of the Drug Utilisation Sub-Committee of the Department wrote⁶² that PBS listing is required for drugs to have a viable market in Australia. He said '... The Government provides a substantial level of subsidy on these drugs for although the general co-payment is \$20.30 the concession co-payment is only \$3.20 and their safety net co-payment ... is zero (see below). Concession category prescriptions where the patient contribution is either low or non-existent constitute about 85 per cent of PBS prescriptions.' He said further '... drugs that receive marketing approval and achieve low levels of use in the community and then get PBS listing and a marked increase in sales. Subsequently, and for various reasons, some of these drugs are then deleted from the PBS and the usage drops from the moment the advance notice of deletion is circulated to doctors and then effective from the deletion date, usage returns to the original low level of use pre-subsidy.' He drew attention to a community database maintained by the Department⁶³ which tracks the use of particular drugs. His view was echoed by Professor David Henry, a significant Australian figure in this area⁶⁴.

It is of interest that on a matter so basic and so important, there is so little hard evidence available publicly.

Most pharmaceutical manufacturers are keen to go through the processes involved in getting their drugs approved for listing. Some commence legal action if listing is refused⁶⁵. They then use PBS listing to underpin advertising and other promotions to capture a larger share of the market for the drug, usually directing their promotions to those who prescribe the drugs rather than to those who will be the end users. The patterns of use of particular drugs are likely to alter over time, partly as a result of drug company promotional activity, partly as a result of altered understanding^{66,67}. Typical changes over time in choices of drugs in clinical situations where choices exist are shown in Figures 7⁶⁸ and 8⁶⁹.

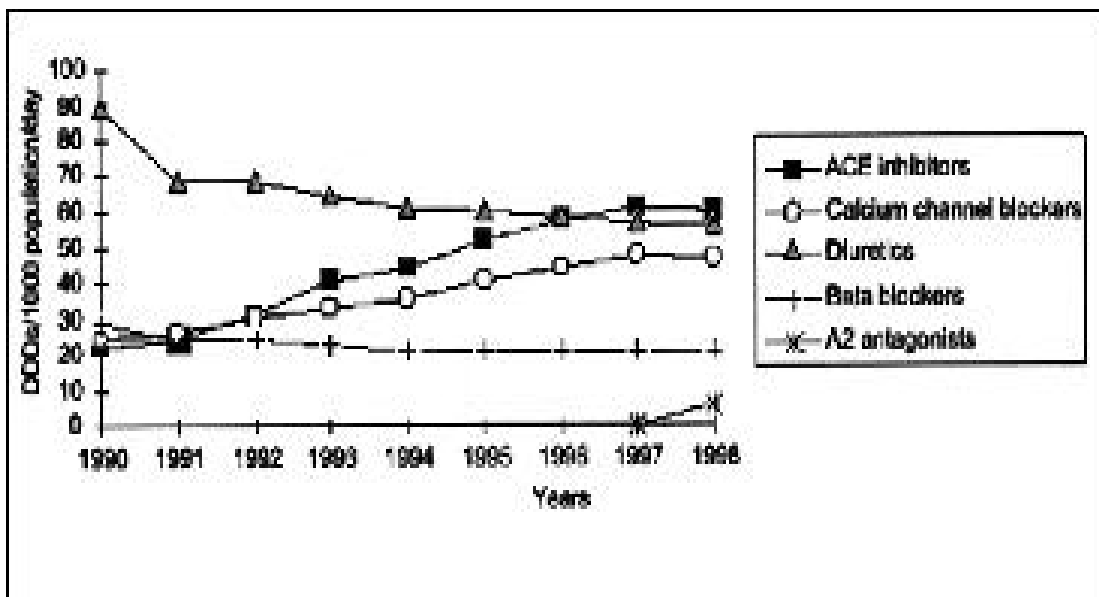


Figure 7. Drugs used in the management of hypertension⁶⁸

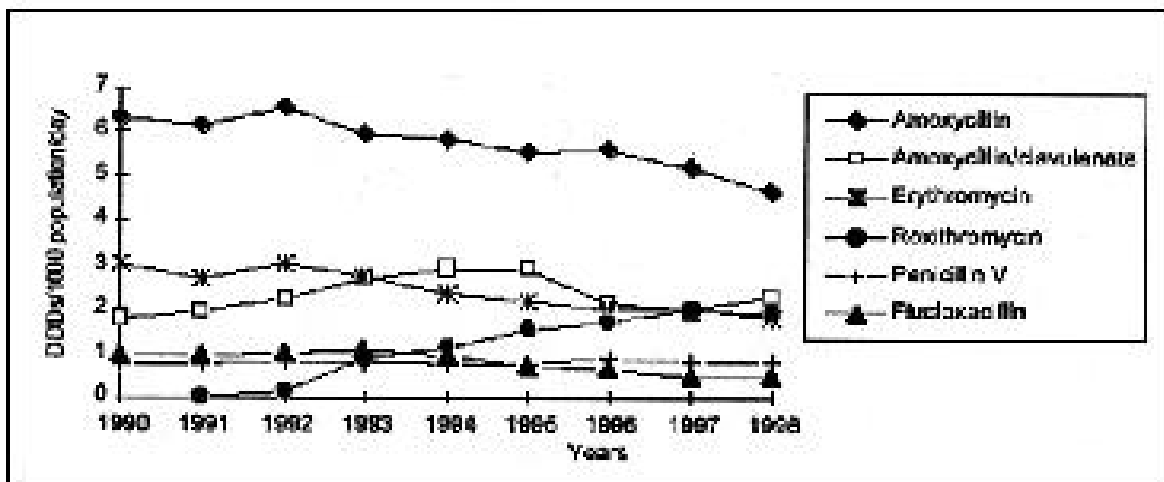


Figure 8. Penicillins and macrolides⁶⁹

Costs of pharmaceutical subsidy

Because pharmaceutical subsidy is often available in Australia, individual circumstances have been less limiting in judgments to use drugs or not than might otherwise have been the case (but see below in relation to the effects of co-payments).

Pharmaceutical Benefits schemes have become increasingly expensive. It has been estimated that the NHS in the United Kingdom spends about 10 per cent of its total budget on drugs⁷⁰ and Australia 12 per cent⁷¹ (and Australia spends a greater percentage on GDP on hospital and medical services than the UK spends on the NHS). Additionally, in Australia, there is a large expenditure, estimated to equal the private expenditure on prescribed pharmaceutical drugs in Australia, on (largely unregulated) complementary and alternative medicines^{72,73,74,75,76,77,78,79}.

In 1998/99⁶² the PBS dealt with 128.9 million benefit prescriptions – an increase of 3 per cent over 1997/98. The cost to government of these prescriptions plus other miscellaneous services (doctors' bag provisions and other special arrangements) was \$A3069.7 million – an increase of 10 per cent over 1997/98. The total cost of the PBS, including patient co-payments, was \$A3671.0 million. The average cost to the Government per prescription increased from \$A20.31 in 1997/98 to \$A21.68 in 1998/99. Average PBS dispensed price as a percentage of average weekly earnings increased in 1998/99 to 3.65 per cent from 3.47 per cent in 1997/98.

The average dispensed price of PBS medicines in 1998/99 was \$A26.35 compared to \$A24.88 in 1997/98.

It took about 40 years for the PBS to cost the Commonwealth a billion Australian dollars annually but in the next 20 years the cost increased again to over 3 billion dollars annually. The cost continues to increase in spite of strategies designed to control cost.

The cost of the scheme to Government is ‘prescriber-driven’ in that exact expenditure becomes apparent only at the end of any accounting period. Prior to that time, all that can be made are careful guesses (historical and fairly accurate) as to likely costs. Taxation relief is given to taxpayers for net amounts expended on medication and some private health funds cover some of the costs of pharmaceuticals.

A PBS policy is that ‘drugs with equal efficacy should be awarded the same price’⁸⁰ so a cheaper drug will set the price for a group if effects are equivalent. Companies go to great lengths to establish points of difference, arguing often that such differences mean that the drugs are not equivalent. Governments and government committees look generally at the equivalence of the active substance, not of the excipient or of the particular formulation.

A general rule in many areas of policy and activity (not just drugs) is that costs are nearly always associated with benefits – and vice versa. It is the balance between costs and benefits that matters most, whether one considers pharmaceutical cost and benefit, economic cost and benefit, or a combination of both. If one looks only at one or other of the two elements, cost and benefit, one is likely to obtain an incomplete and skewed picture. In some ‘cost saving’ exercises it seems that ‘experts’ look mainly at one element without considering the adverse clinical effects of reducing drug availability for those who need it.

Special arrangements (called the ‘safety net arrangements’) exist whereby many individuals pay less for long-term use of pharmaceuticals⁸¹. This is achieved by provisions that provide for no charge or a concessional rate (\$3.20 in late 1999) to apply when people have exceeded a certain level of expenditure (\$166.40 for concessional recipients and \$620.30 for others as at November 1999⁵³) for the calendar year on listed drugs. So, although pharmaceuticals continue

to cost money to general recipients, the amount is less than would be the case without the special arrangements. Pensioners pay nothing once the 'safety net' amount is reached in any calendar year. Safety net arrangements account for 79.3 per cent of the total government cost of PBS prescriptions. That any co-payment at all may have undesirable social or therapeutic consequences is discussed below.

Some patients get into medical trouble because they receive too many drugs⁸², because of drug interactions, or because they do not take the prescribed medication as ordered for them⁸³.

Effects of reduced subsidy arrangements on drug use

Liebowitz and co-workers⁸⁴ have suggested that those in the United States with more generous insurance use more drugs, suggesting either that they are relatively over-medicated or that others receive relatively too little medication. In Australia the situation seems to be similar; Australians entitled to concessions for pharmaceuticals represent 39 per cent of the population but receive 64 per cent of the prescriptions⁸⁵.

Some authors have found that financial controls on subsidised drug prescribing, or the introduction of co-payments, caused the use of discretionary drugs (defined by them as analgesics, non-steroidal anti-inflammatory agents, cough and cold products and skeletal muscle relaxants) to fall markedly, with the use of essential drugs (defined by them as antihypertensives, cardiac agents, diabetic agents and thyroid agents) falling but at a lesser rate^{86,87}. Some of the 'essential' drugs whose use dropped included insulin, frusemide, thiazide diuretics and digoxin. Another study suggested that adverse clinical outcomes from cost sharing were limited to patients with 'low incomes, and hypertension and those with poor vision'⁸⁸.

In Australia the introduction of a co-payment was associated in a decrease in both discretionary and essential drugs (using roughly equivalent categorisations)⁸⁹.

Others^{90,91,92,93} have suggested that making prescription less likely (eg by cancelling hospital outpatient services) can affect health outcomes adversely.

Still others have postulated that any savings in drug costs may be offset by other costs – namely the costs of extra or different consultations and the need for extra institutional care^{94,95}. Unless the bed numbers increased, what this might represent is a different population of people occupying existing beds – perhaps less availability for present potential occupants (‘bumping’) but no real change in immediate direct cost at all. Nevertheless, the principle that costs and benefits often go together is illustrated well where governments, in the name of fiscal rectitude, limit the availability and cost of drugs.

PBS listing and medical and hospital services

First, a word about nomenclature. It is wrong to call medical and hospital services ‘health services’ because they have little or nothing to do with health. They are generally concerned with sickness. This is discussed *in extenso* by Ellyard⁹⁶.

PBS listing has major effects on medical practice. First, certain conditions may be treated with listed drugs increasingly easily in the community resulting in lesser numbers of beds being required. This applies less to conditions likely to be treated surgically.

Second, PBS listing may increase prescribing within hospitals as practitioners alter what they do. Many hospitals have elaborate rules about what may be ordered, about maximum amounts and about the different charges that are levied on different classes of patients⁹⁷. It should be remembered that drug therapy is important for individuals but that its effectiveness is often overemphasised by medical professionals.

Thirdly, the advent of particular drugs may make possible, procedures not previously available. One thinks of an immunosuppressive such as cyclosporin which has made large organ transplantations more possible and more successful. Drugs may also prevent conditions from developing, eg certain antibiotics which help reduce the numbers of people with rheumatic fever, Sabin vaccine to prevent the occurrence of poliomyelitis, and more.

Effectiveness – what it means

Any discussion of health outcomes requires a consideration what is an effective change in outcome.

Generations of students were taught that one specific type of randomised clinical trial (RCT) was the ‘gold standard’ for assessing effectiveness⁹⁸ and that any really effective drug would have to be shown to work in that sort of RCT before it would be accepted universally. In those older trials half the participants received the drug under test, and half received a dummy preparation – no treatment at all. Whenever possible, researchers were ‘blinded’ to which patients received which intervention and the effects over time were measured⁹⁹.

Some writers continue to demand RCTs⁶⁹ – especially where they wish to be rigorous. But it has become apparent (particularly with the advent of the acquired immune deficiency syndrome [AIDS]) that the use of a control group that receives placebo when effective treatment is available is not ethically acceptable¹⁰⁰, because those in the control group would receive no active drug treatment. Those in the control group would help future generations, but not themselves – future generations would be able to use the active drug, drawing on the results of trials in which they had received only placebo. So they saw themselves potentially as sacrificing themselves for no possible personal gain. So strongly did some feel in the past that they threatened to pool and share all tablets in any old-style RCT, so ensuring that everyone would receive a half dose of the active substance and no-one would receive dummy tablets alone.

That older style of RCT is not now used and generally would not receive approval from an institutional ethics committee^{101,102}. Modern trials (still RCTs and still rigorous) usually compare best standard treatment without the new drug, to best standard treatment with the new drug. So what is measured in such a study is the extra benefit accruing from the new treatment, not whether or not that drug is, or is not, better than no treatment for the condition. This newer approach puts government advisory committees charged with determining effectiveness under extra pressure in discharging their duties fairly and diligently.

A good discussion both types of RCT is contained in the work by Muir Gray¹⁰³.

Most recently, Australia's National Health and Medical Research Council has graded ‘evidence’ into

- E1 – evidence gained from a systematic review of all relevant

RCTs,

- EII – evidence obtained from at least one properly designed RCT,
- EIII-1 – evidence obtained from well-designed pseudo-RCTs (alternate allocation or some other method)
- EIII-2 – evidence obtained from comparative studies with concurrent controls and allocation not randomised (cohort studies), case-control studies, or interrupted time series with a control group.
- EIII-3 – evidence obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without parallel control group.
- EIV – evidence obtained from case series, either post-test or pre-test and post-test.¹⁰⁴

The classification places ‘meta-analysis’ as the most reliable and grades other studies against that. The movement today is towards seeking ‘evidence’ to back any claim of effectiveness and the NHMRC has helped grade all likely available evidence.

Rationing

There are not enough resources to allow the provision of pharmaceutical benefits to all who might benefit from them – and there never will be. Moreover, the gap between what is possible and what is provided publicly will grow as new and increasingly expensive drugs develop.

The question changes. It becomes: how do we make choices, in public provision, between competing claims for resources? Each resource claim has merit if viewed alone, but the resources to satisfy all claims are not available. So the choice is to determine who shall miss out.

Although the reduction in frivolous prescribing, the elimination of illegal drug reselling overseas, and the use of medicines in line with the majority view of ‘best practice’ all make sense, they will not remove the cost problem. So it is easy to support moves for ‘best quality coordinated care’, for ‘quality use of medicines’ (QUM)¹⁰⁵. Each of these initiatives has virtue, even if some are based on consensus views which change over time.

But no measure, such as those listed above, will fix the problem totally. There are just too many drugs, the costs of which are increasing faster than the system can accommodate comfortably. The problem has special urgency in State hospitals in which a finite budget is provided to the institutional pharmacy within which that pharmacy is expected to operate. This means that advances in drug therapies are not introduced automatically into hospitals until there has been an examination of the likely impact of such introduction upon the budget of the Unit – opportunity cost considerations again.

Many medical practitioners respond poorly to rationing, engaging in ‘shroud waving’ to get extra total funding for their area of activity. Their actions may reflect specific and strong acculturation received during their courses of study but are not really different from the behaviour of many other groups of people. In public life, the author became used to hearing, sometimes in code, that ‘what the world needs most is more money for me.’ Such an assertion may be comforting to the announcer but it is not likely to be especially effective.

The future: reform of some kind will have to occur

For a start, it will be necessary that the Australian body politic talks about rationing in a better and non-hysterical way. For that to happen, it is necessary to adjust our own ways of thinking, to realise that resources are limited and that opportunity-cost decisions will continue to be necessary. It is necessary to re-educate the media so that they stop projecting a romantic view which demands that all need be met now even if that is not possible. At present commentators fail to apply to questions of health or welfare a fraction of the analytical rigour they bring to bear on economic matters.

Then it is necessary to convince politicians (both those in elected politics and politicians in the bureaucracy) about the limited range of responses available. This involves convincing politicians with intellectual argument and then making it possible politically for them to express publicly views which are other than open-ended utopian promises. At present, such discussions are common in private (‘off-stage’), but rare in public (‘front-stage’). It must become more possible for those with public responsibilities to say ‘no’ more safely, more publicly and more often. Those with a utopian view based on deontological thinking are significant in most electorates,

including the electorates of Cabinet members, with the result that most Cabinet discussions are likely to reflect, at least in part, inputs from those people.

We need nationally to determine how much of our national wealth will be given over to subsidy of pharmaceuticals and then to decide how much we are willing to pay as a community for each substance. We should reject immediately any proposition that subsidy should be for every efficacious substance and should be unlimited. It has been estimated that the United States will have to spend over 20 per cent of its GDP on hospital and medical services within 30 years if it is to maintain the current rate of cost increases and current trends show that the United States is already spending 14 per cent of its GDP on hospitals and medical services, including drugs¹⁰⁶. Probably the United States would have to spend a large part of any overall increase in national wealth to reach those figures.

Immediately the PBS should operate on the basis of a more restricted list of therapeutic drugs. These should be only life-saving drugs and those agents which have a major effect on outcomes and many other substances should not be on the list at all. The use of increasing customer co-payments has had something of this effect, causing many drugs priced below the co-payment to 'come off' the PBS list, but more need to be removed urgently. It follows that the same should be done with concessional schemes like those provided for pensioners and veterans – at present the lists are just too comprehensive and, because co-payments are lower, fewer drugs have come off the list already. Further, these latter two schemes are characterised, among other things, by additions to lists not matched by deletions from lists – so that list lengths have increased steadily. Further, each list contains drugs that are not 'life saving' or 'disease preventing', and it represents one form of equity only to maintain them. It is acknowledged that both the Repatriation and the Pensioner Schemes present greater political difficulties, but it is necessary that each be limited somewhat now to allow easier access later to lists of potentially powerful new agents as they appear.

Examination of a recent schedule⁴³ suggests that many drugs could be considered for deletion including antacids, antiflatulents, antispasmodics, antiemetics, antinauseants, laxatives, many digestives, mineral supplements, many antianaemics, peripheral vasodilators, dermatological preparations, most sex hormones, most NSAIDS, most nasal preparations, cough and cold

preparations, antihistamines, minor analgesics, some otological and ophthalmological preparations, most allergens, all dressings, and so on.

It is not suggested that each of the drugs to be deleted has no beneficial effect. Rather it is suggested that such drugs should not be subsidised publicly. There could well be argument about 'essentiality' and this matter would need to be assessed drug by drug.

It would be necessary to alter the remit of some of the committees that advise the Minister now to make one of them responsible for advice that any drug was either life-saving or dramatic in its effect. One could expect aggressive marketing behaviour by pharmaceutical manufacturers, but such behaviour would need to be assessed and, if necessary, resisted appropriately. Such a change would, incidentally, remove some of the cost pressures now on governments. 'Safety net' provisions would continue to be needed.

The remaining therapeutic drugs would continue to be available but would not be subject to subsidy.

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