The PBS Panic – the consumer perspective

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Paper for the 3rd Annual "Future of the Pharmaceutical Benefits Scheme Conference", Informa Conferences, 24th & 25th August 2005.

Abstract

Concerns about PBS expenditure are misplaced, because they are from a narrow fiscal perspective, that fails to consider the total cost of pharmaceuticals, the benefits of pharmaceuticals, or the context of pharmaceuticals in health care delivery.

Pharmaceuticals are but one input into health care programs. Health programs need to be re-arranged around consumer, rather than provider divisions.

When governments seek to contain public expenditure by raising co-payment thresholds they do not improve economic resource allocation. Rather, they leave consumers dependent on a highly protected retail pharmacy industry shielded from competition.

The Australian Consumers' Association

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The ACA represents and acts in consumers' interests. It lobbies and campaigns on behalf of consumers to promote their rights, to influence government policy, and to ensure consumer issues have a high profile in the public arena.

The ACA is committed to providing information on a whole range of consumer issues including health, financial services, information technology and communications, travel, food and nutrition, computer technology and consumer policy.

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It is almost an article of public policy faith that the PBS is a large and unsustainable burden on our community. The title of this conference is "funding and sustainability"; I doubt if a conference on the banking or auto industry would include the term "sustainability". Yet one can be reasonably confident that in twenty or fifty years time we will still be buying and using pharmaceuticals. Similarly, there is a session titled "blow out", but when, for example, sales of DVDs grow exponentially, do we refer to a "blow out" or do we refer, rather to marketing and technological success?

Underlying some of this terminology perhaps is an assumption that any growing area of public expenditure constitutes a problem (unless it happens to be national security). That narrow assumption dominates thinking in the Commonwealth Treasury Department, who value fiscal stringency ahead of sound economic policy.

In this session I want to make two points relating to consumer interests. First, the view that growing public expenditure constitutes a problem is not one shared by the ACA. That is not to suggest the ACA has an irresponsible "tax and spend" attitude to public finance; rather the point is that this view reflects a narrow understanding of the issue. Second, if we are to control pharmaceutical expenditure without compromising benefits, we need the functioning of either strong markets or strong government. The way most health programs are structured, however, provides consumers with neither form of protection against exploitation and resource misallocation.

Reframing – a world without the PBS

Most consumers most of the time would not have much concern with the PBS, because they have little interaction with health care providers. The use of health services is heavily skewed; most of us have the good fortune of needing very little by way of health care. In any one year 20 percent of the population have no Medicare claims at all; a further 31 percent have between one and five claims a year. While we don't have figures on the distribution of PBS claims, it is safe to suggest that most people will not be in families eligible for the PBS safety net provisions – a point to which we return later.

Most consumers' interests lie in knowing that they have available high quality and affordable health care when they need it. When people do need health care, however, they confront a confusing array of fragmented programs. Let's consider someone with a minor weekend sporting injury – Cathy – who seeks medical attention. Her treatment path may be:

(1) A GP consultation – possibly bulk billed

(2) Diagnostic imaging – free if at a public hospital, otherwise reimbursable up to 85 percent of the Medicare Schedule Fee, and with an open-ended top-up payment;

(3) A specialist consultation – reimbursable up to 85 percent of the Medicare Schedule Fee, and with an open-ended top-up payment;

(4) Dressings and drugs, some of which may be Schedule 2 or 3 pharmaceuticals with no Commonwealth support, some of which may be prescription pharmaceuticals with PBS subsidies – a capped co-payment. She may be in luck and find the pharmacy is not too far from her GP, but to find one open is a challenge, for pharmacy opening hours are generally designed for the convenience of their older, retired customers, without work commitments.

(5) Standard analgesics available from a supermarket;

(6) Physiotherapy – with no government support, but with some limited reimbursement if he or she is part of the minority (43 percent) of Australians with private insurance.

Unless she is willing to wait in a public hospital casualty room, she probably has to wait until Monday even to make an appointment. She will spend much of her time waiting in line, and some of that time filling in forms, in longhand, repeating her name, address and other basic details. (Someone else will transcribe this into unlinked databases, with possibilities for error all along the way.)

That's without mentioning Cathy's possible eligibility for safety nets, which have different criteria for different services, and without her possible need for hospitalization. There are two safety nets for medical services, for example – a gap safety net and a general safety net, one calculated on individual payments and the other on family payments. There is a tax rebate for uninsured medical expenses above $1500. The consumer has one need, and several different payment systems.

To see the full absurdity of this situation, imagine if, when your car develops minor mechanical trouble, you had to go to one place for a diagnosis, another for parts, another for some repairs, another for some other repairs, with different bills from each provider – and with the complication of having to drive around in a defective vehicle to obtain all these parts. Not even the Soviet bureaucracy, in all its bureaucratic glory, managed to impose such a system on consumers.

Yet we persist with an antiquated structure of health care programs. Program divisions are based on providers' demarcations, rather than consumers' needs. This set of divisions determines the perspectives the policy elites, such as Treasury bureaucrats, bring to bear on health care. As an example, the following is one of the key tables from the Commonwealth's *Intergenerational Report*:

Table 1. Projected Commonwealth health spending, by components (per cent of GDP)

	2001-02	2006-07	2011-12	2021-22	2031-32	2041-42
MBS subsidy	1.09	1.10	1.15	1.33	1.58	1.78
PBS subsidy	0.60	0.63	0.79	1.31	2.15	3.35
Hospital and health services	1.16	1.16	1.20	1.34	1.51	1.63
Other	1.12	1.14	1.16	1.22	1.29	1.37
All health	**3.96**	**4.02**	**4.30**	**5.20**	**6.51**	**8.13**

Source: From Table 9, *Intergenerational Report* (Health component only shown)

The most striking feature of that table may be its alarmist projections, but there are two other aspects that are not so obvious – its confinement to fiscal projections and its confinement to one input to health care.

Alarmist projections

To deal with the alarmist projections first. Simply looking at the PBS, we see it as the fastest growing component of health outlays, rising from 0.60 percent of GDP to 3.35 percent of GDP, over 40 years. There is an air of panic in the *Intergenerational Report*.

But let's look at this projection. We can reasonably expect a rising GDP over the next 40 years, and, with a little straightforward mathematics, can show that if we achieve just 0.07 percent annual growth in per-capita GDP, we can afford even these high outlays without having to transfer resources from any other activity.[1] Even the Treasury projections are easily affordable. And it's surprising, given the scale economies in pharmaceutical manufacture, that the Treasury modelling does not assume real price falls as volumes rise; are they assuming the Australian Government lacks the power to negotiate price/volume agremeents in the PBS? Are they assuming that the power of pharmaceutical companies' advertising budgets will be overwhelming?

Fiscal focus

Another feature of this table is that it is presented only in terms of the fiscal costs of the PBS. It is a *financial* projection, not an *economic* projection. An economic projection would include all costs of pharmaceuticals, be they incurred through Commonwealth outlays, state government outlays, or private outlays. And it would include some estimate of benefits; indeed if the benefits of pharmaceuticals did not exceed their costs there would be something seriously wrong.

In fact the Commonwealth accounts for only one half of our expenditure on pharmaceuticals. A more comprehensive table would be of the form shown below in Table 2. If the bureaucrats who prepare the *Intergenerational Report* were concerned with our outlays on pharmaceuticals, rather than on fiscal bookkeeping, they would gather the data to complete the table shown below. Then, at least, we might see how much our pharmaceutical expenditure is projected to grow.

1. If per-capita GDP grows by just 2.845 percent over 40 years, we could devote 3.35 percent of GDP to the PBS. That requires a growth rate of only 0.07%

	Per capita GDP	PBS	All other GDP	PBS/GDP
2001-02	100.000	0.600	99.400	0.60%
2041-42	102.845	3.445	99.400	3.35%

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Table 2. Expenditure on pharmaceuticals (per cent of GDP)

	1992-93	2002-03	2041-42
Commonwealth outlays	0.38	0.68	3.35
Individual outlays	0.43	0.65	??.?
	0.81	1.33	??.?

Source: AIHW *Health Expenditure Bulletins* and ABS GDP estimates

This table, while including individual outlays, still does not include any estimate of the benefits of pharmaceuticals. Furthermore it doesn't include purchases by state governments for hospital pharmaceuticals.

It is meaningless to talk about "affordability" or "blow outs" in isolation – any more than it makes sense to talk about affordability and blow outs in expenditure on DVDs or carrots. We choose to buy pharmaceuticals, either collectively through public budgets or individually through our own pockets, because we perceive pharmaceuticals to be beneficial. Fortunately Australia, in the rigorous cost-benefit processes used by the PBAC, has a means of ensuring we do spend our pharmaceutical budgets wisely. (It's unfortunate that such a disciplined cost-benefit approach used by the PBAC does not extend across the whole of health policy; if it did there could be great potential for cost savings, particularly in the area of public and community health.)

What the Commonwealth, particularly the Treasury Department, seems to be concerned with is not whether we are spending too much or too little on pharmaceuticals – which would require a proper economic analysis. Rather, its concern seems to be purely with budgetary outlays, as if there is something intrinsically undesirable in tax-funded programs.[2]

There is a strong case for collective funding of some or all of our health costs; a large body of evidence suggests that price considerations deter consumers from early intervention in health problems, leading to much more expensive interventions as their problems worsen. And there are equity and social insurance reasons why people choose to share health care costs through public budgets. There are also reasons for using market signals in some aspects of health care, but, as we will see further on in this paper, our Commonwealth and state governments have effectively muzzled market forces in retail pharmacy.

When the Commonwealth economizes on PBS expenditure by lifting safety net thresholds or introducing special patient contributions they do not improve economic resource allocation, because they are transferring expenditure into a highly distorted market – a market which has been distorted by deliberate government intervention.

2. For an illustration of the conflicts that can occur between Treasury and Health Departments, see Steve Lewis "Health cuts bad: Abbott" *The Australian* 10 August 2005. Lewis's article suggests that health Minister Abbott is in conflict with the Treasurer's desire to cut health spending to protect the budget, arguing that health programs represent an investment in a richer and more productive society.

Pharmaceutical focus

The final and more serious limitation of the Commonwealth perspective is that it narrowly focuses on pharmaceuticals. But pharmaceutical therapies are part of health care; they do not stand apart. We can note even from the Commonwealth's own table that other components of health care are rising less steeply than pharmaceuticals.

Our injured weekend athlete, Cathy, shouldn't have to be concerned with separate government programs such as the PBS or Medicare. She has an injury and seeks cure or amelioration. She is concerned that she gets value for money, either through co-payments or her taxes. To return to our car service analogy, we are usually more concerned with our total bill rather than its components – labour, lubricants, electrical parts etc. If, over ten or twenty years, we found that the cost of parts had risen strongly while the cost of labour had fallen, we would accept the benefit of this substitution, and not get too concerned because one component had risen in price.

In health care our governments' program structures are flawed. They are structured around inputs (pharmaceuticals, medical services, hospitals), rather than consumers. There are many ways a consumer-based program structure may be designed. For example, just as most corporations structure their divisions around their customers, we could consider three consumer-based health care programs:

- for those with occasional needs – most consumers most of the time;
- for those with ongoing needs – particularly those with chronic conditions;
- for those with acute needs.

Alternatively, we may structure our programs around demographic groups with particular needs – people in remote communities, adolescents, the aged etc. I will leave it to Professor John Dwyer to suggest how programs can be integrated around patients rather than providers. (That need for integration was the overwhelming theme of the 2003 Health Summit.) For illustration, to help us re-frame our thinking, I have illustrated a possible program arrangement in a simplified matrix below, with the $$ signs indicating where heavy expenditure is likely to be revealed.

		Inputs		
		Pharma-ceuticals	Medical services	Hospital services
Programs	Occasional	$	$	$
	Ongoing	$$	$	$
	Acute	$	$$	$$

Under such a structure, integrated around consumers, attention would be focussed on consumers. Appropriations would be made to these programs (occasional care, ongoing care and acute care in this example), the administrators of which would spend money on services

(pharmaceuticals, medical, hospital), but the prime focus of public policy consideration would be on costs and benefits of these consumer-based programs. As a secondary consideration there may be some consolidation of reporting down the matrix, for example, pharmaceutical expenditure. Treasury would still have its eye on the figures, but its attention would no longer be on inputs by type; it would be concerned with public and private resources devoted to consumer-based programs, and to their outputs and outcomes.

Of course such a rearrangement would be difficult within the present structure of Commonwealth/State responsibilities, but I'm sure John Dwyer will convince us that these barriers can be broken down. Even within the Commonwealth there could be far more integration of services. With all the power the Commonwealth has over the location of pharmacies, for example, it is extraordinary to see that there are still impediments to physical integration of pharmacies with medical clinics.

Would this be the end of the PBS? In name, yes, but it would still be possible to retain the PBAC and the PBPA – they are the bodies giving the scheme its purchasing strength.

Let's return to Cathy. If she incurs her injury once we have a more consumer-friendly program structure, she should be able to get all her services under one roof, with one bill, and one safety net, one set of records. If that one roof is large enough it may cover enough GPs to sustain a basic weekend roster, with a full diagnosis and treatment early in the working week. Her pharmaceutical regime may be developed in a face-to-face consultation between the GP and the pharmacist – perhaps with a physiotherapist also in attendance to help her in a choice of therapies. There would be obvious administrative savings, and risk of receiving conflicting treatment would diminish. And it may be a little more rewarding for the health care professionals to find they are dealing with a whole episode of care – the pharmacists' knowledge, in particular, accumulated over many years of difficult study, would be put to far better use than it is in the task of running a corner store.

What I haven't touched on, as yet, is whether Cathy is provided with free or charged service. I want to turn briefly to that issue.

Markets or governments?

In all markets consumers are concerned with market outcomes – product price, quality, choice, safety and other attributes.

Sometimes these needs can be served in competitive markets, sometimes they can be served in highly-regulated markets with or without public ownership. The consumer movement was a powerful ally of those seeking to reduce Australia's high tariffs, and has supported strong competition policy. The consumer movement has also been a staunch defender of food and pharmaceutical regulation and of publicly funded and publicly provided health care programs.

From a consumer perspective, retail pharmacy is in the worst of all worlds. It is neither competitive nor adequately regulated by governments.

As pointed out, most consumers most of the time are not covered by the Government's safety nets; when they buy PBS pharmaceuticals they have to pay a price up to the $28.60 maximum patient contribution. They may even have to pay more if their prescription is for a brand

name where a generic pharmaceutical is available, or when there is a therapeutically equivalent medication and where a special patient contribution is required.

While many will reasonably argue that the $28.60 co-payment imposes an unreasonable burden on many consumers, it does have the benefit of providing a price cap. If there are to be co-payments in health care, from a consumer perspective capped co-payments are always preferable to open-ended co-payments. (This is one of the consumer movement's objections to the private health insurance support for ancillary services, which cap the insurers' liability while leaving consumers with an open-ended risk. In fact it is a misrepresentation to call such cover "insurance".)

Many pharmaceuticals however, particularly those out of patent, should have a retail price well below $28.60. For these pharmaceuticals the consumer is left dependent on the pharmacist's pricing decision, without the protection of either market competition or government regulation.

Nicola Ballenden, former health policy officer for the Australian Consumers' Association, described in detail common practices in relation to such pharmaceuticals. Pharmacists routinely charge more than the price the Commonwealth pays for similar prescriptions. This is in spite of the fact that sales of unsubsidised drugs are funded with immediate cash payments – Commonwealth PBS payments are on a monthly reimbursement basis.

The items pharmacists routinely add to the Commonwealth price are a $0.95 charge for recording the medicine for safety net purposes (even though it is the consumer's responsibility to manage his or her own safety net records, and most consumers don't qualify for the safety net), and, to quote from Commonwealth correspondence "a further additional patient charge amounting to 10 percent of the maximum patient contribution ($28.60) plus 50 cents (i.e. $2.86 + $0.50)."[3] This is in spite of the fact that pharmacists often receive hefty discounts from wholesalers on generic drugs – discounts they fail to pass on to consumers.[4]

In addition to these practices, at the time of the survey, Nicola found:

> ..some pharmacists appeared to be routinely charging something called a 'further additional patient charge' on some PBS drugs. On pursuing this, ACA also found that certain pharmacy pricing software operated with a default setting that added huge mark-ups leading, ACA believes, to higher prices for consumers. The price guide came from the Pharmacy Guild, the organisation that represents local pharmacists, and in fact one of the software companies is also part-owned by the Guild.[5]

Following the ACA's intervention, which had alerted competition authorities to these practices, the pharmacists' software has been changed to remove the high markups as a default setting. But it reflects poorly on our public policy processes if it has to be left to

3. Correspondence from Pharmaceutical Access and Quality Branch, Department of Health and Ageing to ACA, 14 January 2005.

4. Mark Davis "Chemists' discounts rort under attack" *Australian Financial Review* 14 April 2005.

5. Nicola Ballenden "The pharmacy: why it can't stay a closed shop" *Consuming Interest* Winter 2005.

consumer watchdogs to bring such pressure on the industry. The ACA receives no government support – subscribers and members cannot claim tax deductions – and it has one health policy officer, whose responsibilities cover the entire health arena. By contrast the Guild, receiving generous tax-deductible support from pharmacists, has a number of specialized staff and immense lobbying resources. Before the 2004 federal election, for example, the Guild mounted a massive political campaign against competition reform, aimed at ensuring they would once more receive from John Howard a "letter of comfort" – a guarantee of protection from competition – as they had received during previous campaigns.[6]

Lest anyone believe the Guild is partisan, it should be pointed out that most pharmacists' privileges relating to advertising, ownership and location are based on state legislation. In a rare display of bipartisanship and federal cooperation, in May 2004 Prime Minister Howard and Premier Carr reaffirmed support for protection of the retail pharmacy industry.[7] (As a minor token towards deregulation they did agree to lift a restriction on the number of pharmacies an individual can own from three to five – a move that may allow a few pharmacists to enjoy some scale economies, but which will bring no consumer benefits.)

In fact, the opportunity for exploitative pricing came about during the time of the Hawke Government, in a move which effectively removed Commonwealth responsibility for any price control on non-subsidised pharmaceuticals.

Until 1960, when a five shilling co-payment was introduced, all pharmaceuticals supplied under the PBS were free. The five shilling co-payment, which equates to around $5.50 in 2005 prices, was hardly burdensome, and there were probably few (if any) pharmaceuticals which would have reasonably been priced below that level. Many of the pharmaceuticals which would dominate the PBS in future years were either still in patent or yet to be listed.

For the following 15 years there were a few adjustments to the co-payment. In 2005 prices, it stayed between four and eleven dollars – low enough to ensure almost all pharmaceuticals on the PBS were subject to some Commonwealth PBS contribution and therefore effective price control.

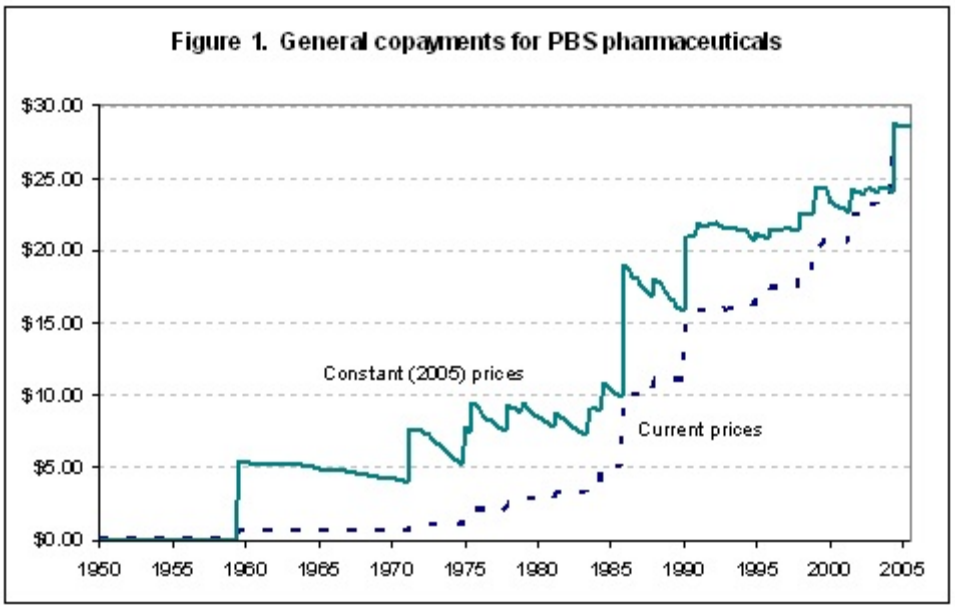
In 1986, however, the Commonwealth raised the co-payment to $10, which, in 2005 prices, is around $19. At the same time many pharmaceuticals were coming off patent. Many pharmaceuticals fell in real and nominal prices, so were no longer requiring a PBS subsidy. This price reduction was seldom passed on to consumers, however – pharmacists could go on charging consumers up to the total co-payment level. The PBS had ceased to be an instrument of price control, except for those pharmaceuticals for which a Commonwealth subsidy is paid.

This change coincided with a fundamental shift in Commonwealth economic policy – a shift which has its roots in budgetary changes in the mid eighties, and which has been extended ever since. Starting with "reforms" such as the Financial Management Improvement Program in 1988 and developing further with the Charter of Budget Honesty in 1998, the Commonwealth has largely abandoned microeconomic management in its budgetary

6. Mark Davis "Seeking prescription to cure competition" *Australian Financial Review* 17 June 2005.

7. Prime Minister media release "Pharmacy and National Competition Policy" 5 May 2004.

processes. Its concern has become a narrow financial focus on its own outlays – in this case PBS subsidies. If it can achieve budgetary savings through cost-shifting on to other parties, such as consumers, then it will do so, provided the macroeconomic effects are not too severe. In most cases it won't even try to measure the extent of the cost-shifting; one will note, for example, that the Commonwealth's PBS statistics, while being extensive for subsidized pharmaceuticals, are silent when it comes to non-subsidized prescriptions.



One may believe that a government does not wish cost-shifting to result in inflation. But low consumer price inflation in other areas (clothing, household goods) has tended to compensate for health care price inflation.[8]

In general, under both Labor and Coalition administrations, the Commonwealth has relied on competition policy to achieve microeconomic reform, but retail pharmacy has managed to shield itself from national competition policy.

To justify this exemption, pharmacists like to portray themselves as "consumer friendly", using emotive terms such as "community pharmacy", but former ACCC Chair Alan Fels, re-frames that perception. The local pharmacy is part of a well-organized highly profitable industry:

> Australia's 5000 pharmacies are among the most protected businesses in the country, wrapped in state and federal regulations that restrict their operations in almost every conceivable way.
>
> The states license both pharmacists and their premises, limit ownership to qualified pharmacists (largely precluding corporate ownership), limit the number of

8. From 1992 to 2003 health care inflation has been at about one percent greater than general inflation (AIHW Health Expenditure Bulletin 2002-03). Over the last five years to 2005, the gap between health inflation and general inflation as measured by CPI components has widened to 2.3 percent.

> pharmacies owned, require a pharmacist to always be in attendance, and restrict advertising and promotion.
>
> Canberra weighs in with another raft of controls on dispensing fees, discount prohibitions on drug prescription costs, limits on the number and location of pharmacies (geographical monopolies) and, of course, further controls on advertising.
>
> Chemists provide a critical health service, and deal in dangerous drugs, so many of these controls are necessary. But successive inquiries have expressed concern at the anti-competitive effects of the awesome array of controls – namely, that consumers pay higher prices.
>
> Community pharmacy in Australia is a $6 billion business with 40,000 employees. It is also very profitable. The average pharmacy operating margin is 8 per cent, several times larger than the "all retailing" average of 2 per cent.[9]

The retail pharmacy industry has become so used to these privileges that it seems to have forgotten what a competitive market would look like. In a use of language that Orwell would classify as Newspeak, the Pharmacy Guild claims that for pharmaceuticals priced below the patient co-payment "market forces apply and pharmacists can compete with each other as to what price they might charge".[10] It's a strange idea of "market forces", when price advertising is specifically prohibited, and when location regulations make it difficult for consumers to shop around. How is a consumer to know what is a reasonable price without any reference point of comparative price information? How is a consumer to find, for instance, unless he or she has a particularly friendly pharmacist, the price the Commonwealth pays for common generic pharmaceuticals – $11.28 for the contraceptive pill and $8.54 for Amoxycillin?[11] If they want market forces to work, why does the Commonwealth not make these prices readily available to consumers on a website? Where can consumers find the agreed "special patient contributions"?

What holds for PBS pharmaceuticals also holds for non-prescription pharmaceuticals in Schedule 2 (pharmacy only) and Schedule 3 (pharmacist only), and for private prescriptions not covered by PBS subsidies. Australians, on average, spend $400 a year on "Medicines, pharmaceutical products and therapeutic appliances" other than prescriptions, most of which would be spent in pharmacies.[12] With private health insurance permitted to cover private prescriptions, there is a further suppression of any market discipline on pharmacists' pricing.

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9. Alan Fels and Fred Brenchley "Dispense some competition to the pharmacies" Sydney Morning Herald April 8 2004.

10. Correspondence from Pharmacy Guild of Australia to the ACA, 28 January 2005.

11. Levonorgestrel with ethinyloestradiol 21 tablets, Ampicillin capsule 250 mg x 24, December 2004 prices.

12. ABS Household tables (Cat 6535.05) indicate average weekly expenditure on "Medicines, pharmaceutical products and therapeutic appliances" to be $11.51, of which $3.71 is for prescription pharmaceuticals.

Conclusion

I have not touched on the issue of whether pharmacies should be permitted to operate within supermarkets. On that delicate topic I'd suggest that it could result in useful price competition and the convenience of more consumer-friendly opening hours. The retail pharmacy industry claims that the quality of professional service would be compromised, but when the ACA surveyed the industry in 2004 it gave the industry a less than glowing report card; the quality of professional advice was below the standard the ACA would have sought.[13] In two thirds of the 87 pharmacies visited by ACA's experts the quality of advice was rated as "poor".

The short term prospects for competitive reform don't look promising, with bipartisan support for the status quo. The history of economic privilege suggests that it is very hard to dislodge; once a group, particularly a small well-defined group, gains privilege, they accumulate the means to defend that privilege.

I recall a similar mythology about tariff protection, however. Tariff protection was an embedded aspect of the Australian Settlement; no government was going to demolish it. But that demolition occurred, from an unlikely quarter – the Hawke Government, inheritor of Labor's tradition of protectionism. I might add that the consumer movement supported those policies strongly.

Competitive reform, however, is not in itself adequate to serve consumers' interests. Pharmacies in supermarkets or big chains like Walgreens would still preserve a separation of pharmacy from other aspects of health care.

We need to think more widely than the existing supply-side structures like the PBS or "retail pharmacy", and call on governments to take the lead in redesigning our health care programs into divisions that respond to consumer interests.

That would be real reform.

13. "Dispensing advice" *Choice* September 2004.