



THE UNIVERSITY OF
MELBOURNE

Centre for Health
Policy Forum

Revisiting Whitlam's Vision for Health: Economists, Data and Efficiency

6th of October 2017, Old Parliament House Canberra.



Hon Edward Gough Whitlam's Parliamentary Speech

Reproduced from Hansard, 27th of September 1967

Mr WHITLAM (Werriwa) (Leader of the Opposition) - Mr Deputy Chairman, one of the problems in discussing health policy in Australia is the lack of reliable official information. This is only partly the result of the capacities of the Minister for Health (Dr Forbes). In large part, it stems from the Government's laissez-faire attitude to health policy in this country. The Government sees its role as largely a passive one - of subsidising a hotch-potch of private medicine, voluntary insurance, private and public hospitals, State and local interests. The Minister is content to authorise the payment of bills which others present, with occasional intervention when abuses become too blatant. Its research is limited very largely to the narrow medical field with little recognition of the importance of economic research and planning of health services.

Last year the Commonwealth itself spent \$278m on health expenditure through the Department of Health alone. Governments, either directly or indirectly, find about 60% of health costs. Yet the Commonwealth Department of Health lacks the proper economic research staff to evaluate the efficiency of this spending. This is not the fault of the very capable and dedicated staff which the Minister has. In fact, he gets better than he deserves, but there is not sufficient staff. In a letter to me of 3rd April this year, the Minister said:

"Some research is undertaken in the field of health economics. There are five officers employed in the Research Section of my Department . . ."

The Canadian Research and Statistical Division, by contrast, has eighty such officers. The Minister did add that economic research is sometimes undertaken by others in the Department. Despite this reservation it is quite clear that the Department of Health does not and cannot conduct comprehensive research in health economics in Australia - the subject on which the Minister for Health has chosen to lecture this House on at least two occasions in the last 6 months.

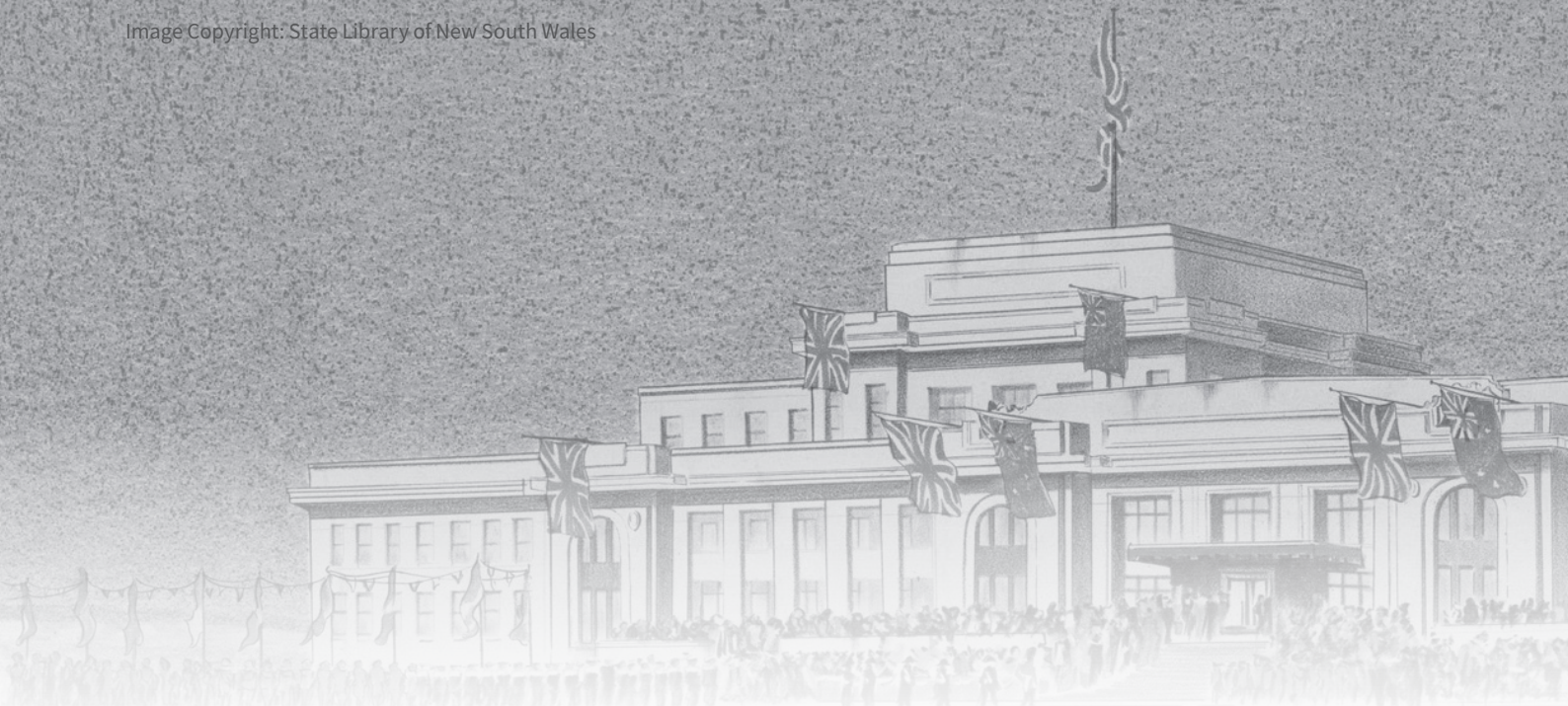
The absurdity of the situation is no more clearly illustrated than by the inability of successive Ministers for Health to provide official figures on total health costs in Australia. In 1965, the former - and the next - member for Hughes, Mr L. R. Johnson, asked the Minister for Health for the total health expenditure in Australia. The Minister replied:

"In the absence of details ... the total expenditure on health in Australia . . . cannot be provided."

Early this year I was bold enough to say that health costs in Australia were relatively higher than those in the United Kingdom whose scheme is so widely criticised as inefficient and costly. In a comic performance in the House in March, the Minister disputed my contention and charged me with loose use of facts. It turned out in subsequent correspondence that the Minister did not know the facts. In the letter to which I have referred the Minister said:

"I have no 'official' figures available of the estimated annual total expenditure on health in Australia. However, the draft WHO report, 'The Cost and Sources of Health Services', quotes \$715.7m as the estimated annual expenditure on health services in Australia in 1960-61. This amount represented 4.9% of the gross national product for that year."

Following this revealing reply I put a question on the notice paper asking for figures from other countries, including the United Kingdom. The Acting Minister for Health, the Minister for Civil Aviation (Mr Swartz), would not disclose publicly what these figures were but was prepared to confirm the figures for Australia which I have quoted. The Acting Minister, however, did write to me on 11th May a letter which stated that the United Kingdom spent 4.2% of its gross national product on health at that time - that is, less than Australia. This description of events does reveal several important facts. The least important is the unreliability and deviousness of the Minister for Health in matters of health economics. The more important facts are first the lack of proper economic research and evaluation of health expenditure in Australia. The Commonwealth Government cannot even provide an 'official' figure of health costs. The second fact is that our health facilities are costly and very costly indeed in terms of the benefits they provide. The Australian Labor Party does not and would not propose a health service similar to the United Kingdom system. With all the defects of the United Kingdom system, however, total health costs are lower in the United Kingdom than in Australia. This year, total health expenditure will exceed \$1,000m and will probably top \$1,100m, of which over \$600m will be provided by governments. In my speech on the Budget, and on many other occasions, I have pointed out that a great deal of excess cost is due to the lack of a balanced national hospital system and the inefficiency and cost which inevitably results from voluntary insurance. When the Minister for Health can say with complete indifference that it is no concern of his if the Hospitals Contribution Fund of New South Wales buys an aeroplane, can we really expect an efficient health system?



One other important cause of high health costs in Australia is drug costs, particularly in the ethical field. In the last 6 years, Commonwealth payments for pharmaceutical benefits have risen from \$59m to \$104m, an increase of almost 80%. In his annual report the Director-General of Health, speaking of pharmaceutical benefits, said:

"I have to again report an upward trend in costs ... the levels of prescribing for ... new drugs were not compensated for by corresponding declines in the use of the older drugs in the particular groups. Prescribing at the government's expense is, as I have said before, simply prescribing at the community's expense. One of the major problems in administration of the Scheme is the assessment of whether the cost to the community of pharmacological treatment is being inflated by the use of high priced drugs where less expensive drugs would be more effective. This complex problem is the subject of a continuous study in my department and it is our objective, in co-operation with the medical profession, to reduce it as far as it is reasonable and practicable to do so."

We wish the Director-General every success. There is certainly room for improvement in a country whose expenditure on medicines is amongst the highest, if not the highest, in the world. Research undertaken by the Institute of Applied Economic Research at the University of Melbourne shows that in 1960-61, the latest year for which comparable figures are available, expenditure of \$167m on medicines in Australia represented 1.4% of our national income compared with 0.7% in the United Kingdom, 0.8% in Sweden, 1.3% in Canada and 1.1% in the United States. Not only is expenditure very high but it is growing very rapidly as the Director-General concedes. Between 1960-61 and 1963-64 total expenditure on medicines rose by just over 20% to over \$200m in the latter year. This year expenditure on medicines in Australia will be in the vicinity of \$250m. Only a small part of this could be attributed to local research costs. A survey conducted by the Australian Pharmaceutical Manufacturers Association showed that 46 pharmaceutical companies spent less than \$1.5m on local research in 1964-65 about 1% of sales.

The report of the Director-General reveals that the total cost of pharmaceutical benefits under the national health scheme in 1966-67 was \$104m. Over \$40m, or about 40%, went in remuneration to chemists. This represented 64% mark up on manufacturers costs. In Britain the comparable mark up for drugs sold under the

national health scheme is 31%. I quote from the 'Australian Journal of Pharmacy', July 1967. The University survey to which I referred pointed out that the cost of distribution of all medicine in 1963-64 represented 46% of the total retail price. The costs of distribution took \$80m out of the total expenditure of \$215m. These distribution costs are very high indeed. In general, chemists in Australia operate on a margin of about 40% on all lines compared with only 25% in Britain.

Several factors account for the high cost of distribution. The public has in general welcomed the change in the nature of grocery retailing. But legislation in various States restricts the expansion of chain store chemists. The retailing of pharmaceutical goods is rife with restrictive practices which penalise the consumer. The growth of friendly societies is restrained. In New South Wales recently the Federated Pharmaceutical Service Guild of Australia showed concern when a large chain store chemist proposed dropping the 49% prescription fee on the supply of contraceptive pills. The result of this 'unethical' behaviour by the chain store was that the Guild was forced to cut the retail price by 20%. The removal of restrictive practices and the introduction of more competition would bring even greater benefits to the consumer and to the taxpayer, who pays so much of the drug bill. The high costs of distribution are in part the result of the large number of chemists in the community. We probably have the world's highest ratio. In 1964-65 there were 9,085 registered medical practitioners in private practice and 5,375 pharmaceutical chemists approved under the National Health Act. So each chemist serviced only 1.7 doctors. Is it any wonder that distribution costs are high and are kept high to give a return to each chemist? In the case of ethical drugs, which are the most important and fastest growing item, even the consumer is not greatly concerned with the price when the national health service meets all but the first 50c on any prescription which in large measure the doctor who prescribes is not concerned with price. The demand for these ethical drugs is greatly influenced by expensive and persistent advertising which is directed not at consumers but at prescribing doctors. Competition results in the promotion of numerous brands, intensive detailing and publicity in professional journals and through the mail. The doctor who prescribes but does not pay is subject to considerable promotion pressure. If doctors prescribed by generic name rather than the proprietary or brand name of the drug, the whole reason for promotion would be lost. Without brand names there could be no advertising war.



Undoubtedly there are benefits to be achieved by brand name prescribing.

Quality and precision in drugs, however, can be just as well if not better assured by thorough public drug testing and evaluation. Honourable members have been given examples of the lower prices resulting from generic prescribing. There is a marked variation between prices charged by various drug houses for the sale of their products to some large buyers, such as hospitals, and the prices paid to pharmacists under the national health service. One explanation is that the scale of institutional buying allows reductions due to packing and bulk purchase. In some instances also, manufacturers regard their sales to hospitals as a form of promotion: They will get young doctors used to prescribing certain drugs.

The method of prescribing, however, is clearly of importance. Figures were prepared several years ago in Australia comparing the prices of certain drugs to hospitals using generic names in their ordering and prices of the same drugs sold by chemists under various brand names. The price to hospitals of 1,000 prednisone 5-milligramme tablets was \$9.42. Chemists selling the same quantity under brand names charged between \$80 and \$120. Tetracycline capsules cost hospitals \$15.40 for 100. Chemists sold the same quantities of the drug for \$26.90. For Ariane and related drugs the prices paid to chemists under the national health service were in general about 300% higher than those paid by hospitals for the same drug. The Kefauver inquiry into the drug industry in the United States, whose report the drug lobbies have been trying to discredit, spending enormous sums in the process, revealed even more spectacular examples of excessive costs resulting from prescribing by proprietary or brand names rather than by generic names. The drug reserpine was available to the public at \$5 per thousand or \$65 per thousand; prices of penicillin G tablets ranged from \$2 to \$40 per thousand tablets; and prices of secobarbital ranged from \$10 to \$30 per thousand. In each case the lower price was the result of generic prescribing and the higher price the result of prescribing by brand name. The companies in the United States benefiting from brand name prescribing as revealed by the Kefauver report are well known companies that have flocked to Australia to profit from the drug bonanza under our national health service. In 1964, two-thirds of the ethical market in Australia was held by American firms and their subsidiaries and the rest was largely occupied by Swiss, German and British firms. The Kefauver report also showed the great benefits

which accrued when bulk buying by the United States armed forces introduced some price competition in the market.

In Australia there is insufficient price competition in the drug field. In a large area of the ethical field there is no price competition at all. Almost all competition is in the promotion field and is directed at the doctor to persuade him to prescribe a certain brand. It is time we set about reversing the situation through competitive tendering for drugs and more generic prescribing. About 70% of all expenditure in the ethical field is under the pharmaceutical benefits scheme. The Commonwealth is in a strong position to force substantial economies and savings in our drug bill. Through negotiation it has secured some price reductions. But it is time it used its power in the market to really force price reductions. For a government that says that it believes in competition it shows little concern with the lack of price competition in large areas of our drug market. Advances in drugs have brought great advances in health standards throughout the world. That is not disputed. But it is clear that in Australia we are being forced to pay too much.

I have shown before the wastes in our health system which inevitably result from voluntary insurance and the duplication and inefficient running of our hospital services. In the drug field - at both the manufacture and distribution level - costs are excessive. This is inevitable when a government subsidises private costs which it cannot control. The public gets the worst, not the best, of both worlds - inadequate private services and high public costs. This excessive cost is the direct result of the Government's timid and laissez-faire attitude to health in this country. It cannot avoid responsibility by trying to hide behind the provisions of the Constitution. Can we expect a fundamental examination of our health services when the Government cannot provide an estimate of health costs in this country? In terms of its benefits, ours is an extremely expensive health system - if it can be called a system.

We can - and a Labor government would - build an alternative public health service within the limits of present health expenditures in Australia. The drug field is a good area in which to start making some economies.

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Program

The economic way of thinking about health & public policy Chair: Bob Gregory

- 9:00 - 9:15 **Whitlam's vision: Before It's Time?**
Philip Clarke
- 9:15 - 9:35 **Health economists, the problem or solution?**
Michael Wooldridge
- 9:35 - 9:55 **Randomising our way to better public policy**
Andrew Leigh
- 9:55 - 10:10 *Questions and discussion*
- 10:10 - 10:40 **Integrating economic thinking into the health policy decision making**
Bronwyn Croxson
- 10:40 - 11:00 *Coffee*

Economic aspects of health policy reform Chair: Alison Verhoeven

- 11:00 - 11:15 **Evaluating pharmaceuticals. How far have we come, how much further to go?**
Rosalie Viney
- 11:15 - 11:30 **Modernising Medicare by reducing low value care**
Adam Elshaug
- 11:30 - 11:45 **Using financial incentives to modernise Medicare**
Anthony Scott
- 11:45 - 12:00 **Bringing home the bacon? Ways to promote efficiency and equity**
Philip Clarke
- 12:00 - 12:30 **Panel discussion**
- 12:30 - 1:30 *Lunch*

Integrating economic evidence into decision making Chair: Andrew Podger

1:30 – 1:45	What can we learn from better use of health care data collected by the private sector Catherine Keating
1:45 – 2:00	Analysing data: fast and slow Henry Cutler
2:00 – 2:15	The vanguard state? Linking up health data in New Zealand Tony Blakely
2:15 – 2:30	Economics, evidence and Indigenous health Ian Anderson
2:30 – 3:00	Panel discussion
3:00 – 3:30	<i>Coffee</i>

Promoting efficiency – Case of pharmacy reform Chair: Meredith Edwards

3:30 – 4:00	Competition and the health sector: Where next? Stephen King
4:00 – 4:25	Prospects for future reform of the pharmacy sector Terry Barnes
4:25 – 4:50	Wrap-up session - lessons for the next 50 years
4:50	Close

We acknowledge the generous support of the Australian Health Economics Society

We acknowledge the Ngunnawal and Ngambri peoples who are the traditional custodians of the Canberra area and pay respect to the elders, past and present, of all Australia's Indigenous peoples.

Speakers

Prof Ian Anderson

Deputy Secretary (Indigenous Affairs), Department of Prime Minister and Cabinet

Prof Anderson was previously the Foundation Chair, Indigenous Higher Education and Pro Vice-Chancellor (Engagement) at the University of Melbourne. He has held a number of academic, policy and practice roles in Indigenous health over a thirty-year period. Prof Anderson was awarded the Order of Australia medal in 2017 for distinguished service to the Indigenous community, particularly in the areas of health equality, aged care and education, as an academic, researcher and medical practitioner, to policy reform, and as a role model. His family are Palawa Trowerna from the Pyemairrenner mob in Tasmania which includes Trawlwoolway and Plairmairrenner and related clans.

Mr Terry Barnes

Consultant, Cormorant Policy Advice

Mr Barnes is a policy consultant, columnist and commentator, and a part-time fellow with UK policy think tank, the Institute of Economic Affairs. Formerly, he was a senior adviser to two Howard government health ministers, Michael Wooldridge and Tony Abbott.

Prof Tony Blakely

Centre for Health Policy, The University of Melbourne & University of Otago

Prof Blakely is an epidemiologist that has been involved in evaluation of public health interventions and cost effectiveness modelling as part of NZHRC-funded Burden of Disease Epidemiology, Equity and Cost-Effectiveness Programme (BODE³). He is a pioneer of the linkage of census and mortality data (the New Zealand Census-Mortality study).

Prof Philip Clarke

Centre for Health Policy, The University of Melbourne

Prof Clarke is Director of Centre for Health Policy at the Melbourne School of Population and Global Health, University of Melbourne. He has contributed to health economic policy debates in Australia, particularly around the pricing of generic pharmaceuticals and more recently the need for better statistics on outcomes and cost in the Australian system.

Dr Bronwyn Croxson

Ministry of Health, New Zealand

Dr Croxson is Chief Economist at the Ministry of Health, New Zealand. She has previously held posts at the New Zealand Treasury. Before moving to New Zealand she worked as an academic in the UK, with research interests focussing on the role of incentives in the public sector and institutional economics. She has a PhD from the University of Cambridge, where she also held a teaching fellowship.

Dr Henry Cutler

Inaugural Director of the Centre for the Health Economy at Macquarie University

Dr Cutler is Inaugural director of Centre for the Health Economy at Macquarie University. He has led or co-authored over 80 health economics reports on a broad range of topics for federal and state government departments, government agencies, and Australian and international non-government organisations. His focus is on policy analysis, economic evaluation, and using quantitative techniques to evaluate health and human services data. Prior to Macquarie University, Henry was the national leader of KPMG's health economics group, and led the Sydney Access Economics' health and social policy team.

Emeritus Prof Meredith Edwards

Institute for Governance and Policy Analysis, University of Canberra

Emeritus Prof Edwards is an economist who has been a lecturer, researcher, policy analyst and administrator through her career. From 1983 to 1997, she advised on some major social policy, education and labour market issues in the Commonwealth Public Service, including in the role of Deputy Secretary of the Department of Prime Minister and Cabinet from 1993. She served as Deputy Vice-Chancellor of the University of Canberra from 1997 to 2002, and set up the National Institute for Governance.

Prof Adam Elshaug

Co-Director, Menzies Centre for Health Policy University of Sydney

Prof Elshaug is an internationally recognized researcher and policy advisor specializing in reducing waste and optimizing value in health care. He is Professor of Health Policy, HCF Research Foundation Professorial Research Fellow, and Co-Director of the Menzies Centre for Health Policy (MCHP) at The University of Sydney. He also heads the Value in Health Care Division within MCHP, is Senior Fellow with the Lown Institute in Boston, a ministerial appointee to the (Australian) Medicare Benefits Schedule (MBS) Review Taskforce and a member of the Choosing Wisely Australia advisory group.

Emeritus Prof Bob Gregory

Prof Gregory has made major contributions to the development of economic policy in Australia. From 1985-95 he was a member of the Board of the Reserve Bank of Australia. Prof Gregory is an elected Fellow of the Academy of Social Sciences and was the Economic Society of Australia Distinguished Fellow (2001).

Dr Catherine Keating

Head of Health Economics & Outcomes, Medibank Private

Dr Keating is Head of Health Economics & Outcomes at Medibank. Her focus areas include designing new healthcare services to improve the health of the membership, predictive analytics to support targeted delivery of programs and formal evaluation of program health and economic impacts. Prior to joining Medibank, Dr Keating had an academic career where her research focused on the cost burden, epidemiology and cost-effectiveness of interventions for chronic health conditions.

Prof Stephen King

Commissioner, Productivity Commission

Prof King joined the Productivity Commission as a Commissioner from 1 July 2016. He was until recently a Professor of Economics at Monash University in Melbourne where he also held the position of Dean of the Faculty of Business and Economics from 2009-2011. Prior to joining Monash, Stephen was a Member of the Australian Competition and Consumer Commission (ACCC), where he chaired the Mergers Review Committee. Previous roles include, Professor of Economics at the University of Melbourne and a Professor of Management (Economics) at the Melbourne Business School.

Hon Dr Andrew Leigh

Shadow Assistant Treasurer and Federal Member for Fenner in the ACT

Hon Dr Leigh is the Shadow Assistant Treasurer and Federal Member for Fenner in the ACT. Prior to being elected in 2010, Andrew was a Professor of Economics at the Australian National University. He holds a PhD in public policy from Harvard, having graduated from the University of Sydney with first class honours in Law and Arts. Dr Leigh is a Fellow of the Australian Academy of Social Sciences, and a past recipient of the 'Young Economist Award', a prize given every two years by the Economics Society of Australia to the best Australian economist under 40.

Prof Andrew Podger

Australian National University College of Arts and Social Sciences

Prof Podger AO was a long-term public servant before joining academia including Secretary of the Australian Department of Health and Aged Care from 1996-2002. Before leaving the Australian Public Service in 2005, he chaired a review of the delivery of health and aged care services for then Prime Minister, John Howard. Since then he has been an Adjunct Professor at ANU and Griffith University, and at Xi'an Jiao Tong University in China. He is also a Visiting Professor at Zhejiang University.

Prof Anthony Scott

Melbourne Institute of Applied Economic and Social Research, The University Melbourne

Prof Scott leads the Health Economics Research Program at the Melbourne Institute of Applied Economic and Social Research at The University of Melbourne. His research interests focus on the behaviour of physicians, health workforce, incentives and performance, primary care, and hospitals. He has undertaken work for the World Bank, Independent Hospital Pricing Authority, and the Commonwealth and State Departments of Health.

Ms Alison Verhoeven

Australian Healthcare & Hospitals Association

Ms Verhoeven holds an MBA with a specialisation in International Business, a Master of Letters, a Graduate Diploma in Education, and a Bachelor of Arts. Her professional affiliations include membership of the Australian Institute of Company Directors and the Australian Institute of Management. She has broad experience in health, education, corporate governance and communications, and has worked in both the private and public sectors in Australia, the Asia-Pacific region, and Europe.

Prof Rosalie Viney

Director of the Centre for Health Economics Research and Evaluation, University of Technology Sydney

Prof Viney is Professor of Health Economics and Director of the Centre for Health Economics Research and Evaluation at the University of Technology Sydney. She has extensive experience in health economics, health services and health policy research. Her research interests include health technology assessment and priority setting, measurement and valuation of quality of life and health outcomes, consumer preferences for health and health care, evaluation of health policy, and the impact of funding arrangements on utilisation and outcomes of health care.

Hon Dr Michael Wooldridge

Former Minister for Health

Hon Dr Wooldridge initially trained in Science and Medicine and now works as a consultant specializing in health care policy, regulation and technology matters. He served as Deputy Leader of the Federal Opposition, Minister for Health and Aged Care (1996-2001) as well as chair of UNAIDS (Geneva) and East Asia/West Pacific Regional Chair of the World Health Organization. He is the longest serving Federal Health Minister from the Coalition parties over the past 50 years.



Revisiting Whitlam's Vision for Health: Economists, Data and Efficiency

6 October 2017

Old Parliament House Canberra





He was the first politician to use the term *health economics* in the Australian Parliament and argued the case for:

- Greater use of economics to inform health policy decision making;
- Improving the collection of health and health care data;
- Increasing health system efficiency by promoting competition.