



GlaxoSmithKline

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The Committee Secretary
Standing Committee on Health and Ageing
House of Representatives
Parliament House
CANBERRA ACT 2600

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Dear Sir/Madam

GlaxoSmithKline (GSK) welcomes the opportunity to contribute to the House of Representatives Standing Committee on Health and Ageing inquiry into Health Funding. This inquiry is both important and timely and will assist in focussing current public and policy interest on the implications of ageing on Australia's health financing challenges.

GSK background

GSK is a world leading, research-based pharmaceutical company dedicated to meeting the healthcare needs of people around the world and helping them do more, feel better and live longer. The company is a global leader in the research, development, manufacture and supply of prescription medicines, vaccines, over the counter medicines, oral care products and nutritional healthcare drinks.

At the forefront of the rapid progress medical science, GSK is committed to sustaining its current R&D intensity and investment. The company allocates approximately \$A7.7 billion (£2.8 billion) to R&D annually and has a significant product pipeline of new chemical entities and vaccines in clinical development. Within Australia, GSK invests over \$A30 million in R&D annually, making it one of the largest contributors to business investment in R&D.

With a longstanding commitment to the pharmaceutical industry, GSK offers substantial insight into its diversity and complexity. The company's perspectives are underpinned by an understanding of future directions in pharmaceutical technology, experience of international trends and commitment to the long-term sustainability of the industry in Australia.

The role and value of medicines

Medicines have played an increasingly important role in the prevention and treatment of diseases over the course of the last century - particularly since major public health challenges were addressed through public works such as sewerage and sanitation.

Mass vaccination has effectively eliminated the risk of many diseases (e.g. polio) which caused substantial rates of disability or premature death in Australia only decades ago. The introduction of modern medicines is continually reducing the burden of disease and changing the way particular diseases are treated. As new treatments are invented and diffused, the means by which we address healthcare needs will continue to evolve.

Medicines save lives, relieve pain, prevent and cure disease. They help keep families together longer and improve the quality of life for patients and caregivers. Medicines enable employees to stay on the job and remain economically productive in the community. They also help people – and the health care system – avoid disability, surgery, hospitalization and nursing home care, often decreasing the total cost of caring for an illness.

However, medicines should not simply be viewed through the prism of reducing other healthcare costs. Medicines can also address unmet medical needs and improve the health state and life expectancy of patients for whom current treatment is inadequate or associated with substantial side effects.

The following discussion outlines the value of medicines in terms of their ability to reduce health care expenditure, reduce mortality, raise life expectancy and increase productivity.

Reduced health care expenditure

Research undertaken for the National Bureau of Economic Research (NBER) in the United States has shown that the use of newer drugs tends to lower all types of non-medicine medical spending, consequently reducing the total cost of treating a condition. Findings suggest that an \$18 increase in spending on new prescription drugs reduces non-drug expenditure by \$71.09, resulting in a net saving of \$53.09¹. This lower non-drug expenditure is due in large part to reduced hospital expenses. Another study has shown that every US\$1 increase in drug expenditure is associated with a US\$3.65 reduction in hospital expenditure².

Similar research in the UK has also demonstrated the cost-effectiveness of medicines there, finding that since the 1950s, medicines have helped halve the number of hospital beds used in 12 major disease areas and reduce the average hospital stay from 45 days to eight. The savings that result from such reductions were reported as being in the vicinity of £10 billion a year.³

Reduced mortality and increased life expectancy

The value of reduced mortality and increased quality of life are hard to quantify, and inevitably involve the consideration of non-economic values. However, the benefits of medicine on mortality and quality of life are clear and their effective use has eliminated or controlled many diseases and conditions with traditionally high mortality rates. Over 45% of the variation in mortality across diseases between 1970 and 1991 is explained by the extent new drugs were used to treat the disease⁴.

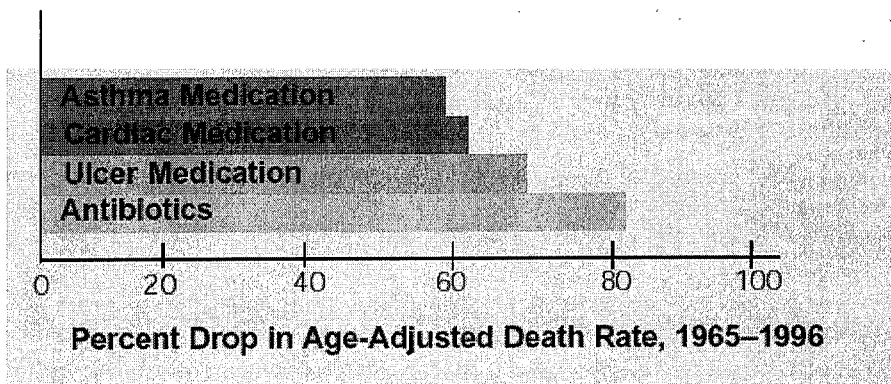
Some specific examples of the reduced mortality associated with certain pharmaceuticals are shown in the following chart:

¹ Lichtenberg F, "Are the Benefits of Newer Drugs Worth their Cost?" Health Affairs 2001; 20(5): 241-251.

² Lichtenberg F, "Do (more and better) drugs keep people out of hospitals" American Economic Review 1996; 86: 384-388.

³ http://www.abpi.org.uk/press/press_releases_97/971210.asp

⁴ Lichtenberg F, "Pharmaceutical innovation, Mortality Reduction and Economic Growth," Presented at the Conference on the Economic Value of Medical Research, December 1999.



Source: PhRMA (1998) & National Centre for Health Statistics (1998).

The benefit of reducing disease-related mortality may be difficult to quantify in monetary terms but should not be undervalued.

Disease-related mortality is closely linked to average life expectancy which has been steadily increasing in Australia over past decades.

Average life expectancy (yrs) in Australia

	1960	1970	1980	1990	1995	2000	2001	2002
Males	67.9	67.4	71	73.9	75	76.6	77	77.4
Females	73.9	74.2	78.1	80.1	80.8	82	82.4	82.6

Source: OECD Health Statistics 2002

While there are a number of factors contributing to increases in average life expectancy, such as improvements in nutrition, increased health awareness, public health campaigns and better health services, pharmaceutical innovation has been critical to these results.

In a study which measured the relationship between new drug launches and life expectancy in 52 nations over the period between 1982 and 2001, average life expectancy was demonstrated to have increased by 1.96 years over this period with 40% of that gain attributed to the impact of *new* medicines⁵. Notably older medicines were accredited little impact in this regard.

A wider study involving 21 OECD countries also investigated the link between pharmaceutical expenditure and life expectancy. The study estimated that doubling pharmaceutical consumption would raise remaining life-expectancy by 2% for the average 40-year old and 4% for the average 60 year old⁶.

Resultant impact on economic growth

Decreases in mortality and increases in life expectancy become cost-effective outcomes partly through their impact on economic growth – primarily driven the increases in the workforce participation rate and productivity. If people live longer and in better health, they will have a greater opportunity to work longer, spend more

5 Lichtenberg F, 'The impact of new drug launches on longevity' NBER Working Paper 9754

6 Frech, H., Miller, D. The Productivity of Health Care and Pharmaceuticals: An International Comparison. Washington, D.C.: AEI Press, 1999.

on goods and services, generate additional tax revenue, while also demanding fewer health care and support services.

Economic research has indeed linked longer life expectancy with economic growth. In a study comparing two nations, identical except for one having a 5 year longer life expectancy, it was found that the healthier nation experienced economic growth at a 0.3-0.5% faster rate per annum. Another study using international data relating to the period between 1960 and 1990, found improved health was found to have had a substantial impact on economic growth. Ultimately, the study concluded that "...a one year improvement in a population's life expectancy contributes to a 4% increase in output"⁷.

Quantifying the benefit

From a policy maker's perspective, assigning a specific value to these benefits can be highly problematic.

- Frequently, they become apparent only over very long periods of time.
- Qualitative benefits, such as improved quality of life, can be inherently difficult to assign an economic value.
- Effective measurement requires comprehensive data, which is often expensive and in Australia is a particular challenge due to divided responsibility for service delivery.
- Moreover, split responsibilities for funding and delivery of services, between different levels of government, also creates a disincentive to fully recognise and value the benefit of certain health interventions.

Any review of the way health is financed in Australia should take account of not only the cost of providing services, but the full value and all the benefits of those services to the community.

Addressing the financing challenge

It is important to consider expenditure on pharmaceuticals as an investment in improved health and productivity. However, even once the full value of medicines to the healthcare system and the broader community is considered, there remain significant financing challenges. While there has been debate around some projections of future healthcare costs, particularly with respect to pharmaceuticals, there is a broad consensus that, without policy change, the financial demands on the Commonwealth Budget through growing healthcare costs, particularly on the Pharmaceutical Benefits Scheme (PBS), will be significant.

New and more expensive medicines are generally only made available through the PBS following an extremely rigorous economic cost-effectiveness analysis. Although the application of this methodology is occasionally controversial, it does ensure that decisions regarding the allocation of funds for new medications are taken within a broader economic and healthcare context. While this process may ensure that publicly subsidised medicines deliver 'value for money', it does not remove the overriding fiscal challenge: As an ageing population increasingly utilises pharmaceuticals and the industry develops new and more effective treatments, demands on the PBS budget will increase. Clearly, PBS sustainability, in this sense, requires a measure of system reform.

7 Bloom D, Canning D, Sevilla J. The Effect Of Health On Economic Growth: Theory And Evidence. Working Paper 8587. 2001. Cambridge, MA, National Bureau of Economic Research. NBER Working Paper Series.

Principles underpinning reform

Before considering the design and impact of measures to address the PBS financing challenge, agreement is necessary on the key principles expected of the scheme. As a core part of Australia's universal public healthcare system (indeed being several decades older than Medicare), the PBS enjoys broad support in providing affordable access to safe and effective medicines for all Australians.

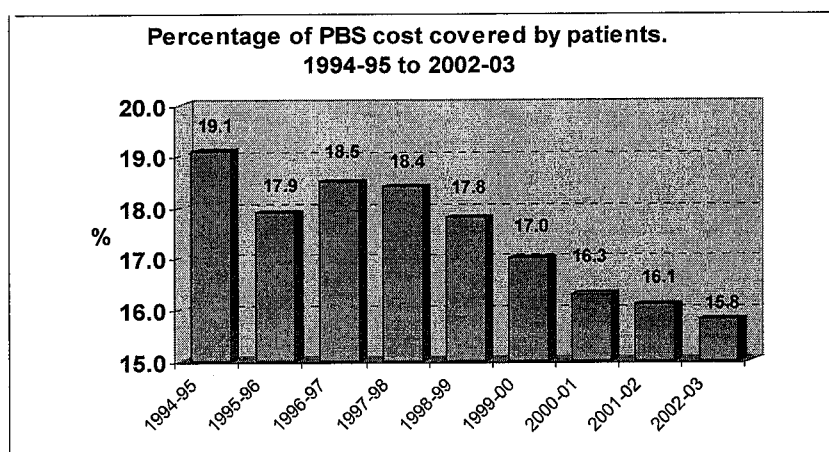
Agreement on the following principles should underpin any consideration of measures to address the fiscal challenge:

- Access to medicines that have been demonstrated as safe and clinically and cost effective should be timely and not delayed or denied purely because of increases in the cost of medicines, or overall PBS costs
- Consistent with the aims of the broader Australian healthcare system, access should be based on medical need, not ability to pay
- Patient contributions are appropriate and consistent with the above aim provided they are designed appropriately and do not undermine equity objectives
- Funding access to medicines should be viewed as part of the broader healthcare system, and not simply through a prism of increasing PBS cost to Government
- Doctors and patients should be free to determine the most appropriate and effective course of treatment, and this should be determined by patient need rather than individual financial restrictions imposed purely to contain costs

Ideas for reform

This challenge of meeting rising demand for medicines in publicly-funded health systems is not peculiar to Australia – it is a common challenge across virtually every OECD economy. GSK believes this challenge can be addressed while still achieving the broad goals of the PBS by directing greater private funds and resources to meet envisaged rising demand.

Total patient contributions represent around 20% of the PBS cost to Government – more when the PBS items not processed by the Health Insurance Commission (HIC)⁸ are considered. Over the past decade, this has tended to drift downwards, increasing when the Government has increased the patient copayment levels. The level is projected to again rise to around 18% when the recently-legislated copayment increase takes effect in 2005.



Source: HIC data

⁸ Scripts for general patients that are below the general copayment level are not captured by HIC data, as no reimbursement to pharmacy is required.

The current patient contribution system has been in place for many years. Being based on essentially two categories with safety nets (general and concessional) it is a relatively blunt welfare mechanism.

The copayment system could be redesigned to require a greater patient contribution to medicine cost and at the same time improve the equity of its application. Some proposals which could be considered include a system based on:

- means testing
- categorisation of medicines
- national health priority areas

While the role played by price signals and on PBS utilisation has only recently become the subject of detailed research, the impact that changing copayment structures have on patient behaviour is crucial when analysing the impact of any proposed change to patient contributions.

Although GSK does not endorse any particular approach, it does support further analysis of the impact of patient contributions and copayments. Such research would better inform the debate around medicine use and the appropriate level of patient contributions. Alternative proposals based around introducing private health insurance mechanisms and/or accessing accumulated private savings may also be worthy of consideration.

Conclusion

The health funding challenge faced by Australia, both now and over the coming decades, is significant, but not insurmountable. Just as there are varying analyses of the extent of the challenge, so there are alternative means of addressing it. The keys will be: recognition of not just the costs, but also the full range of benefits of various health services; explaining the challenge to the Australian community in realistic terms; and drawing them into a consensus which considers alternative sources of funding for anticipated expenditure growth.

GSK appreciates this opportunity to contribute to the Committee's inquiry and trusts the information provided will be of assistance in its deliberations. If there is anything in the submission which requires clarification, or the Committee needs further information relevant to the pharmaceuticals industry, please do not hesitate to get in contact with me on 03 9721 6712. Representatives of GSK would also be more than happy to participate in any planned public hearings undertaken as part of the inquiry, if this is deemed appropriate.

Yours sincerely



Scott Ryan
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GlaxoSmithKline Australia