

# Baker IDI PERSPECTIVES

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## In this edition of Baker IDI PERSPECTIVES

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## MRFF: A game changer for Australian innovation.

**M**uch of the discussion around the Federal Budget seems to be that if it is not 'all good'; it must be 'all bad'. Medical research, which all parties and the public agree is important, has unfortunately been caught up in this oversimplified view.

PROFESSOR GARRY JENNINGS AO

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As some commentators have opined, spending scarce funds in Australia to find a cure for major disease is a waste of money because most likely it will happen overseas. Many have argued that the Budget should be directed at the health system where it is needed now, not medical research that delivers hope for the future. While others have been quick to point out that it takes many years to reap the rewards of scientific discoveries and most innovations will not succeed to market. These are common sentiments that have been expressed since the Prime Minister proposed the \$20 billion Medical Research Future Fund (MRFF), a cornerstone of the Federal Budget. However, the evidence base suggests otherwise – that this investment can transform our health and economic sectors and, importantly, the health of all Australians.

If you look beyond the political rhetoric, as well as the speculation about how the money should be spent and in what areas, fundamentally the fund has value and yet very few people, including those in the medical and health sectors, have acknowledged that to the degree it deserves. For those of us who work in medical research, our scientific work has always been based on evidence; on rigorous analysis and robust peer-review; and if we apply this same scientific lens to criticism of the Fund, perhaps we might see the broad benefits that it offers. Let's examine some of that criticism.

**Spend the money in health not medical research where it is most needed, particularly with regards to vulnerable groups in our community.** In the minds of many, the two are quite separate. And yet those who work at the coalface, where laboratory and bedside

## If you look beyond the political rhetoric, as well as the speculation about how the money should be spent, fundamentally the fund has value.

meet, will know they are intrinsically linked. Scientific research underpins the modern health system. There is significant international evidence that hospitals and healthcare facilities that do research derive enhanced patient outcomes and health system efficiencies.

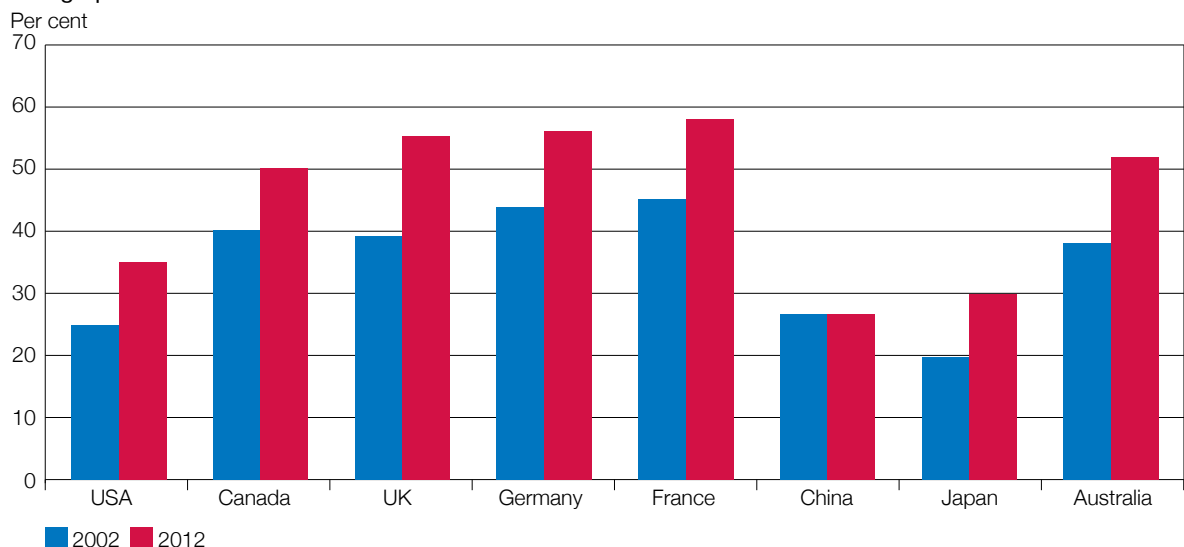
A key theme in the Strategic Review of Health and Medical Research<sup>1</sup> presented to the Federal Government in 2013 was that the best performing health systems are those that embed research in health delivery, which leads to better health outcomes. A case in point is the work of Australian Nobel Laureates Robin Warren and Barry Marshall who made a remarkable and unexpected discovery of the bacterium *Helicobacter pylori*. As a result of their discovery, peptic ulcer disease

is no longer believed to be caused by stress and lifestyle factors, but is rather a disease that can be cured by a short regimen of antibiotics and acid secretion inhibitors. Critical to this discovery was the participation of health professionals in research.

**If a cure for a major disease is to be found, it is most likely to be found in Europe or the United States.** Australian discoveries in health and medical research, such as the Gardasil vaccine against cervical cancer and the Cochlear hearing implant, demonstrate Australia is well and truly capable of discoveries that have a transformational impact on the health of our community. At the Burnet Institute, researchers are working on a point of care CD4 test, funded

### Share of Science and Engineering articles with international co-authors

This graph shows the article counts for selected countries in 2002 and 2012



Notes: Article counts are from the set of journals covered by the Science Citation Index (SCI) and Social Sciences Citation Index (SSCI). Articles are classified by the year they entered the database, rather than their year of publication, and are assigned to a country/economy on the basis of the institutional address(es) listed in the article. Articles are credited on a whole-count basis (ie: each collaborating institution or country is credited one count). Internationally co-authored articles may also have multiple domestic co-authors.

Source: National Science Foundation, National Center for Science and Engineering Statistics and The Patent Board™, special tabulations (2013) from Thomson Reuters, SCI and SSCI, [http://thomsonreuters.com/products\\_services/science/](http://thomsonreuters.com/products_services/science/). See appendix table 5-41. *Science and Engineering Indicators 2014*

by the National Health and Medical Research Council (NHMRC) initially, which is now being manufactured in the UK and is in field trials in three countries. The test, which overcomes the major barriers to the anti-retroviral therapy, stands to benefit approximately seven million of the world's poorest HIV positive people.

Likewise in Australia's Aboriginal health sector, the benefits of scientific research are visible. Life expectancy in Indigenous communities is improving and for the first time, closing the gap in the coming decades is within reach. But the health needs of Australian Aboriginal and Torres Strait Islander people are unique, and will not be addressed by research conducted in Europe or the United States. Most doctors in the developed world have rarely encountered a case of Rheumatic Heart Disease, for example, and yet rates of this condition, among Indigenous communities in Australia, are among the highest documented in the world. Australian researchers are working to eradicate this potentially fatal form of childhood heart disease but without continued investment, health improvements will likely decline.

**Australia only contributes 3 per cent of the world's scientific output.** But we need access to the other 97 per cent, and with this access comes major advances through international collaborations. Australia plays a leadership role in establishing and partnering in global consortia. The US National Science Foundation recently found that more than 52 per cent of published scientific papers in Australia had international co-authors, well above the 25 per cent global rate.<sup>2</sup> Big science has the potential to deliver big impact and Australia is a critical part of this. However, our scientists need access to size and scale when it comes to patient cohorts and technology to speed up research.

At Baker IDI, heart disease researchers are collaborating with scientists in Peking, China, to

evaluate a new biomarker in the diagnosis of acute heart attack. The collaboration is essential to establish access to a high volume of patients and fast-track this work but the innovation comes from Melbourne: from the collaborative work between bench top researchers and clinicians working in one of the country's busiest cardiology units.

**The investment won't deliver dividends now, science works on a much longer timeframe.**

The lifecycle of innovation does take 7-10 years and we do need to get better at commercialising our research but the contributions of science to economic growth are nonetheless impressive. Medical research contributes to a burgeoning medicines industry that contributes more than \$4 billion worth of exports in Australia per annum and in recent years, the medicines industry has been the Australian manufacturing sector's biggest high-tech export earner. While the majority of other manufacturers, including the car industry, continue to lose ground, the medicines industry has been increasing.

The global pharmaceuticals market, which is currently worth around \$890 billion, is expected to be worth nearly \$2 trillion by 2020.<sup>3</sup> With its growing population, rising living standards and an increasing burden of chronic disease, Asia will be one of the main drivers of this growth. This represents a significant opportunity for Australia and increased investment could help build this into one of our key innovative export industries.

**Financial modelling around return-on-investment in medical research further supports the economic benefits.**

Various reports including the Rand Report<sup>4</sup> from the UK, an Australian report by Deloitte Access Economics<sup>5</sup> and others have used different methodologies to show the net health gains, including improved quality of life, and the return on investment to the economy as a result of investment in medical research. The results show that for every one dollar spent on research,

**There is significant international evidence that hospitals and healthcare facilities that do research derive enhanced patient outcomes and health system efficiencies.**

at least two dollars was generated in additional economic output, with this figure much higher in several studies. There are, of course, limitations with this data, particularly with regard to when the returns will be made, but there is general agreement that spending on science generates jobs and economic growth.

**With Australia facing an ageing population and growing rates of chronic disease, we need immediate action.** Research continues to deliver increased life expectancy and better quality of life with a reduction in disability, particularly for the aged. Australian research informs policy; it informs diagnosis, treatment and prevention – all of which contribute to a better quality of life for Australians. One of the world’s largest longitudinal population-based health studies was conducted by Baker IDI to examine the health of Australians over 12 years with regards to heart and kidney disease, diabetes and obesity. This research is critical in guiding how best to spend health dollars, where to investment in treatment and how Australians can play an important role in improving their health. This work also informs what clinicians should be talking about with their patients and what tests they should be doing to prevent complications and disability. This is not pie-in-the-sky research but work that has a direct bearing on people’s health today.

The potential of the MRFF by the Federal Government is enormous. Yes, there are questions to be answered about the Fund, including how it will work and what areas it will fund, but we shouldn’t lose sight of the bigger picture. Australia has one of the best healthcare systems in the world, and research underpins that. The potential to do much, much more is truly exciting. The Medical Research Future Fund is a game changer and the evidence shows all Australians stand to benefit.

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# Medical research for our future.

There are more linkages between Australia's physical and economic health than most people may realise. Properly targeted investments have the capacity not only to improve health outcomes, but to create jobs and drive economies of scale in one of our most innovative industries.

THE HON. PETER DUTTON MP  
*Minister for Health and Minister for Sport*

In the long-term, our health is largely dependent on our ability to understand what makes us sick, and how well our doctors and scientists can address those issues. In the past 50 years, advances in medical science have garnered some remarkable success to that end. In 2009, for example, 63 per cent of people who had a heart attack survived, compared with less than half (45 per cent) in 1994.<sup>1</sup>

The survival rate for many common cancers has risen by 30 per cent in the past two decades. As a result, the death rate from cancer (deaths per 100,000 people) has fallen by more than 16 per cent over the past 30 years, despite a rising number of cases due to population growth and ageing.<sup>2</sup>

While we can only imagine what advances the future may hold, there can be no overestimating the role of research in improving the health of Australians through better disease prevention, detection and treatment. Indeed, it has been estimated that every one dollar spent on health and medical research generates more than two dollars in health benefits alone.<sup>3</sup>

Research can also improve our health system by ensuring that our medical professionals use clinically effective practices. As observed in *Better Health Through Research*, the report of the McKeon Review into health and medical research: "...research must be routinely performed as a part of healthcare delivery and there must be greater linkage between healthcare providers and research organisations."

The report goes on to say "...as we face a trajectory of unsustainably increasing healthcare costs, we must use research to improve the efficiency and effectiveness of the health system."

That speaks, in part, to the significant economic benefits that can flow from research: both indirectly, from the reduced burden of a healthier population on the health system; and directly, from

the earnings of biotechnology, pharmaceutical, and medical technology industries.

Yet only 4.9 per cent of total spending on health in Australia currently goes to research.<sup>4</sup> Australia's OECD ranking on health research funding as a percentage of Gross Domestic Product (GDP) has declined of late, while emerging economies like China, India and Brazil are investing more into research than ever before.<sup>5</sup>

The Abbott Government has acted on the expert advice, building on the strong record of the Howard Government in this field. But long-term investment is critical: it can take many years for basic research to produce results for patients.

It was with this in mind that we formed the Medical Research Future Fund, which was the centrepiece of the 2014-15 Budget. The Fund is the cornerstone of our plan for the health system and represents Australia's largest ever investment in medical research.

Provided our political opponents don't move to block the Fund in the Senate, it will reach its target of \$20 billion capital by 2020, which will be legally protected from any future attempt by Labor to raid it. However, the Fund will start yielding dividends for medical research, primarily to the National Health and Medical Research Council, from 2015-16.

When fully mature, earnings from the Fund will pour an additional \$1 billion a year into medical research – doubling the Government's investment in priority areas. Money for the Fund will accrue from efficiencies and savings in health spending, and \$5 from each \$7 patient contribution for previously bulk-billed GP services and out-of-hospital pathology and diagnostic imaging services.<sup>6</sup>

By the time the Fund reaches maturity, not only will we have modernised Medicare and strengthened it for the decades ahead, but the very mechanism

with which we did so will have turned Australia into a world leader in the unearthing of cures to our worst diseases. Better still, every Australian who has been to the doctor will own a share in it. Our health and medical research sector is already worth around \$6 billion a year, and is the key driver of productivity and innovation in the growing healthcare sector – which employs more than a million Australians.

The biotechnology, medicinal and pharmaceutical products and medical devices industry is a major Australian success story and increasingly important to our modern economy. Over the past 20 years, this sector has grown by an average of 12 per cent a year and is now Australia's largest manufacturing export sector, generating \$4 billion annually in export income.<sup>7</sup>

The Medical Research Future Fund promises to turbocharge the already high-performing sector, creating jobs in manufacturing and boosting

exports. Moreover, it will provide the very platform for the next generation of cutting edge medical discoveries and will save lives, enhance our quality of life, and reduce pressure on the health system. Medical research doesn't just make good health sense. It makes sound economic sense too.

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**While we can only imagine what advances the future may hold, there can be no overestimating the role of research in improving the health of Australians.**

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# Successful transition to a knowledge economy requires bold choices.

Australia's competitiveness is the single most important factor in determining the country's economic success in a global world. For advanced economies like Australia, competing in the knowledge and innovation economy is more important than ever.

ALEX MALLEY  
*Chief Executive, CPA Australia*

Our position in this emerging economy is good but not great, and we lack a systemic culture of innovation. We are surrounded by hyper-competitive, emerging economies such as China and Indonesia that pose some of the most extraordinary challenges and opportunities that Australia may ever face. We have to compete by being smarter, by being innovators. The Medical Research Future Fund (MRFF) is a step in the right direction – with the MRFF effectively doubling the Government's annual investment in Health and Medical Research over the next decade – but it's not enough and it's not part of a comprehensive commitment to innovation. We also need structural changes including improved linkages between research and business; policy settings which incentivise research and development and foster innovation; and greater investment in our workforce of tomorrow. We need to make bold choices and we need to make them now.

When it comes to competing in the knowledge economy, we need to be objective about our performance. If we fail to move past the notion of being the 'lucky country', acknowledge our shortcomings and articulate a vision to be more globally competitive, then we risk succumbing to complacency.

CPA Australia continues to put competitiveness on the national agenda by highlighting what

we believe are the critical drivers of Australia's future economic success. Our landmark publication *Australia's Competitiveness: From Lucky Country to Competitive Country* contains the most comprehensive research into Australia's international competitiveness, drawing on the insights of 6000 Australian and international business leaders. The findings, released last year at the National Press Club in Canberra, emphasised that Australia's economic growth rates are trailing behind those of our major Asian competitors, many of whom are already ranked higher on the competitiveness index.

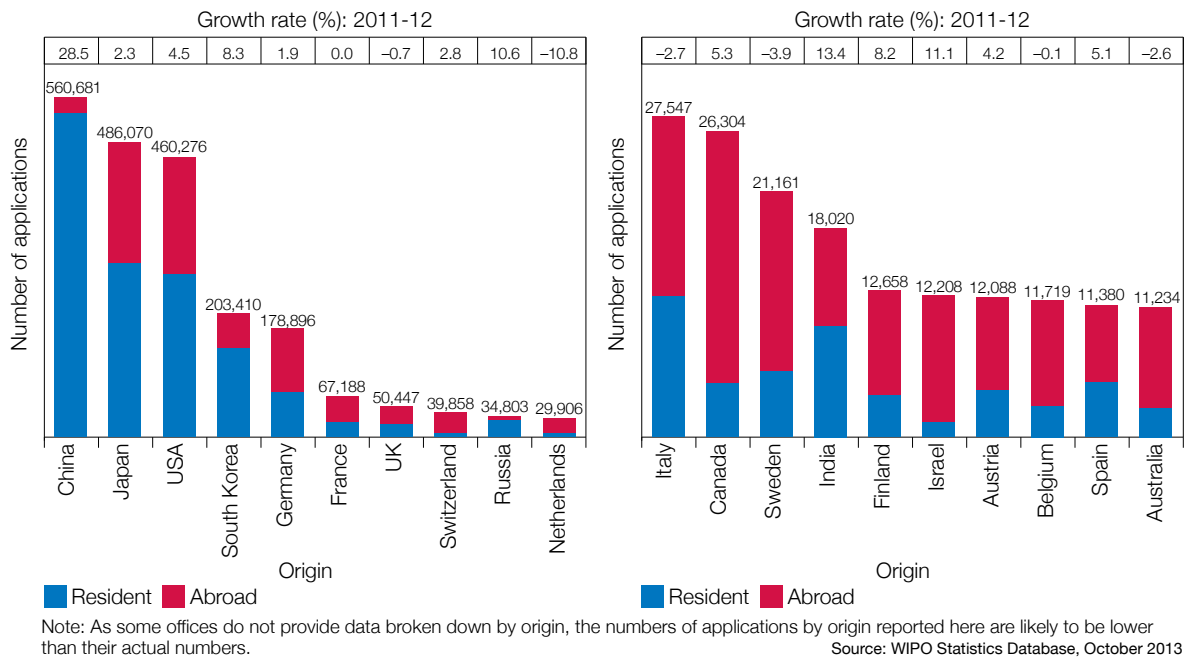
To be globally competitive, Australia needs to remove the barriers that stand in the way of innovation. According to the 2012 Australian Innovation System Report, the innovation performance of Australian businesses is poor by international standards, especially for large businesses which rank almost last in the OECD on innovation. In the five years between 2005-06 and 2010-11, the proportion of Australian businesses reporting one or more barriers to innovation increased to 45 per cent with the two most common perceived external barriers to innovation being limited access to skilled people or access to additional funds.

Australia also needs to improve its ability to commercialise its discoveries. It is not enough to produce world-class research; we must

## We need to make bold choices and we need to make them now.

## Patent applications for the top 20 countries in 2012

As determined by the residence of the first-named applicant



develop the capabilities and infrastructure to transform medical discoveries into products and services. Patents are one measure of successful commercialisation, with global rankings highlighting the challenges that lie ahead. Australia ranks 20th for total intellectual property activity patents behind China, Japan and Korea, and is even trailing smaller nations including the Netherlands and Switzerland.

If Australia is to step-up its international competitiveness we need to ensure we are driving policy innovations that attract investment and nurture research and commercialisation. We must look at what the rest of the world is doing – new Patent Box rules in the UK allow companies that have undertaken the development of a patent in the UK to apply a 10 per cent corporate tax rate to profits earned from any patented inventions – and stay ahead of the policy innovation curve.

Improved linkages between research and business are also needed to enable Australia to successfully transition to a knowledge economy. We need to leverage intellectual capital, facilitate greater collaboration between universities and institutes and improve communication and links between education and business sectors.

We need to learn to compete against new competitors. There is still a question about whether Australia and Australian companies have the knowledge, connections and drive to penetrate new markets, particularly those in Asia.

Australia's growth rates have trailed well behind other growing economies in Asia so there is still considerable room for improvement.

Opportunities abound. With our English language capabilities, we are well-placed to become the Asia-Pacific centre for the 24-hour a day business operations of international companies involved in high-value, knowledge-intensive activities. In addition to health and medical research, these include architecture, design, software, engineering, legal services, consulting and accounting. As an example, with our technology and highly trained and skilled medical practitioners, why couldn't radiologists in Australia provide overnight coverage for the 24-hour operations of big medical centres in the United States?

We need to address fundamental questions such as how to tackle the talent 'brain drain'. When you speak with technology start-ups in Australia it doesn't take long before the conversation quickly turns to why so many amazing ideas and technologies have their humble beginnings in Australia but end up overseas, and, more often than not, in the United States.

One of the key drivers of economic success depends on investing in the workforce of tomorrow. CPA Australia believes a more comprehensive strategy is needed which links education and training to the current and future needs of business. We believe education and training



are long-term investments that require consistency and certainty in policy and funding. While Australia has high levels of education participation and achievement, there is a disparity between the education and training sector and the needs of business. Initiatives such as the Federal Government's New Colombo Plan, which offers Australian undergraduates opportunities for scholarships and study grants in the Indo Pacific region, are a step in the right direction. The Plan provides students with the chance to gain new competencies, to expand their professional networks in our region and to sow the seeds for ongoing collaboration and knowledge sharing with our neighbours. It is this ability to operate in the global business community that we need to foster, including within the medical research sector.

Investment in innovation through the Medical Research Future Fund is but one small step in helping Australia transition to a knowledge economy. It is unclear yet what the MRFF might fund but in order to drive Australia's global competitiveness, it must have a strong focus on commercialisation; on building links between research and business; and on attracting and retaining talented people within the broader innovation sector. The Fund may help attract private investment to Australia and create high-value jobs but we must remain cognisant that our Asian neighbours are already doing this – and doing it well. We need to be smart about how we maximise such an investment and ensure we have a comprehensive framework in place, in the form of good policy and tax incentives, to drive a more globally competitive Australia.

**If Australia is to step-up its international competitiveness we need to ensure we are driving policy innovations that attract investment and nurture research and commercialisation.**

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## A 'point of care' tax will hurt the sickest people in the country.

The health of Aboriginal Australians could be at a tipping point. Hard fought gains in Aboriginal health, including a significant fall in Aboriginal mortality rates in the Northern Territory over the last decade, have almost certainly been achieved through improved access to a higher quality health system. An economic barrier to primary health care as a result of a \$7 GP co-payment proposed by the Federal Government in the Budget could jeopardise this improvement. This 'point of care' tax is likely to lead to worse outcomes for Aboriginal Australians, who are among the country's poorest and sickest people, by reducing their access to primary health care and essential medicines.

DONNA AH CHEE

*Chief Executive Officer, and*

DR JOHN BOFFA

*Chief Medical Officer Public Health,*

*Central Australian Aboriginal Congress Aboriginal Corporation (Congress)*

Such a regressive tax will also lead to greater inequality within the Australian community by further marginalising the most vulnerable members of our society. The co-payment should be scrapped in favour of a progressive tax to fund medical research, which has proven to be effective in delivering better health to the community and driving economic development. Progressive taxation measures are also a key driver to reduce the extreme levels of inequality that have developed in Australia, thereby improving economic growth and public health at the same time.

When it comes to Aboriginal health, the latest *Closing the Gap* report shows there is still a life expectancy gap of 11 years between Aboriginal and non-Aboriginal people in Australia (currently 11.5 years for males and 9.7 for females) and

that meeting the target remains "challenging". The Report says 'Closing the Gap' will not happen by 2031 (which is the government's target) unless the Aboriginal mortality rate declines at a much faster pace – the rate it has been declining in the Northern Territory. Meeting the life expectancy target remains particularly challenging because, among other things, non-Aboriginal life expectancy is expected to rise over the coming years. This latest assessment of Aboriginal health found that if the life expectancy gap is to be closed there has to be a strong focus on the chronic diseases that have a big impact on Aboriginal and Torres Strait Islander people, including heart disease and diabetes. There is plenty of evidence to show that early treatment and good management of chronic disease can prevent more acute complications, including premature death. But this requires universal access

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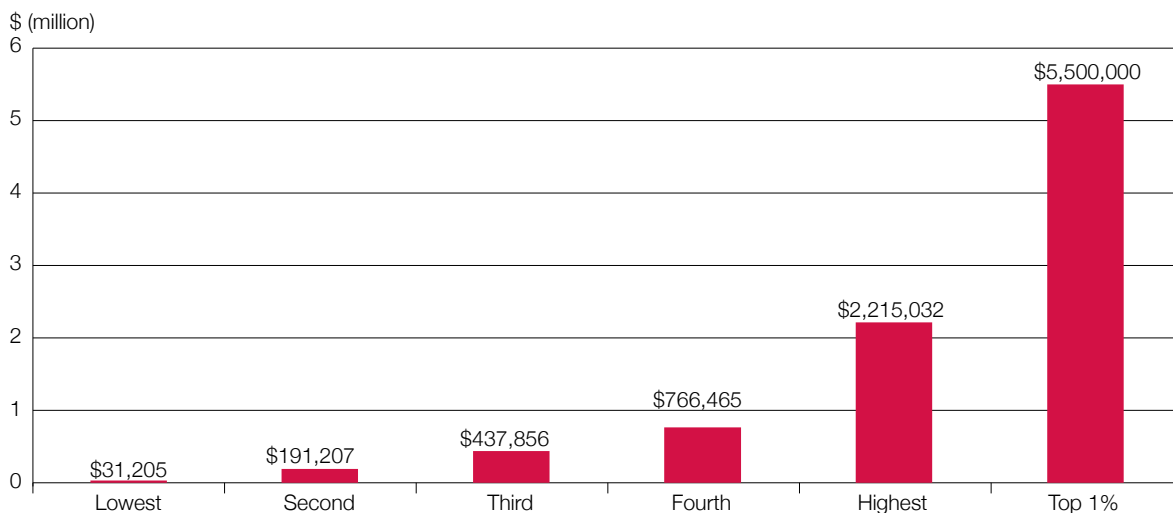
to the most efficient part of the healthcare sector, general practice and primary healthcare. Although it is proposed that care plan item numbers will be exempt from the proposed co-payment, many patients with chronic illnesses present for treatment other than for care plans many times a year. For example, when a patient is commencing blood thinning medications this requires multiple standard presentations and multiple blood tests in a short space of time, all of which will attract the co-payment. A lot of preventative healthcare also occurs as part of standard consultations.

The provision of adequate treatment for Aboriginal people with acute and chronic diseases, particularly those in rural and remote communities, already poses many challenges without the burden of a 'sick' tax. Many people throughout Australia do not necessarily know when seemingly minor problems are enough to cause serious, long-term harm if there are delays in treatment. For example, acute infected skin sores in children and infected throats, if not treated promptly, can lead to permanent damage to the kidneys and heart. The health system needs to maintain and increase its capacity to identify and treat the early stages of chronic diseases in Aboriginal communities before they become more disabling and costly to treat. A case in point is the Alice Springs Hospital, home to the country's largest dialysis unit with 299 people currently on dialysis. With Aboriginal people eight times as likely to begin dialysis or to receive a kidney transplant than non-Aboriginal people<sup>1</sup>, not surprisingly, nearly all of the dialysis unit's patients are Aboriginal. Imposing a 'sick' tax introduces yet another barrier to the type of preventative primary health care that could halt the progression

of renal disease. The COAG Reform Council's final report card, released in June, reinforced this. It showed cost was a barrier for one in eight Aboriginal people seeing a GP and for one third filling a prescription. Australia is already second worst to the US amongst a group of 11 developed nations with 30 per cent of patients choosing to avoid necessary medical care due to out-of-pocket costs<sup>2</sup>. We already have too many out-of-pocket costs in the Australian healthcare system without the burden of a GP co-payment.

A co-payment also goes against the commitment by Australian and international agencies to health equity. The principles of health equity were clearly outlined in the *Statement of Intent to Close the Gap in Indigenous Health Outcomes* in 2008. The World Health Organisation (WHO) also places significant emphasis on health equity, describing poorly performing health services as those that have an unfair burden of out-of-pocket expenses and high proportion of catastrophic household spending on health. Australia's health system has traditionally been recognised as one of the best in the world but this is being threatened. Australia's leading health economists almost universally agree that a co-payment will lead to the poorest and sickest people not accessing care as firstly, they don't have the money, and secondly, they don't know when the care they need is critical. Co-payments are likely to lead to a less efficient health system, ie; greater cost for worse outcomes<sup>3</sup>. Not only does this seem a backward step for an advanced economy like Australia but it also seems inconsistent with the Government's known interest and the Prime Minister's longstanding public commitment to improving Aboriginal health.

### Australian wealth inequality



This graph shows the average level of wealth by quintiles. This figure also provides an average level for the top one per cent of wealth holders, which is represented in the column on the far right.

Source: ABS (2013) Household wealth and wealth distribution, Australia, 2011-12

A second reason to oppose a co-payment is that it makes our country more unequal as wealthier, better educated people still access care when they most need it, thereby increasing the inequity gap. Societies with extreme inequality are bad for everyone's health. Even the richest people in more unequal societies do not have the same life expectancy as their wealthy counterparts in more equal societies<sup>4</sup>. The wealth of the seven richest Australians now exceeds that of the bottom 1.73 million households – inequality is back to the levels prior to the Great Depression and World War II<sup>5</sup>. This should be a concern for everyone and regressive taxes like co-payments are only going to make this worse.

The World Bank Group President, Jim Yong Kim, recently admitted that his organisation had made mistakes in the past, including a belief that poor people should pay at the point of care for healthcare. He warned that the implementation of this policy for ideological reasons led to worse health outcomes<sup>6</sup>. The growing level of inequality in Australia, including policies such as the co-payment and increasing higher education fees, require action, because “inequality is not an accident but rather a feature of capitalism that can be reversed by government intervention”<sup>7</sup>. The OECD's Economic Policy Reforms support a reduction in inequality as a key driver of economic growth and employment<sup>8</sup>. The International Monetary Fund has also joined the chorus of key global institutions recommending the need to use progressive taxation as a means to address inequality.<sup>9</sup>

Given the strong evidence about the damage excessive inequality does to peoples' health, there is a persuasive argument for pursuing new forms of taxation on capital rather than attempting to raise revenue through regressive measures like a co-payment and a higher out-of-pocket cost to attend university. Otherwise, Australia – like other developed nations – will soon be grappling with the ramifications of increasing levels of poverty, a loss of the middle class and declining levels of health among the community, especially for those already disproportionately represented in the poorest quintile. In this context, the improvement in the health of Aboriginal people is likely to halt or even go backwards.

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**There is plenty of evidence to show that early treatment and good management of chronic disease can prevent more acute complications, including premature death.**

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# PM's health cheque fails the reality check.

The Medical Research Fund is a waste of money and nothing more than a political fig leaf to cover the electoral pain of the GP co-payment.

PETER MARTIN  
*Economics Editor, The Age*

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It took Mark Latham to say the unsayable. "If a cure to cancer is to be found, most likely it will happen in Europe or the United States," he wrote in the *Weekend Financial Review*. Spending scarce funds to find a cure ourselves is a waste of money, a political fig leaf to cover the electoral pain of the GP co-payment.

Anyone who doubts that the Medical Research Future Fund is a fig leaf or an afterthought, needs to only look at the pattern of leaks and speeches leading up to the budget. Ministers spoke often about the need to restrain the cost of Medicare, scarcely at all about the need to boost medical research.

They weren't able to prepare the way for the Medical Research Future Fund because it didn't come first. It isn't that pharmaceutical benefits, doctors rebates and future hospital funding are being cut to pay for the fund. It's that the fund was evoked late in the piece to smooth the edges of the cuts.

Under the descriptions of 23 separate cuts in the budget are the words: "The savings from this measure will be invested by the government in the Medical Research Future Fund".

The cuts hit dental health, mental health, funding for eye examinations, measures to improve diagnostic images, research into preventive health, a trial of e-health and \$55 billion of hospital funding over the next 10 years.

We're told the cuts are to build a \$20 billion Medical Research Future Fund, but the immediate purpose is to cut the deficit.

The wonders of budget accounting mean that the savings notionally allocated to the fund will actually be used to bring down the budget deficit except for when money is withdrawn from the fund to pay for research.

It's the same trick Peter Costello pulled with the Future Fund. The government gets two gold stars for the price of one. It can both cut the deficit and build up the funds for medical research. And it isn't yet too sure about what type of research.

Under questioning by senators on Monday, Health Department officials revealed they didn't even know about the fund until late in the budget process and even then provided no advice on how it would work.

Asked about the kind of things the fund would finance, the department's secretary, Jane Halton, said the questions were hypothetical.

Would it include evaluations of potentially life-saving preventive health measures such as SunSmart and anti-tobacco programs? "I think it's unlikely based on the description I have seen, but again we are in an area that we probably can't yet answer," she replied.

A few minutes later she asked for her words to be expunged, saying she really didn't know. "We need to work through this level of detail," she told the senators.

We know that cures for cancer, Alzheimer's and heart disease will be part of the fund's remit, because the Treasurer told us so. "One day someone will find a cure for cancer," he said after the budget. "Let it be an Australian and let it be us investing in our own healthcare."

Latham's point is that the idea is silly. By all means contribute proportionately to a global effort to find cures for diseases, but don't try to lead the pack by taking scarce dollars away from applying the medical lessons we have already learnt.

Small countries like Australia are for the most part users rather than creators of technology, and our funds are limited, as Joe Hockey well knows.

The *Medical Journal of Australia* isn't fooled. This month's editorial says a government genuinely concerned about extending the working lives of Australians would be investing more in preventing chronic disease, not less.

"The direct effects of the proposed federal budget on prevention include cuts to funding for the National Partnership Agreement on Preventive Health, loss of much of the money previously administered through the now-defunct Australian National Preventive Health Agency, and reductions in social media campaigns, for example, on smoking cessation," it says.

"Increased funding for bowel cancer screening, the Sporting Schools initiative, the proposed National Diabetes Strategy and for dementia research are positive developments, but do not balance the losses."

It's the indirect effects of the measures the fund seeks to make palatable that have it really worried. The \$7 co-payment will work out at \$14 for patients with chronic diseases. They'll pay once to see the doctor and then again to have a test. The editorial quoted four studies which have each found that visits for preventive reasons are the ones co-payments are most likely to cut back.

"The effects of these co-payments on preventive behaviour are greatest among those who can least afford the additional costs," it observes. Which is a pity because "the potential for prevention is greatest among poorer patients, who are often at a health disadvantage".

We'll all suffer if co-payments cut vaccination rates, even those of us who aren't poor, and even if the Medical Research Future Fund finds a cure for cancer.

The journal's biggest concern is that the cuts to hospital services will hit preventive health measures because they are seen as less urgent.

"The greatest pity of all is that the proposed cuts to funding for health come at the time when the first evidence is at hand of potential benefits of the large-scale preventive programs implemented under the national partnership agreements," the journal writes. "A slowing in the rate of increase in childhood obesity and reductions in smoking rates among indigenous populations have been hard-won achievements."

Withdrawing from measures we know will work in order to fund new measures we think might work seems a daft way to manage our health. But it'll help cut the deficit.

**We'll all suffer if co-payments cut vaccination rates, even those of us who aren't poor, and even if the Medical Research Future Fund finds a cure for cancer.**

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# Prevention is critical for good health.

The recent Federal Budget announced the establishment of a landmark medical research fund which will provide billions of dollars to explore some of the most intractable medical problems. This could mean the development of a cure for some cancers, a pill to cure Alzheimer's, or improved treatment for diabetes. This is forward-thinking and a world first. However, the use of the Medical Research Future Fund must be expanded beyond clinical care to include prevention and public health.

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In the face of frightening obesity and diabetes statistics in Australia, it is well understood that treatment cannot be the sole solution. We also need effective prevention to protect Australians from debilitating, costly and potentially deadly chronic diseases and to give our children a healthier future, and we have started to make progress in this area. But effective reduction of the burden of diseases such as diabetes and obesity depends on the continued development of research to identify the right mix of preventative and public health strategies alongside the optimal mechanisms for their implementation.

Currently, the Fund will not be used for research to improve health more broadly, such as how to address risk factors that lead to disease in the first place, or how to more equitably allocate health services. This is important because around the world the focus for action is moving to prevention of non-communicable diseases, such as heart disease, cancer and diabetes – including the developing world. As obesity and diabetes increase rapidly worldwide, much of the burden of these diseases is preventable and can be apportioned to risk factors such as poor diets, sedentary behaviour and smoking. Today the majority of Australian adults are overweight or obese, and we urgently need to prevent this increasing in future generations. Australia is an exemplar when it comes to tobacco control due to the adoption of a comprehensive approach including effective social marketing, taxation, smoke-free environments, warning labels and now, plain packaging. But a cohesive strategy on prevention of other key risk factors – alcohol; poor diet; physical inactivity; and sedentary behaviour – is sadly lacking.

Under the National Partnership Agreement on Preventive Health (established in 2008 and extended in 2012), Australia was starting to see the implementation of comprehensive systems to improve nutrition and activity for all Australians. The dissolution of this Partnership funding, \$367.9m from June this year, will have huge implications for the states and territories who have set aside funding to collaborate on meeting the targets set by the Commonwealth. These targets are around healthy weight, fruit and vegetable consumption and physical activity. In Victoria, this has led to the establishment of a world leading systems approach to prevention, Healthy Together Victoria, that has also recently been adopted by New Zealand. A similar whole of community approach has also been set-up in South Australia with the OPAL project. And the Australian Capital Territory established an international best-practice approach to support healthy eating for children in schools. These approaches empower communities in a range of settings to improve the food supply, reduce sedentary behaviour and make the healthy choice, the easy choice.

The benefits of prevention can be hard to see on a budget spreadsheet, as the effects are felt into the future and across a wide range of health and productivity outcomes. Prevention can also be seen as complex as it relates to a comprehensive set of strategies rather than a single pill or device. However, the previous federal government investment in the National Partnership Agreement on Preventive Health has already done the hard work of starting to establish the preferred mix of strategies. Funding cuts now simply mean we will not reap the fruits of the previous investment

if the established systems need to be dismantled. Ironically, there is also high support in the community for government engagement in this area. Overweight and obesity, mainly driven by poor diets, is the norm for all Australians, with those in lower socioeconomic groups more at risk. In May, a picture of the shocking reality of what we eat was confirmed, with the release of the first dietary survey in 15 years. This showed that more than a third of what is eaten was not considered integral to a healthy diet. Among teenagers, in particular boys, their diet was dominated by burgers, fries and soft drinks. We know that people are becoming overweight or obese at younger ages, with this survey sounding an early warning for the future. We urgently

need to prioritise prevention funding, research and practice to protect our children from this downward health spiral.

Based on current projections, by 2025 around 83 per cent of males and 75 per cent of females aged 20 years and older will be overweight or obese, as well as one third of 5–19-year-olds. Even now if you are a healthy weight, you are in the minority. This is not going to be solved using medical research alone. Dismantling funding streams for public health research and practice is short-sighted. We need to see the same degree of innovation applied to chronic disease prevention as we have to medical research funding if we are to avoid the forecast increases in ill health, hospitalisation costs and productivity losses.

**The benefits of prevention can be hard to see on a budget spreadsheet, as the effects are felt into the future and across a wide range of health and productivity outcomes.**



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