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PHARMACEUTICAL BENEFITS

REPORT FROM THE HOUSE OF REPRESENTATIVES SELECT COMMITTEE

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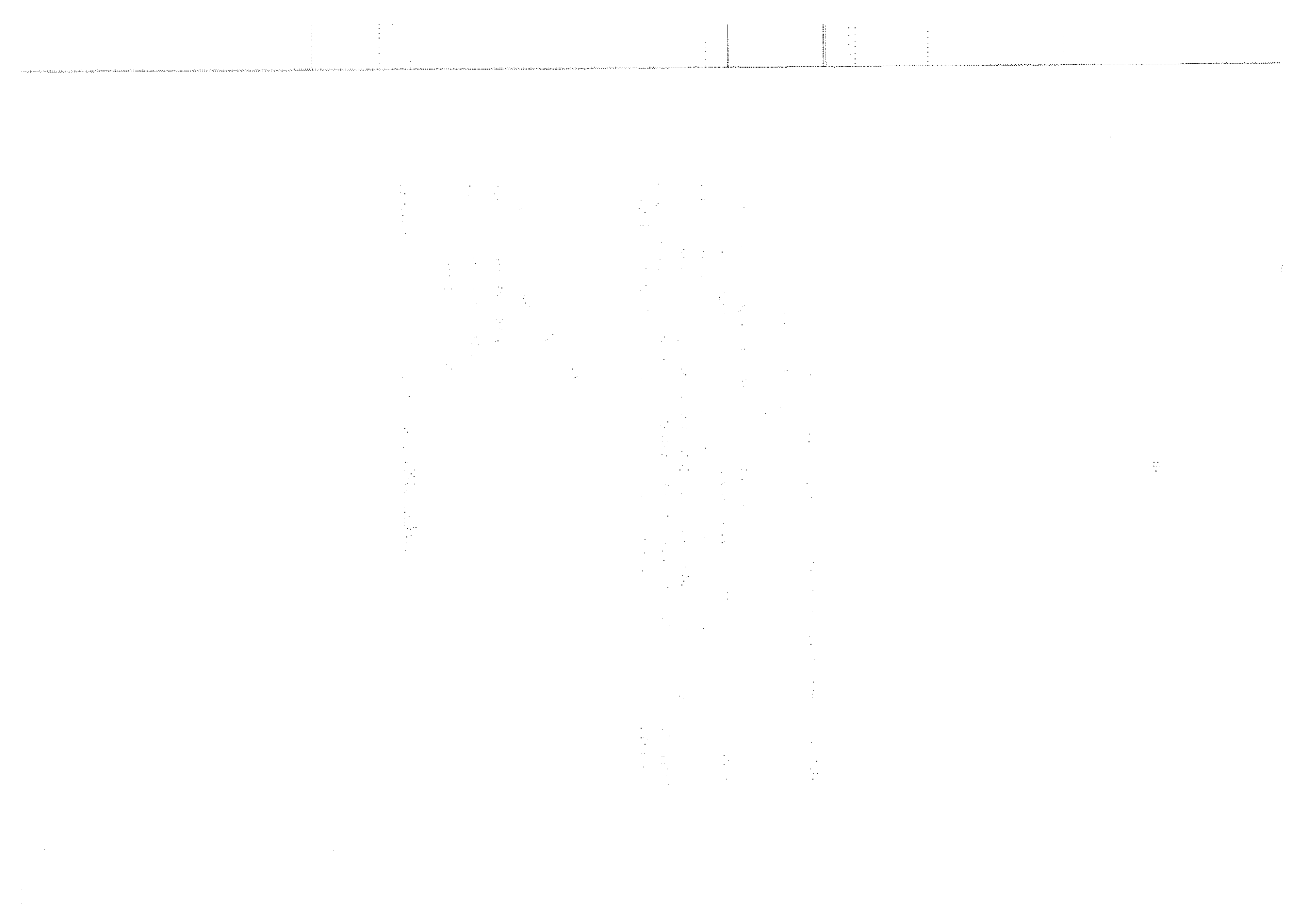
During the course of the Inquiry the original Chairman, the Hon. M. G. Mackay, M.P., withdrew following his appointment as Minister for the Navy; the Hon. R. V. Garland, M.P., withdrew following his appointment as Minister for Supply; and the Hon. I. L. Robinson, M.P., withdrew following his appointment as Assistant Minister assisting the Postmaster-General. Mr P. E. Lucock, C.B.E., M.P., withdrew from the Committee on 22 October 1970.

Clerk to the Committee: Mr R. J. Beggs.

Technical Adviser to the Committee: Mr H. West, Commonwealth Department of Health.



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RECOMMENDATIONS

The Committee recommends that:

1. The Commonwealth give financial support for gathering statistical information on the common illnesses, particularly the infectious, indicating the history of the illness with or without different kinds of drug therapy and including the incidence of untoward effects. (Para. 40 (a))
2. Financial support should be given to bodies such as the Royal Australian College of General Practitioners and university departments of medicine able and willing to conduct such surveys. (Para. 40 (b))
3. Up-to-date information arising from surveys be made available expeditiously through a departmental publication. (Para. 40 (c))
4. Tied grants be made available by the Commonwealth for the establishment of departments of clinical pharmacology in all Australian medical schools. (Para. 51 (a))
5. Financial assistance be provided to support refresher programmes of doctor education by professional bodies on a continuing basis. (Para. 51 (b))
6. Eventually, accreditation to prescribe under the National Health Scheme be dependent on participation in such programmes. (Para. 51 (c))
7. Continued listing of a drug on the Pharmaceutical Benefits Scheme should be conditional on the observance of minimum drug advertising standards. Requirements should include guidelines for the publication of side effects and contra-indications and for generic names to be given adequate prominence. (Para 69 (a))
8. The Department of Health undertake the publication, on a monthly basis, of a journal similar to *The Prescribers Journal,* and that this be made available to all doctors, and on request to chemists. (Para. 69 (b))
9. There should be an intensive review of the listed drugs by the Department of Health in association with the Pharmaceutical Benefits Advisory Committee, the Australian Drug Evaluation Committee and the specialist medical associations concerned, to determine which drugs have been replaced and should be de-listed. (Para. 80 (a))
10. A campaign be instituted to bring doctors' attention to the drugs which are being overprescribed and those which are dangerous and should not be prescribed if avoidable. (Para. 80 (b))
11. The Department of Health streamline the issue of authorities to prescribe to reduce the present delays. (Para. 89 (a))
12. The Department of Health seek the co-operation of medical associations in a campaign to remind doctors of the need to actually restrict medication available for specified purposes to the listed diseases. (Para. 89 (b))
13. Specialists in each speciality be given the right to endorse prescriptions now requiring an authority from the Commonwealth Department of Health and that such prescriptions should be notified to the Department on a regular basis. (Para. 89 (c))
14. The Commonwealth give encouragement to the establishment of health centres, where the work of doctors is integrated with that of social workers,

nurses, dieticians, physiotherapists and other para-medical personnel, so that alternatives to drug therapy are readily available. (Para. 91)

15. Doctors be permitted to continue prescribing generically or by brand name according to their own choice. (Para. 98)
16. All tablets of a dangerous nature be individually packed in strip foil by manufacturers. (Para. 104)
17. The Department of Health encourage the introduction of social pharmacology as a unit within teachers' training courses. (Para. 111 (a))
18. The Department of Health seek the co-operation of doctors to warn patients of potential reactions to medication, including those which may affect their driving performance, especially if combined with other drugs such as alcohol; also to warn patients of the dangers of dependence. (Para. 111 (b))
19. The Department of Health co-operate with schools, colleges and universities to provide lectures in social pharmacology to teachers and students, and to have these lectures introduced as a normal part of the courses. (Para. 111 (c))
20. Universities be encouraged to investigate methods of treatment without the use of drugs. (Para. 118)
21. The patient contribution should be reduced to no more than the same proportion of the current average prescription cost that the 50 cents charge represented at its introduction in 1960. In round figures this would now be 60 cents. (Para. 143 (a))
22. Beneficiaries of the Subsidised Medical Benefits Plan be placed on the same basis as beneficiaries of the Pensioner Medical Service for the purposes of the Pharmaceutical Benefits Scheme. (Para. 143 (b))
23. The cost of non-profitable activities conducted by Commonwealth Serum Laboratories in the public interest be met by the Commonwealth. (Para. 167 (a))
24. The Commonwealth investigate the economic feasibility of expanding the operation of Commonwealth Serum Laboratories to produce non-biologicals in competition with private manufacturers. (Para. 167 (b))
25. The present patent laws be maintained. (Para. 178)
26. The Department of Health co-operate with the Pharmacy Guild of Australia to examine the regulations applicable to chemists with a view to allowing chemists to rectify minor omissions from prescription forms, such as a patient's address or pension number. In each case it should be sufficient for the chemist to certify that the particulars added are correct to the best of his knowledge. (Para. 228 (a))
27. National Health (Pharmaceutical Benefits) Regulation 19 (1.)(a) be amended to require that prescriptions be typed or written in block letters. (Para. 228 (b))
28. There be consultation between the Pharmacy Guild of Australia and the Commonwealth to establish criteria for the limitation of future approvals to dispense National Health Scheme prescriptions. (Para. 256)
29. The late fee should be reviewed at the same time as other fees and increased appropriately for each prescription handled. (Para. 262)

30. In the event of the Commonwealth approving any expansion of the rights of contributors to Friendly Societies Dispensaries to receive rebates for National Health Scheme prescriptions, other organisations should also be approved to provide similar benefits at private pharmacies on payment of a similar contribution. (Para. 268)
31. Where original packs are dispensed chemists' identifying labels showing the name of the patient and dosage be affixed in such a way as not to obscure the manufacturer's label. (Para. 274 (a))
32. When drugs are dispensed without the manufacturer's original label the information on the chemist's label should include the expiry date, the name of the patient, name and strength of the drug and explicit dosage routine. (Para. 274 (b))
33. Manufacturers be required to provide drugs in 'dispensing size' packs to replace bulk packs which require chemists to re-pack by hand. (Para. 274 (c))
34. Wherever possible manufacturers be required to provide 'dispensing size' packs in bottles of suitable shape, labelled in such a way as to leave adequate space for the chemist's label. (Para. 274 (d))
35. The Department of Health confer with pharmaceutical manufacturers and the Pharmaceutical Guild of Australia with a view to the issuing of an instruction sheet for the patient with each dispensed item. (Para. 274 (e))
36. In respect of National Health Scheme products, it be made a condition of listing that provision of bonuses by manufacturers or wholesalers should be discontinued. (Para. 312)
37. Dentists be provided with modified medicine chests, free through the Scheme, similar to the arrangements for doctors' emergency supplies. (Para 327 (a))
38. Dentists be authorised to write prescriptions for the supply of a limited range of drugs for dental purposes only, under the *National Health Act* 1953-1971. (Para. 327 (b))
39. The Pharmaceutical Benefits Advisory Committee consider the listing of oral contraceptives where required for certain specific medical reasons. (Para. 332 (a))
40. The Commonwealth provide substantial subsidies for the expansion of Family Planning Clinics. (Para. 332 (b))
41. The Pharmaceutical Benefits Advisory Committee be strengthened:
    (*a*) by creating specialist sub-committees within medical colleges to review existing drugs and consider new drugs relevant to their specialities;
    (*b*) by increasing its secretariat with the employment of a full-time pharmacologist;
    (*c*) by meeting at least six times a year and employing some members in a full-time capacity. (Para. 335)
42. The Pharmaceutical Benefits Advisory Committee and the Australian Drug Evaluation Committee be combined into one committee with, if necessary, sub-committees. (Para. 337 (a))
43. A systematic review be carried out on the efficacy of the commonly prescribed drugs. (Para. 337(b))

1. INTRODUCTION

General

1. On 16 September 1970, the then Minister for Health, the Hon. A. J. Forbes, M.C., M.P., moved for the appointment of a Select Committee on Pharmaceutical Benefits, the motion being agreed to unanimously by the House. The resolution of appointment required the Committee to inquire into and make recommendations on all aspects of the provision of, and arrangements for the supply of, pharmaceutical benefits under the *National Health Act* 1953-1971, with particular reference to:

(a) the scope of the Scheme;
(b) all factors contributing to the cost of the Scheme; and
(c) the effects of the Scheme on the health and welfare of the community.

Assistance from State Departments

2. The Committee was required by its terms of reference to consider the role of hospitals in relation to the Scheme. Each of the State Ministers of Health was advised of the Committee's establishment and its terms of reference, and their assistance was sought in providing information on hospital drug purchasing procedures and prices of certain individual drugs. Extensive information was subsequently received and the Committee records its appreciation of the valuable assistance which furthered the Inquiry. Additional appreciation is recorded for the Queensland State Department of Health which arranged for the Committee to inspect the Royal Brisbane Hospital drug distribution facilities and to have discussions with managerial staff.

Assistance from Commonwealth Departments, Private Organisations and Private Citizens

3. The Committee invited Commonwealth Departments and instrumentalities, medical and para-medical associations and individual doctors and academics prominent in their fields, as well as other interested groups, to present submissions. The Committee also advertised widely in the daily press inviting submissions from interested organisations and persons.

Submissions

4. The Committee received ninety-one submissions. (See Appendix VIII—List of Witnesses).

Hearings, Inspections and Evidence

5. Public hearings of evidence were held in Sydney, Canberra, Melbourne and Adelaide. There were twenty-two public hearings and a number of inspection tours including two factories, the Royal Brisbane Hospital and the Commonwealth Serum Laboratories. In due course, the published transcript of evidence taken at public hearings will be available for inspection at the National Library of Australia, Canberra, and at the Committee Office of the House of Representatives, Canberra, A.C.T.

2. THE SCHEME

Background of the Present Scheme

6. The present form of the Pharmaceutical Benefits Scheme was established by the *National Health Act* 1959 although its genesis was in the work of the Parliamentary Joint Committee on Social Security between 1941 and 1946. Earlier attempts to

introduce a scheme had been unsuccessful because of constitutional problems and the antipathy of the medical profession. A constitutional amendment in 1946 allowed the Pharmaceutical Benefits Act to be passed in 1947. However, the medical profession still resisted its implementation and successfully challenged the compulsory use of a prescription form. Few doctors prescribed under this Scheme. With the change of Government in 1949 policy was altered to provide free life-saving and disease preventing drugs. This Scheme was introduced by regulation in September 1950.

7. From July 1951, pensioners and their dependants could be provided with free drugs and medical preparations by regulations under the *National Health Service Act* 1948-1949. The *National Health Act* 1953 and Pharmaceutical Benefits Regulations came into operation in May 1954, combining pensioner and general benefits. The Scheme continued in this form until March 1960. After 1960 the range of drugs available as general benefits was greatly increased and the patient was required to contribute 50 cents per prescription. Patient participation in the cost of the Scheme was designed to introduce an element of control and stability. Members of Friendly Societies Dispensaries were not required to pay the 50 cents on the grounds that they already paid a subscription for which they received medicines at reduced charges. Following chemists' protests about expansion of Friendly Societies Dispensaries' membership and Commonwealth concern at proposals to establish schemes to provide insurance against prescription costs, legislation was passed in 1964 requiring new members enrolled on or after 24 April 1964 to pay the 50 cents contribution.

8. In the 1971 Budget the patient contribution was increased to $1.00, effective from 1 November 1971. Eligible social service pensioners and their dependants are not required to make this contribution. Provision was also made through the Subsidised Health Benefits Plan to provide benefits at the old rate of 50 cents, for persons in low income groups, those receiving unemployment, sickness and special benefits under the Social Services Act and for migrants in their first two months in Australia. Members of Friendly Societies Dispensaries who joined on or before 24 April 1964 are eligible for rebates up to $1.00.

9. All medical practitioners registered in Australia are able to write prescriptions for the supply of pharmaceutical benefits and they receive new schedules of benefits at regular intervals of four months.

10. General unrestricted benefits are available subject only to the maximum quantity and number of repeats as specified in the Schedule. All items listed as unrestricted general benefits are available for pensioners, together with additional drugs listed as pensioner benefits only. If a benefit is prescribed for a pensioner the doctor must write the patient's pension number on the prescription.

11. Restricted pharmaceutical benefits may only be prescribed for the diseases or conditions specified in the Schedule and are subject to any other specified restrictions. Where a benefit is for a specified disease or condition, the doctor must write the letters 'S.P.' (specific purpose) on the prescription or obtain an authority from the Department of Health.

12. Patients may have prescriptions written under the Scheme dispensed by the chemist of their choice.

13. Pharmaceutical benefits are supplied by approved chemists, including Friendly Society dispensaries, approved hospitals (both public and private) and by approved medical practitioners in areas where there is no chemist within reasonable distance. Supply is also made under certain special arrangements, e.g. medicine chests to

isolated groups served by the Royal Flying Doctor Service and the Queensland Ambulance Transport Brigade (Aerial). Some bush nursing hospitals are stocked with a comprehensive range of benefits at Commonwealth expense.

14. The Commonwealth also provides free to medical practitioners, certain emergency drug supplies for which the patient is not required to make a contribution.

15. The *National Health Act* 1953-1971 prohibits the supply of another brand, drug or medicinal preparation in lieu of the benefit prescribed.

The Philosophy of the Scheme

16. The expressed philosophy of the 1949 Scheme was to provide a list of 'lifesaving and disease preventing drugs'. One hundred and thirty-nine drugs were listed at that time. In 1951, provision was made for the supply of all drugs and medicinal preparations listed in the British Pharmacopoeia free of charge to pensioners and their dependants. The present objective of the Scheme has been stated by the Director-General of Health to be an adequate list of drugs for the proper and safe treatment and prevention of disease, with adequate administrative safeguards to ensure that the Scheme is provided at reasonable cost without causing hardship to the patient.

17. Additions to the Schedule of Benefits may only be made after a recommendation by the Pharmaceutical Benefits Advisory Committee.

The Scope of the Scheme

18. The range of drugs was expanded in 1960 as the Commonwealth sought to relieve patients of the burden of onerous drug costs. At the same time it was hoped that by giving medical practitioners a wider choice of drugs that could be prescribed as benefits it would be possible for them to prescribe the most appropriate drug for the illness under treatment. This could encourage the prescribing of less expensive drugs for less serious illnesses.

19. Since the present Scheme was introduced the range of benefits provided has increased substantially. In 1961 there were 436 individual drugs (excluding those for extemporaneous compounding) listed as benefits, while in 1972 this had grown to around 700. Extemporaneous prescriptions are those compounded by the chemist rather than items supplied by manufacturers to chemists in ready prepared form.

20. Applications for listing of drugs as benefits come from the pharmaceutical manufacturers, various societies such as the Pensioners' Society or the Ileostomy Society, various members of the medical profession and individuals writing to their Member of Parliament or to the Minister and asking for certain drugs to be listed.

The Cost of the Scheme

21. The total cost of the Scheme is financed by a combination of Commonwealth and patient contribution, and is dependent upon such factors as:

(a) scope of the Scheme;
(b) cost of the drugs;
(c) the cost of distribution and the rate of chemist remuneration;
(d) maximum quantity and other restrictions on prescribing;
(e) population growth;
(f) patterns of sickness in the community; and
(g) prescribing habits of doctors.

22. The cost of the Scheme has more than doubled over the ten years to June 1971 whilst the number of prescriptions has almost doubled; private spending on drugs being replaced as the scope of the Scheme was increased. Pensioner benefits rose at a higher rate than general benefits whilst hospital and miscellaneous services increased at an even higher rate.

23. The total cost of the Scheme increased from $83.4 million in 1961-62 to $184.7 million in 1970-71, a rise of 121 per cent. This included hospital and miscellaneous services which rose from $7.6 million in 1961-62 to $26.9 million in 1970-71, a rise of 256 per cent. General benefits, the major section of the Scheme, increased from $57.6 million to $112.6 million, a rise of 95 per cent over the ten years to June 1971. Of this, the patient contributed $13.0 million in 1961-62 (22.6 per cent of general benefits), and $24.4 million (21.7 per cent of general benefits) in 1970-71.

24. The total number of prescriptions rose from 37.7 million (26.1 million general benefits) in 1961-62 to 71.5 million (49.0 million general benefits) in 1970-71. Over the same period the average cost per prescription rose from $2.01 to $2.21, the rise in 1970-71 of over 6 per cent being larger than in any other year. The average cost actually fell between July 1963 and June 1965 by approximately 5 per cent.

25. Persons in the pensioner age bracket are heavier users of medication than the general population. In 1970-71, 4.26 prescriptions were written at a cost of $9.80 per head for general benefits, whilst for pensioners 18.73 prescriptions were written at a cost of $37.59 per head.

26. The cost of pensioner benefits rose from $18.2 million to $45.2 million, an increase of 148 per cent over the ten years to June 1971 (compared with 95 per cent rise in general benefits). Annual increases ranged from 4 per cent to 22 per cent, the rise in 1970-71 being 10 per cent.

27. The number of pensioner prescriptions rose from 11.7 million to 22.5 million, a rise of 92 per cent over the ten years to June 1971. The average cost per pensioner prescription rose from $1.56 to $2.01 in the same period.

28. The cost of prescription benefits can be divided into chemists' remuneration and ingredients and containers. The cost of ingredients and containers rose 113 per cent from $46.7 million in 1961-62 to $99.4 million in 1970-71, whilst chemists' remuneration doubled from $29.1 million to $58.4 million.

29. Tables covering paragraphs 22 to 28 for the ten year period ending 30 June 1971 are provided in Appendix I.

3. DRUGS IN THE COMMUNITY

30. The great increase in the use of drugs is cause for concern. However, fundamental answers to this problem are not to be found within the Pharmaceutical Benefits Scheme alone; the cause and cure of the problem can only be found by a searching examination of society itself. Attempts to attribute the blame to the Scheme or to other single problem areas in society identify symptoms rather than causes.

31. Nevertheless, the Committee believes that pursuant to its findings from the Inquiry, certain changes should be made to the Scheme. Many of these changes would be beneficial but are only peripheral to the whole problem of drug use and abuse, of which the increased cost of the Scheme is merely a symptom.

32. The Committee found that there is an essential need for preventive medicine but that measures required may, in many cases, be as much social as medical.

4. THE ROLE OF THE MEDICAL PROFESSION

Prescribing Habits of Doctors

33. It is apparent that doctors' prescribing habits are a major factor in the cost of the Pharmaceutical Benefits Scheme. It is impossible to make an objective judgment as to how much prescribing may occur before 'overprescribing' can be said to exist. Individual judgments vary as to the place of drugs and these judgments have a significant influence on the health and welfare of the community.

34. Prescribing habits are determined by:

(a) formal academic training;
(b) the promotional efforts of the pharmaceutical industry;
(c) example of peers;
(d) testimonials of colleagues;
(e) expectations of patients and their relatives;
(f) listing under the National Health Scheme;
(g) pressure of business.

These determinants are considered in subsequent sections.

Overprescribing

35. Most doctors giving evidence before the Committee agreed that overprescribing does exist and is much greater for pensioners than for other patients. There was, however, considerable variation in opinion as to its extent. Estimates were given that between 5 per cent and 15 per cent of all patients entering hospitals suffer from some drug induced disease. These are, in many cases, caused by interaction between drugs; excessive medication with the drug used; treatment with the wrong drug; or adverse reactions where correct treatment has been applied.

36. Witnesses claimed that many patients were seen who had been prescribed for without any compelling reasons or who were suffering from unnecessary over-exposure to drugs. This over-exposure takes the form of the use of more than one drug when one drug would do, or the treatment of several complaints with different drugs without giving sufficient consideration to the interaction of the drugs prescribed.

37. The Committee believes that many cases of unnecessary prescribing result from the fact that clinical pharmacology as a science is in its infancy. The doctor prescribing an antibiotic as a prophylactic against bacterial infection, secondary to a viral infection, knows that the antibiotic is superfluous in most cases. Nonetheless he prescribes it because he does not wish any secondary infection to occur which might be attributed to his neglect. It is thus not likely that mere exhortation to prescribe less, or claims that secondary infection is uncommon (estimated to be in only 5 per cent of cases) will induce doctors to refrain from this practice. Prescribing as a precautionary measure poses serious problems. Not only can it render valuable drugs useless by developing resistant strains but also by destroying harmless organisms, the overgrowth of disease-producing organisms can occur.

38. It is necessary that the doctor should know the statistical likelihood of the outcome of each case, but there is a lack of research in this field, indicating a need for a survey in which diagnoses would be recorded and related to prescriptions.

39. The Committee found that there is significant and avoidable overprescribing of listed drugs and that this contributes to the high cost of the Scheme and to drug-induced disease as well as reducing the future effectiveness of valuable drugs. Frequently drugs are prescribed as an act of hope rather than an act of faith and in preference to telling the patient that there is no known cure for his illness, but that he will get better anyway.

40. The Committee recommends that:

(a) the Commonwealth give financial support for gathering statistical information on the common illnesses, particularly the infectious, indicating the history of the illness with or without different kinds of drug therapy and including the incidence of untoward effects;

(b) financial support should be given to bodies such as the Royal Australian College of General Practitioners and university departments of medicine able and willing to conduct such surveys; (See Appendix IV)

(c) up-to-date information arising from surveys be made available expeditiously through a departmental publication (See Para. 69.)

Education of Doctors

41. The large number of sophisticated drugs, and the constant introduction of new drugs, accentuates the need for sound basic education in pharmacology and therapeutics, and for continuing education of doctors in drug theory and usage. Unfortunately, it would appear that neither under-graduate nor post-graduate facilities for these purposes are adequate.

42. In Australia, at present, there is a great need for medical graduates trained in depth in pharmacology and therapeutics to be able to train, to teach and to undertake research.

43. Of the eight medical schools within the Commonwealth providing training to the Bachelor of Medicine, Bachelor of Surgery level, only three have a department of pharmacology. The staff establishment in pharmacology at some schools is only for junior lecturers without medical qualifications.

44. The time devoted to formal instruction in clinical pharmacology and therapeutics is also insufficient relative to the major role which drug therapy now plays in the practice of medicine.

45. During hospital residence (not compulsory in Victoria) no formal training is provided in the systematic use of drugs, yet this would seem to be an ideal time for practical training in this field.

46. More adequate instruction in pharmacology and therapeutics could be expected to produce direct economies both by reducing the cost of drugs prescribed unnecessarily or ineffectually, and by lowering the incidence of disease induced by drugs.

47. Professional and academic opinion was unanimous in supporting a change in the emphasis of medical education towards this end. At the under-graduate level it was suggested that there is ample scope to reduce the content of anatomy instruction, for example replacing the time made available in this way by increased training in pharmacology and therapeutics.

48. The inadequacy of under-graduate education in these fields also occurs at the post-graduate level. At present there is no post-graduate diploma in pharmacology in Australia, although such diplomas are available overseas. Present post-graduate

education and re-education of practising doctors is predominantly carried out, where it exists at all, by the professional medical societies.

49. The medical colleges include in their objects the provision of post-graduate education programmes but these have had to be restricted in recent years due to lack of finance. The Royal Australian College of General Practitioners has a national training plan for the College entry examinations.

50. The Committee found that there is a need:

(a) for the establishment of additional departments of pharmacology;

(b) to completely review the content of medical courses, which do not at present fully equip graduates to deal with the proliferation of modern drugs;

(c) for the provision of continuing post-graduate courses in which doctors should be required to participate to keep abreast of advances in drug therapy.

51. The Committee recommends that:

(a) tied grants be made available by the Commonwealth for the establishment of departments of clinical pharmacology in all Australian medical schools;

(b) financial assistance be provided to support refresher programmes of doctor education by professional bodies on a continuing basis;

(c) eventually accreditation to prescribe under the National Health Scheme be dependent on participation in such programmes.

Available Drug Information

52. An obvious requirement for doctors is drug information which is adequate, reliable and objective. If such information were available and doctors were willing and able to assimilate it, at least some of the problems of continuing education of doctors might be overcome. At present too much is left to the pharmaceutical industry.

53. The major current sources of drug information are:

(a) advertising by drug manufacturers in medical publications and mailed brochures;

(b) package inserts;

(c) company representatives (detailers);

(d) articles in medical journals;

(e) summarised information in drug indexes such as *New Ethicals, The Australian Physician's Index, Monthly Index of Medical Specialities;*

(f) fellow doctors and academic institutions.

Occasionally, information on specific topics is circulated by the Department of Health and the National Health and Medical Research Council.

54. Although numerous objections have been raised about the type of information provided by detailers, brochures and advertisements, it is evident that doctors obtain a great deal of assistance from them, supplementing other sources of information, and that this is necessary in the absence of other forms of education.

55. Objections to the present forms of advertising included views that:

(a) drug manufacturers regard the putting of the brand name of their product in the doctor's mouth as of greater importance than giving him information;

(b) advertisements sometimes fail to represent the situation accurately or fully. Often they give only a limited amount of information and only quote the favourable results of a clinical trial they have supported.

(c) Some advertising borders on the sensational or tries to gain attention by being novel or unusual and claims are often unsubstantiated.

56. In reply, the Australian Pharmaceutical Manufacturers Association submitted that advertising is a rapid and efficient means of communicating with doctors. Whilst the only result may be to replace one manufacturer's product by another, it may lead to new and improved ways of treating disease. Performance of the product however, must be good as sales will not increase because of advertising alone.

57. Significant advances or failures were stated to be promptly reported in medical journals and are of more significance than advertising claims.

58. Some doctors object to the activities of medical representatives (detailers), even to the extent of refusing to see all or most of them. However, this reaction can hardly be typical, given the persistent heavy emphasis which the manufacturers continue to place in this form of promotion. It is also significant in this context that departmental records indicate that sales of a company's drugs in an area often rise markedly following a visit by a detailer.

59. The opinion of the Australian Pharmaceutical Manufacturers Association is that detailers do have a great effect on the decisions of doctors. Manufacturers spend around 16 per cent of the value of sales on advertising and promotion, over 40 per cent of which is spent on detailing. It is the detailer's job to communicate full and factual information on his company's products. It is then up to the doctor whether he responds by prescribing the company's products. The detailer feeds back information on adverse reactions and other results of the company's products which he learns from the doctor and this assists the company's world-wide knowledge and is also fed back to the Department of Health. The manufacturers regard detailers as being generally an honest, devoted, sensible group who are often made the 'whipping boys' in the industry.

60. The flood of literature doctors receive in the mail led them to complain that there is too much information available for individual doctors to cope with and that much of the information is too brief and is not conducive to a proper evaluation as would be the case with material in a medical journal.

61. Doctors suggested that the following types of publications would be beneficial:

(a) regular bulletins on drugs;

(b) an Australian journal on the lines of *The Prescribers Journal* on the management and treatment of specific diseases;

(c) an appendix to the Pharmaceutical Benefits List showing toxic effects, comparative costs and the optimal efficacy of drugs, especially new drugs;

(d) authoritative literature on drug action and interaction;

(e) publication of the results of clinical trials;

(f) more scientific articles;

(g) an extension of the Department of Health documentation of important drugs and diseases such as the one on *Intal.*

They added that the Department of Health should encourage bodies striving to produce critical reviews of new and existing drugs and on principles of drug usage.

62. Many witnesses criticised the advertising content of journals and other publications. A representative of *The Medical Journal of Australia* said that it publishes submitted articles which include descriptions of side effects, objectively controlled experiments (examinations of effectiveness of drugs) and that it co-operates with the Department of Health in publishing articles on side effects, etc. Advertising material submitted to it is responsibly prepared and generally acceptable.

63. The Committee had difficulty in accepting that medical publications could be completely unbiased in the material they summarise or articles they publish when they are dependent upon advertising for their revenue.

64. *The Prescribers Journal*, which is compiled in Britain and reprinted for Australian distribution, was said to be acceptable to most doctors but is written by British academics and is often not strictly applicable to Australian conditions. There is a need for more Australian articles. The information it does provide is good but inadequate. There is frequently a serious time lag before important drugs are reported. The fact that it includes no advertising makes it more acceptable, but an Australian journal put out on a monthly basis would be more useful.

65. Some witnesses praised the *U.S. Medical Letter* and suggested that it be distributed with the Department of Health Handbook. It is a fortnightly publication and currently has a limited Australian distribution. Others criticised it as taking a negative approach.

66. *New Ethicals* was said by the Department of Health to be the type of publication most useful for doctors. However, there is still objection to the inclusion of advertisements and a need for publishers' independence.

67. Descriptions of the publications *Monthly Index of Medical Specialities, The Australian Physician's Index* and *New Ethicals* are given in Appendix III.

68. The Committee found that doctors receive a large volume of drug information from various sources, much of which is subjective, originating from manufacturers. Company representatives although criticised by doctors, are of some use in communicating new drug information in the present circumstances. This must be seen more as a criticism of the present situation for although drug advertising is usually regarded as a legitimate means of communication, it is frequently inadequate and leaves out key facts. Available medical publications are mainly issued free to the doctor and are useful as far as they go. However, there is a need for at least one critical publication which is not reliant on advertising income.

69. The Committee recommends that:

(a) continued listing of a drug under the Pharmaceutical Benefits Scheme should be conditional on the observance of minimum drug advertising standards. Requirements should include guidelines for the publication of side effects and contra-indications and for generic names to be given adequate prominence;

(b) the Department of Health undertake the publication, on a monthly basis, of a journal similar to *The Prescribers Journal,* and that this be made available to all doctors, and on request to chemists.

Specific Drugs

70. Doubts have been raised about the efficacy of many individual drugs listed under the Scheme, even to the extent of suggesting that a substantial proportion

of drugs prescribed under the National Health Scheme are of no significant benefit to the patient, either because they do not do what is claimed by the manufacturer, or because that drug is not appropriate for that patient. The patient's recovery is due to the natural course of the illness, or the placebo effect creating a beneficial psychological reaction.

71. In relation to the treatment of gastric ulcers, the opinion was given that while antacids may relieve the pain they do not heal the ulcer and that only five drugs of the anticholinergic type are, in fact, effective.

72. Another suggestion was that the Scheme contributed significantly towards higher dependence on barbiturates, and that major tranquillisers being less toxic, should have less restriction placed on them with the objective of avoiding the use of major anti-depressants.

73. The Australian and New Zealand College of Psychiatrists gave evidence on psychotropics. Psychotropics embrace all drugs having specific effects on the mental function and behaviour of patients and cover a wide variety of potent drugs important in the treatment of psychiatric disorders. These drugs have revolutionised the treatment of the severely disturbed patient in recent years and are used extensively by psychiatrists and most general practitioners.

74. Recent major changes in listing under the Pharmaceutical Benefits Scheme have resulted in most tricyclic anti-depressants and several types of non-barbiturate hypnotics being listed as unrestricted benefits. However, no anti-depressant drugs of the monoamine oxidase type are presently listed. Major transquillisers have unrestricted listing for pensioners with certain disorders and for ex-patients of mental or other hospitals. To prevent possible misuse only one minor tranquilliser is available under the Scheme. In the absence of minor tranquillisers the College said that major tranquillisers in smaller doses would be substituted with some undesirable effects. Tranquillisers of both major and minor types are considered far safer in the event of overdoses than anti-depressants.

75. The danger arising from the combination of alcohol and psychotropic drugs is of increasing concern. Psychotropic drugs have their dangers and problems so that absolute safety cannot be achieved. There must, therefore, be some restrictions to remind the doctor and the patient of the potential dangers.

76. Barbiturates disturb the normal sleep pattern and are commonly used in attempted suicides. They are still available as unrestricted benefits, and are considered by the College to be the major drug in the problem of chronic dependence. Withdrawal from barbiturate addiction is a dangerous process comparable with that of heroin. Recently an increasing number of safer non-barbiturate hypnotics have been introduced which are as effective as barbiturates and are only slightly more expensive.

77. There are widely differing opinions as to the best type of psychotropic to use in any particular condition. It is generally acknowledged that outside the group of psychiatric specialists the majority of Australian doctors have not been adequately trained in psychiatry.

78. The College recommended that a complete range of psychiatric drugs of proven value be made available as benefits, subject to some restrictions especially in cases of long term usage. This applies mainly to the drugs of dependency such as barbiturates and tricyclic anti-depressants and other more dangerous psychotropic drugs.

79. The Committee found that there is overprescribing of antibiotics and barbiturates with potential ill effects on the health of patients. Also, that drug therapy is used too frequently instead of considering other forms of treatment.

80. The Committee recommends that:

(a) there should be an intensive review of the listed drugs by the Department of Health in association with the Pharmaceutical Benefits Advisory Committee, the Australian Drug Evaluation Committee and the specialist medical associations concerned, to determine which drugs have been replaced and should be de-listed;

(b) a campaign be instituted to bring doctors' attention to the drugs which are being over-prescribed and those which are dangerous and should not be prescribed if avoidable.

Problems and Suggestions

81. Many doctors gave evidence that they have considerable problems with the present Pharmaceutical Benefits Scheme. These problems include the range of drugs listed, the Department of Health Handbook, restrictions, issue of authorisations, departmental surveillance of prescribing and return of prescriptions by chemists.

82. It was suggested that 'Hospital Only' lines should be available to specialists if, in their opinion, these are necessary to keep ex-hospital patients alive, or to prevent hospitalisation. It is irrational to have to hospitalise patients before treatment can be provided.

83. Some complaints were directed at the complexity, layout and frequency of reprinting of the Department of Health Handbook. However, the present layout appears to be generally acceptable.

84. Specialists feel strongly that restrictions are an affront to the integrity and intelligence of the prescriber if based medically, and unfair to the patient if based financially.

85. The need to obtain approval from a departmental officer for the use of some drugs is time-consuming and a source of annoyance. Professionally trained men feel insulted at having to obtain approval and being asked to explain their experience and the basis of diagnosis to an outsider who has no knowledge of the case. The necessity to apply for every authority was said to call for a considerable increase in the doctor's office staff and the ethics of disclosure of diagnosis is doubtful. It was suggested that telephone communication could be used to avoid the delay in getting the authority but the Department of Health does not have adequate facilities to ensure that the prescriber can get prompt contact with the relevant person.

86. The computer surveillance of doctors' prescribing habits was said to be not very reliable as it is made on a comparative basis by areas and tends to give nonsense results.

87. Certain pharmaceutical benefits may only be prescribed for a particular class of person, for a specified purpose, disease or condition, or with written authority of a Commonwealth Director of Health. Where doctors fail to endorse the prescription with the pensioner's number or to mark it 'S.P.' (specified purpose) the requirement that the form must be returned to doctors for correction is the cause of much friction. If the prescription is written on a National Health Scheme

pad and given to the patient in duplicate, this should be sufficient indication that it is a benefit and could be endorsed as such by the chemist.

88. The requirement for general practitioners to obtain a written authority may be necessary to permit some control over the indiscriminate use of expensive drugs. In the case of specialists, however, particularly psychiatrists whose prescriptions are almost entirely for restricted drugs, there is no reason why their diagnosis and prescription should not be accepted. An identification number for each specialist, printed on his prescription pads would indicate his authority to prescribe. This could be checked by sending a monthly summary of patients, with diagnoses, to the Department of Health.

89. The Committee recommends that:

(a) the Department of Health streamline the issue of authorities to prescribe to reduce the present delays;

(b) the Department of Health seek the co-operation of medical associations in a campaign to remind doctors of the need to actually restrict medication available for specified purposes to the listed diseases; and

(c) specialists in each speciality be given the right to endorse prescriptions now requiring an authority from the Commonwealth Department of Health and that such prescriptions should be notified to the Department on a regular basis.

The Organisation of Medical Practice

90. Rising costs and the pressures of modern practice have resulted in the aggregation of practitioners into group practices or clinics. There is a need to integrate the activities of doctors with social welfare and para-medical services for optimum health care. The inclusion of a chemist in this type of group once it has reached a certain size seems logical. Rapid and accurate diagnostic services are necessary if the practice of scientific medicine is to flourish. The technical possibility of using computers to assist doctors in making accurate diagnoses is a development which will lead to more accurate prescribing and eliminate some of the guesswork which must now frequently occur.

91. The Committee recommends that the Commonwealth give encouragement to the establishment of health centres, where the work of doctors is integrated with that of social workers, nurses, dieticians, physiotherapists and other para-medical personnel, so that alternatives to drug therapy are readily available.

Generic Prescribing

92. Many arguments were advanced for and against generic prescribing rather than by brand name. These are summarised in Appendix II.

93. Generic prescribing is the practice in most hospitals but the majority of doctors in private practice prefer brand name prescribing. The main arguments in favour of generic prescribing are cost savings and consistency in terminology between undergraduate training and usage in academic circles and journal articles and names used in practice.

94. In some hospitals generic equivalent dispensing is practised whereby the doctor prescribes either generically or by brand name; the chemist may substitute a generically equivalent drug of suitable quality unless the prescriber specifically insists on that brand. This eliminates the need for stocking many different brands,

or excessively expensive brands where they are prescribed by a doctor merely because he does not know the generic name of a drug or where he prescribes a particular brand merely from habit.

95. There are, however, real differences in formulation between various brands of the same generic substance which may prevent a doctor from maintaining proper control over a patient's progress. A tendency to minimum rather than maximum standards of quality control could be anticipated if brand name prescribing were eliminated.

96. Varying absorption rates and bio-availability have been observed between various brands of the one drug. In the case of at least some drugs, chemical equivalence does not guarantee equivalent clinical effectiveness. It is accepted that there can be real differences between brand names of the same generic substance, and doctors generally have established brand preferences over the years. They are, however, apparently willing to accept generic prescribing for their patients when under closer observation in hospital.

97. The elimination of brand name prescribing would inevitably involve great disruption to the Australian pharmaceutical industry and a weakening of Australian links with major international groups. This should be considered against the relatively modest potential cost saving of $2.7 million estimated by the Department of Health.

98. The Committee recommends that doctors be permitted to continue prescribing generically or by brand name according to their own choice.

5. THE PATIENT AND THE SCHEME

Social Problems of Drug Explosion and Proliferation of Drugs

Dependency

99. The Pharmaceutical Benefits booklet contains an abundance of unrestricted drugs which are capable of producing habituation and drug dependence. The *National Health Act* 1953-1971 in its present form must be considered as a significant factor contributing towards the increase in drug dependence. These drugs are largely in the hypnotic and sedative group of medications, by far the most important example being barbiturates.

Suicides and Accidental Poisonings

100. With the proliferation of new drugs there has been an alteration in the pattern of suicides. Since the anti-depressants have been an unrestricted benefit nearly all the increase in attempted suicides has been due to overdoses of these drugs.

101. Currently more than 95 per cent of attempted suicides are drug overdoses. Of suicides through drug overdoses a 1969 study showed 45 per cent due to barbiturates and 35 per cent due to other prescribed drugs (most commonly tranquillisers and anti-depressants). This leaves only 20 per cent due to drugs for which a prescription is not required. There is strong circumstantial evidence suggesting that there is a relationship between the rise in successful suicide and increased drug availability. The incidence of drug suicide as a proportion of total suicides is higher in Australia than in any other country in the world. The proportion of drug suicides in women is about 60 per cent and in men about 20 per cent.

102. Accidental overdoses sometimes occur with fatal results.

103. The Committee believes that one method of combating this suicide pattern, and of preventing accidents, would be for potentially lethal drugs to be individually packed in strip foil, making it harder for people to actually get at the tablet and also reducing the possibility of people taking extra doses by mistake.

104. The Committee recommends that all tablets of a dangerous nature be individually packed in strip foil by manufacturers.

Road Accidents

105. Statistics are not available but there are indications that doctors should consider the effect which drugs they are prescribing may have on their patients' driving ability. This should influence the choice of therapy and the advice given to patients.

The Demand by Patients for Drugs

106. Australia is recognised as being highly drug orientated and has been described as a nation of pill takers. General practitioners find that patients are disappointed if they leave the consulting room without a prescription. Their willingness to take drugs is also indicated by the high incidence of self-medication in the community. While there is a place for self medication, it can obscure a serious problem and there is undoubtedly abuse of non-prescription medicines. It is well documented that laxatives, purgatives, alkalis and pain killing drugs can produce or obscure serious medical conditions.

107. The demand by patients for drugs from their doctors was given as a major reason for overprescribing by the medical profession.

108. Reasons suggested for the absence of doctor resistance to patient demand for drugs include the following:

(a) the patient is often given a drug on the basis of a suspected rather than a proven condition;
(b) a patient may feel dissatisfied with a doctor who does not prescribe and may go to another doctor;
(c) the pressure of work on a general practitioner is great and it is easier and quicker to prescribe than to explain that a drug is not necessary.

109. One of the duties of the doctor should be the education of the public not to take medicine unnecessarily. However, it requires quite an exercise in discipline to tell a patient that he does not need medication. The medical undergraduate should be made aware, by his education, of the pressure to prescribe and the need to resist and discourage this pressure and of differentiating between patients who really need drugs and those who would not need drugs if adequate counselling were provided.

110. The following possible solutions to the problem of patient pressure were suggested:

(a) the introduction of a unit in social pharmacology for students taking teacher training courses with a view to encouraging informed discussion in schools;
(b) the Commonwealth should encourage the integration of the activities of the medical practitioner with the social worker and other paramedical services.

111. The Committee recommends that the Department of Health:

(a) encourage the introduction of social pharmacology as a unit within teachers' training courses;

(b) seek the co-operation of doctors to warn patients of potential reactions to medication, including those which may affect their driving performance, especially if combined with other drugs such as alcohol; also to warn patients of the dangers of dependence;

(c) co-operate with schools, colleges and universities to provide lectures in social pharmacology to teachers and students, and to have these lectures introduced as a normal part of the courses.

Drugs and the Environment

112. As the term 'drug' encompasses virtually any chemical substance which has a biological action, pharmacologists are concerned with the biological effects of pesticides, air pollutants, industrial chemicals, etc., as well as substances such as barbiturates, aspirin and antibiotics.

113. While there is increasing awareness of the effects of chemicals in the environment, little is known about their interactions with drugs. All substances such as detergents, polishes, hair preparations, etc., may be involved in such interactions.

114. The potential for drug interactions is very great, for example—a man visiting his doctor will almost certainly drink tea or coffee or both; add alcohol and nicotine to his regular drug use, plus aspirin, a sedative and a laxative. He is then using six drugs before he consults his doctor.

115. The Committee found that there is a need for an investigation of the implications of the massive exposure of the community to drugs and chemicals.

Alternative to Treatment by Drugs

116. A witness, Dr Ainslie Meares, claimed that he has a simple and natural method for improving the mental and bodily sense of well-being. His method does not require lengthy and costly psychiatric treatment, tranquillisers or unnatural aids but involves the patient practising simple relaxing mental exercises. He said that his method is often effective in the treatment of asthma, insomnia, anxiety, neuroses and blood pressure.

117. The Committee believes that further investigation of the treatment of patients without the use of drugs is warranted.

118. The Committee recommends that universities be encouraged to investigate methods of treatment without the use of drugs.

The Patient Contribution

119. World-wide experience indicates that doctors will prescribe more under a scheme whereby patients obtain drugs free or at nominal cost than they will if the full cost of the drug has to be met. With the extension of the Scheme, a new outlook by doctors and patients emerged. They expect all pharmaceutical items to be provided at nominal cost. This expectation is compounded by the growth of the Pensioner Medical Service with its comprehensive list of drugs available to the pensioner free of charge.

120. The Department of Health quoted the British experience which suggests a correlation between patient contribution and prescription volume.

Date	Patient contribution	Change in prescription volume over next 12 months
December 1956	Commenced	12.2 per cent decrease (but average cost per prescription rose)
March 1961	Raised	11.8 per cent decrease
February 1965	Discontinued	20 per cent rise
June 1968	Reintroduced	9 per cent decrease

121. The relevance of the British experience to Australian conditions is suggested by the initial reaction to the increase in the local patient contribution from 50 cents to $1.00 in November 1971. The number of prescriptions dispensed under the Scheme in December 1971-January 1972 was 7,021,000, a decrease of 6.7 per cent compared with the 7,522,000 prescriptions dispensed in the comparable period of 1970-71. By contrast, pensioner prescriptions, which were free throughout, increased by 3.4 per cent, that is from 3,513,399 in December 1970-January 1971 to 3,631,974 in December 1971-January 1972.

122. The Friendly Societies Dispensaries Association of Australia claimed that their experience with pre-1964 members indicated that a patient contribution has no deterrent effect on usage. However, statistics provided by Friendly Societies Dispensaries were fragmentary and in any event did not bear out their assertion.

123. The purpose of the increase in patient contribution from 50 cents to $1.00 was said to be a deterrent and was introduced because of the sharp increase in the average cost (expected to rise to $2.47 in 1971-72) due to the high cost of many new drugs added to the Schedule. It is unfair to impose a deterrent of such severity on the patient who must depend on the medical practitioner's judgment.

124. Many witnesses considered that most people could afford to pay for many of the drugs themselves. The amounts are small compared with expenditure by the community on smoking, alcohol and gambling. However, if patients themselves had to pay for drugs, it would be the lower income groups and the chronically ill who would suffer most.

125. In general the medical profession favoured a system whereby drugs were graded. One suggested scheme was that immediate life-saving preparations and long term preparations such as anti-epileptic drugs, insulin and digoxin, should be available free or at a nominal charge while other drugs such as sedatives, cough mixtures, laxatives, vitamins, antacids, antihistamines and anticholinergics, if listed at all, should be at a higher charge.

126. The problem with this suggestion is that it would tend to re-create the situation which existed before the expansion of the current Scheme and the introduction of the patient contribution. Doctors would be pressured to prescribe the free drug if possible, even though it might be more expensive and not the most suitable drug to use.

127. The Department of Health supported the view that the patient contribution does act as a deterrent, by comparing the average cost per person for general

benefits with that of the much higher average cost of pensioner benefits, and said that there has been evidence that much treatment prescribed for pensioners was medically unnecessary.

128. If there is unnecessary treatment of pensioners then some deterrent should be sought. However, it is not valid to compare the usage of drugs by pensioners and that of the general population as the elderly are heavier users of drugs. Unfortunately, no statistical analysis is available which would show usage under general benefits for non-pensioners of pensioner age.

Increase in Patient Contribution to One Dollar

129. On 17 August 1971, the Treasurer announced during the budget speech that the level of contribution by patients towards the cost of each supply of a general pharmaceutical benefit would rise from 50 cents to $1.00. This took effect on 1 November 1971.

130. It has been estimated by the Department of Health that this will increase the patient contribution towards the Scheme by $23.8 million a year. During the year ended 30 June 1971, patients contributed $24.4 million towards a total cost of $184.7 million for operating the Scheme in that year.

131. Items available under the Scheme with a price less than $1.00 were deemed not to be pharmaceutical benefits except in the case of pensioners and persons holding a Subsidised Health Benefits entitlement.

132. At 1 September 1971, there were 229 ready prepared items listed as benefits where the dispensed price was less than $1.00. These 229 items comprised twenty-five under 50 cents and 204 items between 51 cents and $1.00. Sixty of these 204 items were increased in price in the Department of Health Schedule for October 1971, just sufficient to keep them available for general benefits. Of the remaining 144 items, seventeen were for pensioners only and 127 were available for pensioners and Subsidised Health Benefits.

133. The removal of items, the dispensing price of which would have been more than $1.00 when dispensed as private prescriptions, would have caused hardship for many patients, especially those with chronic conditions.

Pensioner Benefits

134. In June 1951, the Commonwealth made the National Health (Medicines for Pensioners) Regulations under the *National Health Service Act* 1948-1949 authorising the provision of medicines for pensioners. The benefits provided free of charge included all the drugs and medicinal preparations listed in the British Pharmacopoeia or specified in the schedule to the National Health (Medicines for Pensioners) Regulations, together with combinations of these drugs and medicinal preparations. These benefits were made available to all persons receiving Australian age, invalid, widow's or Service pensions. Dependants of these pensioners were also entitled to benefits.

135. Persons in the age group of sixty years and older generally have special needs in relation to pharmaceutical benefits and consequently attract prescriptions in excess of the average annual number recorded for all age groups in the general benefit category.

136. The cost per head of population for pharmaceutical benefits prescriptions in 1970-71 was $9.80 for general benefits and $37.59 for pensioner benefits, and in 1971-72 there are estimated to be 19.73 prescriptions per head written for pensioners compared with 3.93 for general benefits.

The Subsidised Health Benefits Plan

137. Concurrent with the rise in the patient contribution the Commonwealth decided to extend the scope of the Subsidised Medical Service to include an entitlement by the beneficiary to receive pharmaceutical benefits at a contribution of 50 cents. The broadened scheme is known as the Subsidised Health Benefits Plan.

138. Three groups are entitled to this new assistance:

(a) low income earners;

(b) people who are entitled to unemployment, sickness and special benefits;

(c) migrants.

139. Low income earners have their means assessed on information supplied by the applicant to the Department of Social Services and receive the entitlement for a period determined by the Director-General of Social Services and for a further period of four weeks beyond the date on which the beneficiary receives notice that the determined period has expired. The assessment of low income earners is on the history of their earnings and the current and potential level of their earnings.

140. Those in the second category, i.e. people on unemployment, sickness and special benefits, also retain an entitlement under the Subsidised Health Benefits Plan for four weeks beyond the date on which their Social Services Benefit is terminated and the assistance to first entry migrants commences from the date of arrival in Australia and is valid for two months from that date. Despite the existence of the Subsidised Health Benefits Plan, there have been only 44,552 prescriptions dispensed for the four months ending February 1972, nearly half of which were in February.

141. The Department of Health said it was vigorously advertising the new plan, but apparently it was not getting through to the people who qualify. The number of registrations made for this benefit is only a small fraction of the number estimated to be eligible.

142. The Committee found that the patient charge does have a deterrent effect but that there is insufficient evidence of the extent to which this operates against unnecessary as opposed to necessary prescribing. In any event the increase in fee to $1.00 is considered excessive.

143. The Committee recommends that:

(a) the patient contribution should be reduced to no more than the same proportion of the current average prescription cost that the 50 cents charge represented at its introduction in 1960. In round figures this would now be 60 cents;

(b) beneficiaries of the Subsidised Medical Benefits Plan be placed on the same basis as beneficiaries of the Pensioner Medical Service for the purposes of the Pharmaceutical Benefits Scheme.

6. DRUG MANUFACTURERS

Description of the Industry

144. Statistics provided by the Commonwealth Bureau of Census and Statistics show that there were 228 factories in the pharmaceutical and toilet preparations industry at June 1968. The Department of Health records that 154 companies supply prescription medicines to the Pharmaceutical Benefits Scheme. This includes

the Commonwealth Serum Laboratories. Many firms in the industry also supply proprietary and veterinary medicines and agricultural chemicals and allied products.

145. The Australian Pharmaceutical Manufacturers Association (A.P.M.A.) estimated that 8,000 people are employed by its members for a total annual wages bill of nearly $30 million. The industry is a substantial employer of graduates, who make up approximately 9 per cent of the total. It is one of the less labour-intensive industries compared with the average for all industries.

146. Headquarters of parent companies are located as follows:

	Number	Share of market
		Per cent
United States of America	36	60
Britain	33	9
Europe	31	18
Australia	52	7
Other	2	6*
Total	154	100

* Includes some European and unidentified firms.

147. Twenty manufacturers supplied 74 per cent of the market in 1969-70. Only one of these was an Australian-owned company which supplied 3 per cent.

148. There is some inter-relation between many companies. Companies can be classified under five headings:

(a) Australian subsidiaries of overseas companies, with local manufacturing capacity;
(b) Australian subsidiaries of overseas companies importing finished goods or using local third party manufacturing facilities;
(c) Australian companies with manufacturing capacity. Many do work for other suppliers, some act as agents for overseas producers or are engaged also in wholesaling activities;
(d) Australian companies importing finished goods and/or having their products produced by third party manufacturers;
(e) local agents who import products manufactured by overseas companies.

149. There is an inevitable trend towards internationalism due to the high cost of the search for new and improved products requiring large numbers of qualified personnel and highly specialised research techniques. Local industry benefits through a flow of information and new products.

150. In recent years the industry has established a substantial export trade, growing at the rate of 15 per cent per annum. Exports were approximately $23 million in 1970-71. Imports of medicinal and pharmaceutical products in 1969-70 totalled $52.1 million, but several firms are planning to establish integrated manufacturing facilities in Australia.

Competition

General Aspects

151. The A.P.M.A. said that price competition is intense once a patent expires and that this is not entirely overcome by brand name marketing. However, it is

clear that brand names are sometimes able to retain their dominant situation (see under Patents and Brand Names). The Department of Health negotiates prices and continuously exerts downward pressure on all prices, including patented products. Even whilst patents exist there are other products which overlap the patented ones in use, and in some cases concurrent licences are held by several firms.

152. The A.P.M.A. also submitted that product competition is much more important than small price variations as quality is of utmost importance. Service can also be an important factor.

153. The industry claims that the era of cost savings being passed on as price reductions is at an end due to the impact of cost inflation and price squeeze. However, the Committee points out that the cost-price squeeze may have been relaxed somewhat as a result of the reduction in discounts to wholesalers.

154. The Department of Health accepts the fact that the situation is highly competitive and could give no evidence of collusive practices in Australia. Overseas ownership of Australian firms could permit some price controlling but it would be difficult to show that cartels are operating against fair and reasonable pricing.

155. Statistical data supplied by the Department of Health showed that major manufacturers tend to concentrate their output in certain types of drugs and to supply large proportions of the market for that product. In this way economies of scale are achieved.

Pricing

156. The industry does not comply with the normal economic theory of price fixation by demand and supply because:

(a) the actual consumer does not make the decision to buy. It is the doctor who makes the decision as to what product will be used;
(b) the consumer pays only a part of the price whilst the Commonwealth often pays the greater proportion;
(c) the Commonwealth makes the decision as to how much it will pay after negotiation with individual suppliers;
(d) the Commonwealth is a single buyer with a large number of sellers and is therefore to some extent in a monopoly buyer situation;
(e) prices are determined within the framework of competitive international prices.

157. The Department of Health can not require a manufacturer to submit detailed costs but it does use overseas price information to assess suitable local prices when negotiating with firms. Britain is the best source of comparative data when making direct comparisons. Factors taken into consideration are:

(a) the British market is bigger, comprising a population of around four times that of Australia;
(b) distribution costs differ because of geographical factors and comparative sales volume;
(c) where drugs are imported additional costs are incurred for freight, duty and landing charges;
(d) there are no drug listing restrictions in Britain;
(e) wholesale discounts used to be different—20 per cent in Australia compared with 15 per cent in Britain. Discounts in Australia have now been reduced to 15 per cent by almost all large manufacturers.

158. International comparisons of wholesale prices for seventeen drugs representing 30 per cent of the expenditure on pharmaceutical benefits are provided in Table I of Appendix V.

159. These figures show that two Australian products were lower priced than the British equivalents, whilst thirteen and twelve respectively had lower prices than U.S.A. and Canadian products, in some cases being less than one third. Ten Australian products were priced up to 50 per cent higher than British products with four up to 130 per cent higher, one of which was penicillin phenoxymethyl. Only three products were higher priced than American and Canadian products. In general, Australian prices compared favourably with overseas prices.

160. There is a voluntary price regulation scheme in Britain where drug companies submit to the Government annual returns on profitability and costs. This would tend to exert a downward pressure on prices. The British-Australian comparisons are more valid than the others as similar schemes do not operate in Canada and the U.S.A.

161. Australian drug prices have shown an opposite trend to most other commodities and falling drug prices have made a significant contribution to slowing the rise in cost of the Scheme. This trend is illustrated by Table II in Appendix V, showing forty-one products which were amongst the fifty top selling lines.

162. Price reductions have been possible because listing has given an assured market and the general local increase, as well as increased export sales, has allowed economies of scale. Also, as firms have written off establishment costs the upward pressure on price is relieved. Many drugs are now at their long term minimum level and price rises are envisaged by the A.P.M.A.

163. The Director of Commonwealth Serum Laboratories (C.S.L.) said that if the C.S.L. charter was widened to permit the production of non-biologicals in competition with commercial firms, the price structure of pharmaceutical benefits products would be significantly reduced. He also claimed that an important reduction in National Health Scheme costs would be achieved if C.S.L. did not have to load the price of penicillin to recover its expenditure on research and unprofitable biological activities. These include the preparation of sera, vaccines, blood fractionation and bacteriological products.

164. For the Commonwealth to enter into the production of non-biologicals, it would be necessary to build or purchase suitable premises or to acquire an existing pharmaceutical company with its existing plant and equipment, range of established products and marketing force.

165. The Committee found that Australian prices of drugs are not excessive by world standards. Prices for many products are at a low point and increases may be inevitable. Cost savings may still be possible by a reduction in the number of listed manufacturers and by reduction in advertising and promotion expenditure.

166. The Committee found that the requirement for C.S.L. to cover all expenditure from revenue, imposes an excessive burden on the cost of its profitable activities and this is a large factor in swelling prices, especially that of penicillin.

167. The Committee recommends that:

(a) the cost of non-profitable activities conducted by Commonwealth Serum Laboratories in the public interest be met by the Commonwealth;

(b) the Commonwealth investigate the economic feasibility of expanding the operation of Commonwealth Serum Laboratories to produce non-biologicals in competition with private manufacturers.

Patents and Pricing

168. The A.P.M.A. submitted that:

(a) patents are a powerful factor in providing incentive, thus promoting dynamic medicine;

(b) the industry is built on innovative research programmes and the existence of individual firms depends upon their ability to develop new medicines;

(c) patents increase competition as each patent offers its producer a share of the market, resulting in a large number of firms each researching for new or replacement products;

(d) most major drug innovations in the last forty years originated commercially;

(e) the removal of patents would be contrary to good social order and progress because the results of innovative talent and risk taking can be expropriated by others;

(f) in the short run patent rights allow the seller to charge a monopoly price; but the costs of innovation and development must be recovered over a relatively short effective patent life. In Australia the present life is sixteen years, but this is lessened by development and early years of possible unprofitable operation. This effective life can be further shortened if the product is replaced before its patent expires;

(g) there has been a trend in Western Europe—France, Germany and Scandinavia, towards greater patent protection. Italy, in the past, excluded pharmaceuticals from patent protection, resulting in a large number of imitators usurping the inventor's property without compensation or contribution to product development. However, in December 1970, a draft bill was introduced to reverse this situation;

(h) Australia, being part of the international scientific network, has the benefit of a reasonable patent law. This ensures a steady flow of therapeutic innovation with a minimum call on scarce risk capital.

169. The Department of Health said that when patents expire there is a tendency for the price charged by new manufacturers to be around that of the original product. Examples were given of tetracycline being the same, erythromycin and imipramine being 10 per cent less and promethazine and probenecid being 6 per cent less.

170. Brand preference was said by the Department of Health to continue after a patent has expired. In some instances a brand may retain over 90 per cent of the market. In this case the Department is not really in a position to delist in order to force a reduction, even if the differences in prices are quite high. Brand preference established during patent life may be just as effective, therefore, in maintaining prices as the patent itself.

171. The A.P.M.A. said that price reductions normally occur when a product is listed, regardless of patent status. Analysis of price indices provided by the A.P.M.A. for five products for which the patents had expired, showed that price reductions were made on most products before the patents expired and there was some delay after the expiry of patents before further reductions were made. One product remained at the original price for five years after expiry and then fell only 10 per cent. Statistics for other products showed that many of the unpatented lines had only minor reductions in price over the years, compared with patented products. Some of the patented lines held their prices or, in a few cases rose, but most prices fell, many quite drastically, before the patent expired.

172. A summary of the price index is in Table III of Appendix V. It shows that sixteen out of twenty-six patented products in April 1971 were still between 71 per cent and 100 per cent of their original price at listing, whereas six out of ten unpatented lines by 1971 were between 41 per cent and 70 per cent of their listed price.

173. Evidence received from hospitals indicates that they receive large reductions on the wholesale price of unpatented lines but only small ones, if any, on patented lines. (See paras. 318 and 319 under **Hospitals**).

174. Tariffs are of minor importance in the industry's pricing scale despite the Tariff Board's estimate of 68 per cent effective rate for the pharmaceutical and toilet preparations industry. Comparison between local and overseas prices indicates that the trend to manufacturing in Australia has led to efficient and economic local production. Australian companies are finding it harder to arrange for production under licence as most viable overseas firms already produce in Australia. Also, by-law is widely granted so that protection is only relevant to some antibiotics and vaccines.

175. The Committee found that the industry is generally competitive in that there is a large number of producers, none of which has an excessive share of the total market. There is considerable competition through product differentiation except where patents still exist or one brand name is predominant. The Department of Health forces keen price competition through its negotiations and has been responsible for considerable price reductions despite the existence of patents.

176. The Department of Health Pricing Bureau is to be congratulated on the effectiveness of its continuous pressure for reduced prices.

177. The Committee found that patents are necessary in the pharmaceutical manufacturing industry to provide the incentive for research. Any benefit gained in the short run by abolition of drug patents may be lost in the long term.

178. The Committee recommends that the present patent laws be maintained.

Other Aspects

Risk

179. The risk factor must be considered when assessing the profitability of the industry. Some risks were said to be unique to the pharmaceutical industry and to justify higher than average profits. Risk cannot be quantified and provided for as it is not predictable. The market share of firms changed considerably between 1963 and 1970, with dramatic fluctuations for several companies. Risk factors were stated to include:

(a) time lags between discovery and marketing of a drug;
(b) innovation or investigation which is costly and in a high proportion of cases fails to produce a marketable product. Research may have to be abandoned and outlay is not recoverable;
(c) existing products may be rendered obsolete by new discoveries;
(d) trials may expose unexpected side effects with consequential loss of market;
(e) exclusive profits under patent are short term and company fortunes fluctuate.

180. The Committee found that the main risk factor is obsolesence, forcing drugs firms to outlay large sums on research for new products. However, local

firms rely to a great extent on overseas innovation. Research is generally written off in assessing profits in each year. Other risk factors are associated with the need to grow, meet higher standards and cope with more complex processes. This is off-set to some extent by the Pharmaceutical Benefits Scheme itself which tends to guarantee a growing market.

Research and Development

181. The A.P.M.A. said that growth of the industry depends upon research and that this has resulted in a remarkable rate of innovation. Most drugs available today have been developed since the 1930s. Research is a long term process, calling for a large scale operation, below which there is small chance of discovering and developing a new, effective drug. Most advances have been made through commercial research rather than by governmental research.

182. Large sums are spent overseas on research. International firms tend to centralise their basic research in the home country of the parent company. There is, however, a growing trend for their firms to increase their research activities in other countries as business develops there, particularly in adapting products to local conditions.

183. Countries leading in developing new products are the United States of America, Switzerland, Britain and Germany. The United States research budget in 1970 was approximately $US624 million, a rise of 13.7 per cent over 1969. This represented 11.1 per cent of sales revenue, whilst 12.3 per cent of aggregate capital investment was for research equipment. In Britain £20 million stg was spent on research, 80 per cent applied and 20 per cent basic.

184. Research and development expenditure by firms answering the Committee's questionnaire (see paras 191-206 on Financial Questionnaire) was just over 2 per cent of sales. Further details are shown in Appendix VI on the financial questionnaire.

185. Although large scale research is not undertaken in Australia, local firms contribute to that conducted overseas by parent companies. Their contribution to research in Australia mainly consists of payments to research institutions in support of clinical trials for product development.

186. There is a diverging trend between research costs and research productivity because of the:

(a) growing sophistication of basic sciences;
(b) greater refinement of clinical trial methods making them longer and costlier;
(c) greater awareness of potential side effects;
(d) stringent regulations requiring more data;
(e) successes already achieved mainly leaving more difficult diseases to be tackled.

187. Riker Laboratories Australia Pty Ltd set up an extensive research establishment to carry out pure research but this activity has been abandoned because of the cost. Professor Bornstein's research at Monash University on diabetes treatment was given as an example of limited research which may be desirable in Australia rather than expending meagre resources on larger projects.

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188. The main sources of Australian medical research funds in 1968 were:

	Per cent
Commonwealth Government	56.5
State Governments	3.9
State universities	6.9
Public research and bequests funds	17.3
Hospital and medical research institutes	10.3
Pharmaceutical companies	2.1
Overseas sources	2.9

These represent donations to research institutes and exclude research expenditure by firms within their own establishments.

189. The cost of developing a new chemical entity and marketing it as a new pharmaceutical product would be beyond the means of most Australian firms. The chances of the Australian pharmaceutical industry, as presently structured, developing a unique product are therefore slight.

190. The Committee found that there is scope for more research into the suitability of drugs for Australian requirements and that the diversion of a proportion of industry funds at present spent on advertising, is desirable.

Financial Questionnaire

191. With the co-operation of the A.P.M.A. and pharmaceutical manufacturers, a financial questionnaire was prepared and forwarded by the Committee to over forty major manufacturers of pharmaceutical benefits products. All major firms co-operated, returning 43 completed questionnaires. (See Appendix VI).

192. The questionnaire requested costs of materials purchased from parent companies for comparison with material prices paid by Australian firms. This was designed to see where the major profit was being taken and to show up international price support activities. This question was not answered by most firms as their overseas parents would not co-operate or were forbidden to do so by law. The extent of any loading of materials prices is therefore unknown.

193. Information was requested covering four years, from 1968 to 1971, including where necessary, estimates for 1971. The financial years of some firms did not finish on 30 June so that the years include a mixture of closing dates.

194. Profits for pharmaceutical benefits products rose over the four years at the rate of only 4 per cent per annum in money terms, despite increased sales of 10 per cent per annum because costs rose by 12 per cent per annum. This was most marked in the groups with recent sales between $2 million and $3 million per annum and the group over $4 million per annum. Profits actually fell for these groups despite increasing sales. The group with recent sales of between $3 million and $4 million per annum had the best results with average profits for firms between 1968 and 1971 rising from $534,000 to $858,000 as sales increased from $2.4 million to $3.7 million.

195. A Committee survey of the returns of individual firms showed that in 1971 actual or expected profits of 27 firms were less than 15 per cent on sales, whilst 15 firms expected profits in excess of 15 per cent on sales. Only four firms expected profits in excess of 30 per cent on sales and six firms showed losses.

196. Profits to funds employed declined from 26.5 per cent in 1968 to 20.8 per cent in 1971. This went against the Australian average which rose from 11.4 per cent in 1968 to 13.0 per cent in 1970. However, the industry still has one of the highest returns on funds.

197. The industry has expanded capital at a higher rate than sales in recent years, partly due to more stringent regulations covering good manufacturing practice.

198. Materials represent the largest cost element because much of it is purchased in an advanced stage of manufacture. Advertising and promotion represented between 19 per cent and 25 per cent of total costs for the first four groups and 14 per cent for the highest sales group. Thus, for most firms, over 20 cents in every dollar of cost is spent in advertising and promotion, whereas expenditure in Australia on research and development represented only 3 cents in the dollar of cost.

199. Costs of advertising and promotion rose at a faster rate than sales. Expenditure on company representatives represented over 40 per cent of advertising and promotion costs.

200. Unit costs of producing individual products together with prices, were requested for major representative products. All firms answering the questionnaire provided these costs.

201. Examination of individual product costs of local producers did not reveal the high mark-up on cost indicated by inquiries in other countries. The average unit costs of some products actually exceeded their prices although others had substantial profit margins. An assessment of the cost pattern between patented and unpatented lines showed no really conclusive result. It did, however, indicate that for patented products (compared with unpatented lines) as a proportion of total costs:

(a) manufacturing costs are proportionately lower;
(b) selling costs are proportionately higher;
(c) administrative costs are proportionately higher;
(d) royalties are proportionately higher.

202. The selling margin above cost for patented products is generally around 50 per cent higher than on unpatented lines.

203. The Committee noted that on patented lines total profits, including those of parent companies, could be significantly higher than is reflected in the accounts of the Australian subsidiary. The available evidence does not provide a basis on which hidden profits can be measured.

204. The industry has been amongst the highest overall profit earning Australian industries but there has been a downward trend in profitability in recent years.

205. The Committee found that factors contributing to falling profitability include:

(a) price negotiations by the Department of Health;
(b) competition within the industry;
(c) high expenditure on advertising and promotion;
(d) more stringent regulations governing manufacturing practice necessitating capital expansion;
(e) the industry is fragmented into a large number of firms, preventing the achievement of optimum economies of scale.

206. The Committee found that present profits for most firms, as indicated by returns to the questionnaire, are high by comparison with the Australian average but are not excessive given the special nature of the industry, and prices for most products do not give large margins above cost. There are several firms which, because of temporary advantages, have been able to earn substantial profits in recent years but these are off-set by others which have incurred losses.

7. DISTRIBUTION OF DRUGS—RETAIL

Role of the Retail Chemist

207. The chemist is the final qualified person with the responsibility of seeing that the doctor's patient takes the right medication, and only the right medication, at the right time and in the right dosage and right manner. He is the only person normally able to intervene to rectify a prescribing error.

208. The legal responsibility for the supply of pharmaceutical benefits is placed on the chemist by the *National Health Act* 1953-1971 and State Pharmacy Acts.

209. Under the National Health (Pharmaceutical Benefits) Regulations the chemist has the obligation:

(a) to dispense the medication ordered by the doctor, advise on its correct use, and label clearly;

(b) to dispense only those items listed in the Schedule of Benefits, in such quantities as the current Schedule permits for the number of times and under such restrictions as are set out in the Schedule;

(c) to check dosage, strength, incompatability and interaction;

(d) to record details as required, including filling in the computer grid on the prescription form with the quantity ordered and supplied, the brand ordered, the chemist's serial number and his own identifying number.

210. The chemist must police the prescription to ensure compliance with all requirements including those of the relevant State Acts. Extensive recording and checking procedures are necessary with each prescription.

211. The chemist is an important point of control in the procedures for ensuring that regulations are observed. The regulations are designed to enforce maximum prescribable quantities of listed drugs, to minimise fraud and to discourage doctors from writing prescriptions incorrectly. There are twenty-one points on which a payment for a prescription may be refused by the Department of Health. If the item is not a benefit there will be no further payment. In four categories, adjustment will be made when the chemist's next claim is being processed. For sixteen categories some action by the chemist will generally be needed.

212. The chemist's role has been criticised as involving little more than counting pills and changing labels. However, the responsibility towards the community goes much further than this.

213. Dispensing of extemporaneous prescriptions has declined in the last twenty-five years, due mainly to the need for more accurate and complex processes than are possible in most pharmacies. Tablets and capsules, the most acceptable dosage forms, are more appropriately manufactured by the pharmaceutical manufacturing industry. Extemporaneous compounding, however, is still important. Although the proportion of total prescriptions has fallen from 23.2 per cent to 9.5 per cent over ten years, extemporaneous prescriptions in 1970-71 totalled 6.7 million.

214. Correct drug storage presents a number of problems including temperature changes, light, heat, humidity and interaction with packaging. Chemical changes may cause reduced potency or increased toxicity. This sensitivity to environment varies over a wide range of drugs and leads to varying shelf life. Special protection and recording procedures are required for drugs of addiction.

215. When advising a patient the chemist must satisfy himself that:
(a) the prescriber's intentions have been correctly interpreted;
(b) there is no incompatability between the drugs prescribed or between drugs prescribed and some other substances being taken. If necessary he must check this with the doctor before any change can be suggested.

216. The chemist must ensure that the customer understands how to correctly use the medicine. He should advise on the dangers of the drugs; on the disposal of unused drugs; that the drugs be restricted to the person for whom they were prescribed; as well as potential dangers of the drugs if abused; and reactions with other drugs and food (including alcohol). Advice to the patient on dosage is often necessary because verbal instructions given by the doctor are not always remembered due to illness or stresses at the time of examination.

217. The Pharmaceutical Association of Australia (P.A.A.) said that chemists are under-utilised rather than over-trained. The future role of chemists was seen to indicate an increase in advice to patients and the monitoring of patients' drug intakes. There is a need to recognise the professional status of chemists, to encourage purely dispensing pharmacies and the establishment of more extensive information services for doctors.

218. The Committee found that the chemist is a major link in the chain of supplying pharmaceutical benefits and his role far exceeds the mere counting of tablets and dispensing prescriptions.

Education of Chemists

219. The education of chemists has been expanded in the last ten years to keep pace with the development in medicine during the last twenty-five years. The system has changed in that period from a part-time course with apprenticeship to a three year full-time degree course followed by one year's practical experience before registration.

220. A majority of graduates enter the retail trade. However, the course has not been designed simply for retailers but must also consider other avenues of employment of graduates including manufacturing, hospital dispensaries and employment in hospitals at the ward level.

221. The Bachelor of Pharmacy degree is based mainly on applied chemistry, including pharmaceutical chemistry, pharmaceutics and pharmacology, together with other background subjects. The P.A.A. claimed that the pharmacy student is taught more pharmacology than the medical student and chemists should be consulted where no pharmacologist is available. However, doctors generally do not welcome advice from chemists nor do they seek it.

222. In recent years there has been a considerable increase in interest in post-graduate education, aimed at up-dating the chemist and keeping abreast of world knowledge. Higher degrees have been a feature of the School of Pharmacy at Sydney University since 1960 and more recently in other universities.

223. The Committee found that chemists' training has kept pace with world standards and modern medical requirements.

Relationships with the Department of Health

224. Witnesses had many complaints about the relationship between chemists and the Department of Health. It was stated that whilst the doctor is 'requested' to do certain things, the chemist is 'required' to do them. There were complaints regarding inadequate remuneration (to be covered later), extreme regulations concerning the handling and checking of prescriptions, stock-taking and the general requirement of policing the regulations for the Department. Chemists complain of the regulation requiring them to know doctors' signatures. One of the strongest complaints made was the difficulty of interpreting doctors' writing. It was suggested that, except for narcotic drugs, typing of prescription forms should be permitted in lieu of the present requirement that prescriptions must be in the doctor's own hand-writing.

225. The Pharmacy Guild of Australia (Guild) requested the implementation of measures to reduce clerical work and remove from the chemist the burden of policing the actions of others, and a method of regular review of the rates of payment to chemists be established by the adoption of an up-dating formula and provision of recourse to arbitration.

226. The Committee found that the chemist is an important point of control of the Scheme's administration, and that his reimbursement is dependent upon fulfilment of all departmental requirements, some of which are considered to be too rigid.

227. The Committee found that handwritten prescriptions are a continual source of potential error in patient treatment and cause difficulties for the chemist.

228. The Committee recommends that:

(a) the Department of Health co-operate with the Pharmacy Guild of Australia to examine the regulations applicable to chemists with a view to allowing chemists to rectify minor omissions from prescription forms, such as a patient's address or pension number. In each case it should be sufficient for the chemist to certify that the particulars added are correct to the best of his knowledge;

(b) National Health (Pharmaceutical Benefits) Regulation 19 (1.) (a) be amended to require that prescriptions be typed or written in block letters.

Chemists' Remuneration

229. Chemists' dispensing fees are determined by the Minister for Health after consultation with the Guild under Section 99 of the *National Health Act* 1953-1971.

230. When the Scheme was expanded in March 1960 the Guild sought a provision for adjustment of the dispensing fee and a formula was agreed upon for up-dating the dispensing fee according to the rise and fall in the weighted average award rates for registered assistants. A clause in the agreement allowed for a review if there were a 'freakish' adjustment. In 1960 a very large increase in wages was granted in Victoria as a result of which the adjustment would have been an increase of 22 per cent. The Minister granted an increase of only 10 per cent, bringing the fee to 30 cents per ready prepared prescription, and sought to negotiate a completely new arrangement for future adjustments.

231. In accepting the National Health Scheme in the first place, the Guild agreed to a reduction in customary mark-up from 50 per cent to 33⅓ per cent and at that time the mark-up factor was not considered part of the formula.

232. The Guild claimed that, when accepting the introduction of the Scheme, it was assured by the Commonwealth that chemists would be secured against deterioration in their economic position due to participation in the Scheme. The Guild was unable to produce any written confirmation of such assurance.

233. In February 1965 the Guild proposed a survey to provide information on costs, earnings and profits. The Commonwealth agreed to share the cost of the survey which was duly carried out by the Associated Industrial Consultants (Aust.) Pty Ltd (A.I.C.), under the supervision of the Joint Committee on Pricing Arrangements. In mid-1969 the Commonwealth decided that the rates of payment would remain unaltered, claiming that the report of the survey indicated a substantial margin in the 'total' remuneration above the cost per prescription. This was denied by the Guild.

234. The technique used in the A.I.C. survey was to measure all activities by analysis of financial statements and through random activity sampling, to determine how each person in the pharmacy spent his time. Direct costs were then attributed to either retailing or dispensing whilst indirect costs were apportioned on the basis considered most appropriate.

235. In spite of disagreement on costs the Commonwealth granted an increase of two cents in the dispensing fee from 1 July 1970, and sought a new survey. The Guild refused to co-operate on the ground that the proposed survey was to be conducted on the same lines as the previous one.

236. The Guild commissioned a firm of consultants, Economic Research Associates (E.R.A.), to advise on a suitable formula.

237. Considerable confusion exists as to the relevance of retailing in assessing the cost of dispensing. Various bases for allocating costs reveal essentially arbitrary decisions, variation in any of which alters the relative profitability of retailing and dispensing and also the dispensing cost per prescription. The E.R.A. likened the allotting of joint costs in a multi-product business to trying to determine which part of a tree trunk supports a particular branch.

238. One very questionable result of the A.I.C. survey was the conclusion that the dispensing side of pharmacies in 1964-65 was profitable (after allowing for notional wages of the proprietor and notional rent where the shop was owned), whereas retailing was unprofitable. The results of the average shop in the modal group showed:

Dispensing Profit		*Retail Loss*		*Overall Profit*
$3,020	—	$2,024	=	$996

The E.R.A. pointed out that if this were the case pharmacies could triple their profits merely by avoiding retail trading and that this was a nonsense result. The real test of the profitability of retailing, they said, is whether extra sales will exceed extra costs and whether sales will contribute positively to profits.

239. A formula was suggested by E.R.A. on which remuneration could be up-dated after allowing for economies of scale due to prescription volume increases per chemist, together with cost and wages increases. The technique of regression analysis was used to up-date the A.I.C. report results for 1964-65 and was suggested to replace the cost accountancy approach in any further review.

240. The precise form of equation is a matter for discussion between the Department of Health and the Guild, but in view of the complete breakdown that had occurred in the Pricing Committee the only solution to the long disagreement over the dispensing fee seemed to be to put the matter to an independent arbitrator for decision on a base from which future adjustments could be calculated.

241. Making a comparison of price increases over a ten year period the Guild claimed that the average adult wage rose 59 per cent, the Consumer Price Index rose 29 per cent, doctors' fees under the Pensioner Medical Scheme rose a minimum of 127 per cent whilst the chemists' increase of two cents was less than 7 per cent.

242. The Guild claimed that the Commonwealth has relied upon effects of increased volume and decreased extemporaneous dispensing to keep pharmacy viable. However, this has often been at the expense of previously profitable private dispensing. When a product is listed under the Scheme:

(a) the chemist receives a lower dispensing fee;

(b) the rate of mark-up falls from 50 per cent to 33⅓ per cent;

(c) the product price falls (further reducing mark-up);

(d) the demand for non-listed private prescriptions falls and chemists are left with surplus stocks.

243. The large increase in volume of prescribing does not necessarily result in economies of scale in labour. It may mean that the chemist has less time to devote to other activities, or it may become necessary to employ more labour to perform activities previously done by the dispenser.

244. On 13 August 1971, the Guild requested the Minister for Health for an 8 cents interim rise in dispensing fee, after which its members would co-operate in a survey based on the use of regression to replace random activity sampling. The Department of Health, however, thought that the Guild's survey would not provide the essential factual information needed.

245. The Minister for Health announced on 5 April 1972:

(a) retrospective to 1 January 1972, an increase of 7 cents in the dispensing fee per prescription;

(b) a new enquiry to be carried out for the financial year 1972-73 to assess chemists' costs and earnings from National Health Scheme prescriptions using both the Commonwealth and Guild approaches;

(c) the new rates of 39 cents per ready prepared prescription and 64 cents per extemporaneous prescription to remain in force until January 1973 when they will be up-dated;

(d) if the results of the new enquiry become available in 1974 they will be used as the basis of new rates retrospective to 1 July 1973, to be up-dated thereafter at 1 July in each year in between enquiries;

(e) further enquiries to be held no earlier than every three years with either party having the right to request a new enquiry;

(f) increased powers for the independent chairman of the Joint Committee on Pricing Arrangements to provide for him to make recommendations direct to the Minister where agreement cannot be reached, the chairman's recommendations to be made known to all committee members;

(g) should either the Commonwealth or the Guild be not prepared to accept decisions of the chairman, provision to be made for either party to have the issue referred to judicial arbitration without delay and both parties have agreed they will abide by the decision of the arbitrator;

(h) special consideration to be given to problems associated with increased costs being passed on to chemists in regard to drugs of addiction and to the problems associated with reductions in discounts allowed to wholesalers by manufacturers; appropriate retrospective adjustments to be made as soon as possible.

246. This decision is in conformity with the evidence received by this Committee and is in accord with the recommendations being formulated by the Committee at the time of its announcement.

Ownership and Distribution of Pharmacies

247. The Guild suggested that the Commonwealth Minister for Health establish a committee to regulate the number of pharmacies by refusing approvals of new pharmacies to participate in the Scheme in areas where adequate service is already available. The future trend is expected to be consolidation of small retail pharmacies into larger, more economically viable units, and the closing of uneconomic pharmacies.

248. Wholesalers contribute to the excessive number of shops by financing the chemist to open in uneconomic situations. The Guild submitted that wholesalers should not finance retail pharmacies and it would co-operate in any legislation to enforce this by itself arranging finance for new pharmacies found to be warranted or for the acquisition of existing businesses.

249. There has recently been a falling trend in the ratio of pharmacies to population in at least three States. More females than males are currently studying pharmacy and female chemists are less likely to open pharmacies.

250. The ratio of pharmacies to population in Australia is high by world standards; this inflates the cost of the Scheme and is detrimental to the members of the profession themselves. The Guild said that the lower 30 per cent of pharmacies account for only 17 per cent of total sales. Other evidence indicated that many self-employed chemists are earning no more than award wages.

251. The ownership of pharmacies is restricted by legislation which differs from State to State. One example is the varying maximum number of pharmacies that one chemist can own. Unqualified ownership was previously permitted in some States, but now ownership can only be transferred to a registered chemist. The number of pharmacies which can be owned by one person varies between States as follows:

New South Wales—one shop plus an interest in a co-operative or up to three shops in partnership.
Victoria—two shops plus an interest in one shop in partnership.
South Australia—four shops.
Western Australia—two shops.
Tasmania—three shops.
Queensland—no restrictions.
Australian Capital Territory—no restrictions.

252. Limited liability companies and Friendly Societies Dispensaries are restricted in the number of pharmacies which they may operate to those held in a base year. Witnesses claimed that it is in the interest of the community that ownership be in the hands of qualified chemists only. However, it is difficult to achieve full economies of management and purchasing except in groups such as Friendly Societies Dispensaries and existing companies operating chains of shops.

253. The Guild felt that chain pharmacies do obtain good economies when purchasing non-ethical goods but that there is little scope for savings in the prescription drug field. Evidence received from the Friendly Societies Dispensaries Association of Australia of their purchasing and distribution through their own bulk stores and in the efficient organisation and use of dispensing labour, indicated that there are definite economies in larger stores and shops operating as a group.

254. Some chemists are co-operating in forming purchasing groups to obtain rebates and discounts. The operation of co-operative wholesalers is another form of group activity, which results in additional income for the pharmacies concerned.

255. The Committee found that the number of pharmacies in Australia is excessive. This prevents optimum economies of scale, reflected in higher costs to the Scheme and a number of chemists operating at marginal economic levels.

256. The Committee recommends consultation between the Pharmacy Guild of Australia and the Commonwealth to establish criteria for the limitation of future approvals to dispense National Health Scheme prescriptions.

After Hours Fees

257. Regulation 29 of the National Health (Pharmaceutical Benefits) Regulations states as follows:

> (1) An approved pharmaceutical chemist may make a special charge in respect of the supply of a pharmaceutical benefit outside normal trading hours of an amount not exceeding—
>
> (a) if the pharmaceutical benefit is supplied before eleven o'clock in the evening—Twenty-five cents; and
>
> (b) if the pharmaceutical benefit is supplied after eleven o'clock in the evening—Fifty cents.
>
> (2) Where two or more prescriptions are presented to an approved pharmaceutical chemist at the same time, being outside normal trading hours, for the supply of pharmaceutical benefits to the same person, the approved pharmaceutical chemist may make one such special charge only.

258. This regulation was interpreted by some group and individual chemists to cover all prescriptions filled after hours (say after 5.30 p.m.) who were charging this fee. A court hearing upheld the Department of Health's view that the fees were to cover the chemist who has to specially open up and could only be charged once. Normal trading hours was interpreted to include the opening hours displayed by the chemist or late night group co-operative.

259. The provision of service over long hours is a feature of pharmacy practice, which has resulted in the establishment of groups of late night, weekend and after hours pharmacies. However, these service groups have been losing money and there is grave doubt as to their ability to continue this service.

260. There has not been a rise in the after hours fee since the beginning of the Scheme.

261. The Committee found that the late fee has not been reviewed since the Scheme commenced.

262. The Committee recommends that the late fee should be reviewed at the same time as other fees and increased appropriately for each prescription handled.

Friendly Societies

263. There are 160 Friendly Society Dispensaries throughout Australia serving 250,000 members and their dependents. Benefits provided are quite high for non-National Health Scheme prescriptions (as much as one-third of retail price) but for prescriptions under the National Health Scheme, benefits are restricted to pre-1964 members and their dependents under 16 years of age. The largest group is in South Australia, with twenty-nine pharmacies.

264. Friendly Societies Dispensaries submitted that Section 91 of the *National Health Act* 1953-1971 imposes an onerous restriction on their approval to dispense. Dispensaries opened since 1964 can be granted only a limited approval to dispense National Health Scheme items to members and dependents.

265. Since the 50 cents patient contribution was introduced in 1959, the Act has forbidden the granting of any rebate by private approved chemists on National Health prescriptions. Friendly Societies Dispensaries, however, were exempted from this restriction. Other groups then proposed to establish similar insurance schemes. In 1964, to avoid a general breakdown in the deterrent effect, the Act was amended, restricting the giving of rebates on National Health prescriptions to pre-1964 members and their dependents under sixteen years of age. The Friendly Societies Dispensaries sought the removal of this restriction.

266. The Friendly Societies Dispensaries have been able to prosper with the existing remuneration and to give large rebates to members on non National Health Scheme lines. This was shown to be due to several factors:

(a) subscriptions from members of 5 cents a week;

(b) a guaranteed clientele of members;

(c) bulk purchasing and supply through bulk stores in some areas;

(d) a large throughput of prescriptions allows more efficient organisation of dispensing labour including the use of non-qualified clerical and pharmacy assistants in the dispensary (although a qualified person was said to check each prescription).

267. The Committee found that Friendly Societies Dispensaries can effect significant economies that are largely passed on to members due to:

(a) the privileged position of operating chain pharmacies;

(b) exclusive rights to operate a prescription insurance scheme for pre-1964 members.

268. The Committee recommends that in the event of the Commonwealth approving any expansion of the rights of contributors to Friendly Societies Dispensaries to receive rebates for National Health Scheme prescriptions, other organisations should also be approved to provide similar benefits at private pharmacies on payment of a similar contribution.

Labelling

269. Many prescription items are supplied to the chemist in original manufacturers' packs, on which is recorded the batch number, expiry date and special warnings. Usually a leaflet is included showing, among other things, contra-indications and side effects. It has become the dispensing practice to remove the

manufacturers' label and/or re-pack, and also to discard the leaflet, leaving the patient with only a chemist's label which often gives no more than the name of the patient, prescription number and the instruction 'take as directed'.

270. Recent events have highlighted the danger to the community of this disregard for valuable information which should be in the hands of the user. Several witnesses from medical associations urged that there is sometimes a need for doctors to identify dispensed drugs and that where possible original packs and labels should be dispensed, unless the doctor feels there is good reason for not doing so and orders otherwise.

271. Apart from the physical difficulty of accommodating chemists' labels to fit varying sized bottles there seems to be no reason why chemists' labels should not be affixed to the reverse side of the bottles, leaving the original manufacturers' labels intact. In the case of very small phials and some ointments a compromise could be necessary.

272. Special pricing arrangements applying to 'high velocity' items (five or more prescriptions for that item dispensed during a month) encourage the chemist to purchase in bulk packs as he risks some loss of income by supplying from smaller packs where sales of that particular item amount to five in any one month. However the saving in bulk pack pricing is comparatively small and it could possibly be as cheap to produce in required sizes in the factory as to re-pack in the pharmacy.

273. The Committee found that it is desirable for patients to receive the original pack so that valuable information supplied by the manufacturer is preserved.

274. The Committee recommends that:

(a) where original packs are dispensed chemists' identifying labels showing the name of the patient and dosage be affixed in such a way as not to obscure the manufacturers' label;

(b) when drugs are dispensed without the manufacturers' original label the information on the chemist's label should include the expiry date, the name of the patient, name and strength of the drug and explicit dosage routine;

(c) manufacturers be required to provide drugs in 'dispensing size' packs to replace bulk packs which require chemists to re-pack by hand;

(d) wherever possible manufacturers be required to provide 'dispensing size' packs in bottles of suitable shape, labelled in such a way as to leave adequate space for the chemist's label.

(e) the Department of Health confer with pharmaceutical manufacturers and the Pharmaceutical Guild of Australia with a view to the issuing of an instruction sheet for the patient with each dispensed item.

Substitution

275. Chemists are not permitted to substitute one drug for another, even within the same generic group except with the doctor's permission or in emergencies if the doctor cannot be contacted.

276. Only a few substitution cases have been brought before the Departmental Committee of Inquiry; but it would be hard to assess the full extent of substitution as it is difficult to police.

277. The Guild said that it believed substitution by Australian pharmacists was rare and the chances of detection are extremely high. Chemists are meticulous in supplying what doctors order.

278. The bonus system provides some incentive for chemists to substitute. Manufacturers of best selling brands do not usually engage in this type of selling, although in some cases large manufacturers supply the bulk product to smaller manufacturers who may offer bonuses as an inducement to push their brand.

279. Substitution in the United Kingdom and United States of America has resulted in substandard drugs being purchased cheaply and substituted for reputable brands. This is not a feature of the Australian situation.

280. The Committee received no evidence of widespread substitution of drugs in Australia. However, bulk selling and bonuses tend to indicate that there may be some incentive for substituting within generic groups.

Additional Roles of the Chemist

Hospital Chemists

281. The Society of Hospital Pharmaceutical Chemists of Australia submitted that the hospital chemist is an indispensable member of the health team. The dramatic increase in medical knowledge and new medication makes it necessary for the hospital chemist to be professionally competent and to be capable of administering a large budget, if he is to provide the highest quality medication but control spiralling costs.

282. Only twenty-six hospitals were said to have pharmacy departments and only around 64 per cent of hospitals have drug committees, of which the hospital chemist is a member.

283. The hospital chemist is concerned with the usage rate of drugs and the prescribing habits of doctors within the hospital. He must control the overall amount of stock held of any particular substance, for example by having only one brand of any drug in stock, as approved by the hospital drug committee. It appears to be the practice in some hospitals to spread the business by changing periodically to other brands.

284. The chief chemist is a purchasing officer in his own right and therefore has considerable influence on the cost of drugs used. The Victorian Hospitals and Charities Commission listed the following duties of a hospital chemist:

(a) to review regularly and control the drug usage in the hospital;
(b) to study reasons for abnormal variations in usage and expenditure;
(c) to advise medical staff of the time limits for which drugs should be prescribed;
(d) to suggest economical chemical or therapeutic equivalents;
(e) to arrange for regular inspections of all drug cupboards so that unused drugs may be returned to stock;
(f) to consider use of bed indicators as a means of keeping members of the staff informed of drugs which individual patients are ingesting.

Other Roles

285. There is an increasing role for the hospital ward chemist who acts as a check on the medication of the patient by inspecting patients' bedside charts for errors in prescribing, over-medication, cross reactions, etc.

286. It was also suggested that the chemist has a future role in group medical practices. Other roles are in the field of clinical pharmacist, pharmacology, and in research.

8. DISTRIBUTION OF DRUGS—WHOLESALE

The Role of the Wholesaler

287. Evidence was given by several wholesalers on their part in supplying the drugs used under the Scheme. These included full-time and limited-line wholesalers, some of which were co-operatives whilst others were ordinary commercial companies.

288. The distribution of pharmaceuticals appears to be impossible in its present form in Australia without the service provided by full-line service wholesalers. Distribution direct from the manufacturer would probably increase costs and act against the community's health and welfare. Recent reduction in the wholesalers' margin must affect the services they give and tend to eliminate the rebate system which is part of the distributing system.

289. Wholesalers are a diversified, flexible and efficient channel for mass distribution of pharmaceuticals in small quantities to all parts of Australia. Competition is vigorous and healthy.

290. Wholesalers provide the link between almost 6,000 pharmacies and over 200 manufacturers for distributing around 8,000 ethicals, including 'dangerous' drugs requiring special handling. Branches in the metropolitan and country areas ensure minimum delays. The geographical spread and stock range of the full-line wholesaler does increase his costs compared with the short-line wholesaler, who deals only within a limited area of delivery.

291. Australian wholesalers were said to be more efficient than those overseas, and very cost conscious. The large number of drugs and packs makes it impossible for a chemist to hold more than the faster moving lines and he needs access to a full-line wholesaler for quick delivery. He may also deal with a short-line wholesaler, to gain some advantage by way of rebate on quantity purchases.

292. Chemists are telephoned in a regular pre-arranged pattern. Many orders are for one only of an item and also include unprofitable service products. This requires expensive mechanical systems to ensure prompt delivery. It is clear that this adds to cost but seems necessary to retain business in the face of intense competition.

293. The wholesaler's margin is set by the manufacturer and he must work within it to make a profit. Full-line wholesaling is very labour intensive although the use of computers has reduced this. The combination of fixed discounts, rising wages and rebates to chemists has squeezed wholesalers' profits.

294. The services provided by the full-line wholesaler include:

(a) replacing faulty and dated goods;
(b) free telephone calls and freight for country chemists;
(c) maintaining 'dangerous drug' facilities;
(d) buying in products outside their range;
(e) assisting chemists by promotion schemes to compete with chain stores, etc.;
(f) a telephone pricing service;
(g) arranging sale or purchase and valuation of pharmacies;
(h) financing pharmacies;

(i) providing relief staff;
(j) advice on industrial awards;
(k) stocktaking services;
(l) financial and trading advice when chemists are in difficulties.

295. Wholesalers claim that it is because of their efforts in improved services and higher rebates that chemists have remained viable. The Committee found that this is substantially correct but ignores the fact that their efforts have also contributed to the proliferation of pharmacies and to the number of small uneconomic pharmacies. There are signs that wholesalers are now endeavouring to improve this aspect.

296. Major factors in reducing the full-line wholesalers' profitability include:

(a) the need to increase rebates because of competition from:
  (i) short-line wholesalers;
  (ii) direct sale by manufacturers to individual chemists;
  (iii) Chemists groups formed to purchase direct from manufacturers;
(b) twice daily deliveries to chemists;
(c) extensive and increasing services to chemists;
(d) the Commonwealth imposed reduction in discount from 20 per cent to 15 per cent on products such as antibiotics and diuretics;
(e) extending services into country areas by opening branches;
(f) considerable duplication through intense and excessive competition.

297. Offsetting this, there has been a large increase in the volume of items handled and the wholesalers have sought to reduce handling costs by mechanisation, the use of computers and by cost studies.

298. Short-line wholesalers service a limited area and a restricted range of goods, mostly of the faster moving lines. They do not provide the same services to chemists as do full-line wholesalers. Orders are usually received for larger quantities whilst less frequent deliveries are made, enabling the short-line wholesaler to give higher rebates to chemists.

299. Over thirty manufacturers have recently reduced their discounts from 20 per cent to 15 per cent on all products, further restricting wholesalers' margins available for providing services.

Deliveries and Freight Costs

300. Competition was said to have forced wholesalers to provide frequent deliveries to chemists. Most wholesalers deliver twice daily, telephoning the chemist on a prearranged schedule and organising his deliveries accordingly. This arrangement is less chaotic than alternative arrangements and is not necessarily more expensive.

301. The large increase in the number of drugs available under the Scheme has contributed to the need for frequent deliveries. A similar delivery pattern operates overseas.

302. Because of lack of storage, limited shelf life, slow moving stock and the cost of stock holding, the average chemist carries only around 1,500 ethical lines whilst the wholesaler carries up to 8,000 pharmaceuticals. This makes it necessary to deliver at short notice any of the 6,000 or more items not held in the chemist's stock. However, the system of wholesalers financing retail outlets,

coupled with the twice daily system of deliveries to chemists, has fostered the development of retail chemist shops with limited storage space and, of course, their consequential dependence on the continuation of this system.

303. Wholesalers agreed that a reduction in the number of deliveries would cut costs but, as they are on a fixed margin, this would not reduce the cost of the Scheme. Despite differing opinions about the economies of twice daily deliveries the consensus seems to be in favour of their continuation as a necessary community service in this type of industry because of the large number of individual items and the emergency aspects of demand.

304. Chemists receive subsidies from the Scheme to cover freight costs to outlying areas. However, wholesalers have been forced by competition to absorb most of the freight to country areas and have also established depots. Duplication of these services by different wholesalers is costly.

305. The Committee found that the present pattern of deliveries is costly but it cannot be eliminated because of the general dependency on it of retail chemists.

Discounts, Rebates, etc.

306. The Guild said that the Commonwealth was aware of the established discount patterns at the time of the 1959 agreement but reduced the wholesale margin on diuretics and antibiotics from 20 per cent to 15 per cent, leaving 5 per cent less wholesale margin available for discounts to chemists. In the past these discounts have been a significant factor in enabling chemists to stay in business.

307. The Guild also said that bonusing over and above discounts by individual manufacturers, is diminishing, and also is rarely available on National Health Scheme lines, but that chemists should be allowed extra profits if they are efficient and can buy better than competitors. The recent decision of several major producers to reduce wholesalers' margins to 15 per cent on all products will considerably affect rebates available to chemists.

308. Co-operatives said that normal dividends to shareholder chemists are based on their shareholdings (which are based on their purchases) and are not considered by the Department of Health as hidden rebates. Although these dividends are paid on shareholdings, they could be construed as an additional discount, as they must act as an incentive to purchase through the co-operative.

Profitability

309. Wholesalers complained of having to handle low velocity and low value items at the same margin as the faster moving higher value items. For example, 89 per cent of sales value comes from 2,000 out of 8,000 ethical items. The average cost of storage, handling, distribution and control of these slow moving lines, exceeds the net revenue earned and must be off-set by profits on the top 25 per cent of the range.

310. Wholesalers indicate that they have experienced falling profitability and that their profits are less than the Australian average. The 5 per cent reduction in discounts on certain lines and the withdrawal by some manufacturers of 2½ per cent settlement discount, has lowered wholesalers' profitability. This will be further eroded by the latest reduction of 5 per cent applied to all other lines.

311. The Committee found that wholesalers passed on varying percentages of their discounts to the chemist as rebates and bonuses. There is intense competition between full-line wholesalers, both co-operative and private companies, and between full-line wholesalers, short-line wholesalers and manufacturers who sell direct to chemists. In some instances wholesalers act more like retailers by supplying at short notice and in quantities of one only, but they form a vital link in the chain of distribution.

312. The Committee recommends that in respect of National Health Scheme products, it be made a condition of listing that provision of bonuses by manufacturers or wholesalers should be discontinued.

9. HOSPITALS

313. Approved private hospitals are paid for supplying pharmaceutical benefits on the same basis as approved chemists.

314. Approved public hospitals are reimbursed on a formula consisting basically of a proportion of cost plus 20 per cent for handling and dispensing. From 1954

pricing, etc., which would be unprofitable and bankrupt a firm if this were its only source of outlet or if it had to supply wholesalers in small amounts at the same prices.

320. The Committee found that expenditure on hospital drugs represents a substantial part of the cost of the Scheme. However, it is in the hands of the State Governments who meet on average around 25 per cent of the cost but who are also reimbursed for handling costs. The State systems of purchase and distribution of drugs for hospitals results in lower prices than is possible in other sections of the Scheme. The large increase in total hospital costs is mainly due to changing methods of treatment with greater drug usage.

10. DENTISTS

321. The Australian Dental Association submitted that dentists should be allowed to prescribe for patients under the Scheme. At present dentists can prescribe outside of the Scheme, items listed in the restricted substances schedules of State Poisons Acts. These include antibiotics, analgesics, sedatives, anti-convulsives, anti-inflammatory, and anti-hypertensive agents, vaccines, hormones, etc., providing prescriptions are endorsed 'for dental treatment only'.

322. Currently, when a dentist's prescription is dispensed the patient has to pay the full price. However, the patient can obtain the prescription under the Pharmaceutical Benefits Scheme if he consults a doctor as well as the dentist.

323. Dentists receive undergraduate training in pharmacology and therapeutics and are familiar with the drugs they normally prescribe.

324. The Association said that the advantages of dentists being allowed to prescribe are:

(a) immediate commencement of antibiotic treatment when required;
(b) saving to the National Health Scheme of the medical consultation fee and to patients of time needed merely to obtain a prescription, from a medical practitioner;
(c) economy in the use of antibiotics;
(d) avoidance of the division of clinical responsibility.

325. Dentists were said to each currently write around two prescriptions per week. The Association said that allowing dentists to prescribe under the Scheme would not lead to an increase in prescribing.

326. The Committee found that there is a need to provide benefits for dental patients.

327. The Committee recommends that:

(a) Dentists be provided with modified medicine chests, free through the Scheme, similar to the arrangements for doctors' emergency supplies;
(b) Dentists be authorised to write prescriptions for the supply of a limited range of drugs for dental purposes only, under the *National Health Act* 1953-1971.

11. CONTRACEPTIVES

328. The Committee heard evidence on the need for the listing of contraceptives as pharmaceutical benefits on medical as well as social grounds.

329. The need for education in family planning was stressed. Removal of sales tax and customs duty was also suggested. The role of family planning in relation to the problems of world over-population were also discussed. It was submitted that Australia is in a position to avoid its population problems before they become acute, without social trauma.

330. The Family Planning Association claimed that there is a need for establishing more family planning clinics and that doctors are not properly trained to advise on family planning although medical students recently have been attending these clinics as observers. These clinics fulfil a role in the health system and would tend to reduce medical and pharmaceutical demands from the relevant section of the community.

331. The Committee found there is no case for unrestricted listing of the oral contraceptive. However, where there are genuine medical reasons for the use of the oral contraceptive pill it should be available under the National Health Scheme.

332. The Committee recommends that:

(a) the Pharmaceutical Benefits Advisory Committee consider the listing of oral contraceptives where required for certain specific medical reasons;

(b) the Commonwealth provide substantial subsidies for the expansion of Family Planning Clinics.

12. HEALTH COMMITTEES

333. Representatives of the Pharmaceutical Benefits Advisory Committee and the Australian Drug Evaluation Committee gave evidence and additional information was supplied by the Department of Health concerning the background and activities of other health committees and the National Health and Medical Research Council. This information is summarised in Appendix VII.

334. The Committee found that specialist sub-committees would be a more efficient way of obtaining a balanced critical appraisal of drug data than by direct consultation with specialist societies. It is likely that the people who serve on such specialist sub-committees would also be members of the relevant specialist societies.

335. The Committee recommends that the Pharmaceutical Benefits Advisory Committee be strengthened:

(a) by creating specialist sub-committees within medical colleges to review existing drugs and consider new drugs relevant to their specialities;

(b) by increasing its secretariat with the employment of a full-time pharmacologist;

(c) by it meeting at least six times a year and employing some members in a full-time capacity.

336. The Committee, whilst recognising that there are different administrative tasks performed by the Pharmaceutical Benefits Advisory Committee and the Australian Drug Evaluating Committee, considers that there is duplication in activities between these two bodies.

337. The Committee recommends that:

(a) the Pharmaceutical Benefits Advisory Committee and the Australian Drug Evaluation Committee be combined into one committee with, if necessary, sub-committees;

(b) a systematic review be carried out on the efficacy of the commonly prescribed drugs.

A. A. BUCHANAN
Chairman

APPENDIX I COST OF THE SCHEME

TABLE I

COST OF PHARMACEUTICAL BENEFITS 1961–62 TO 1970–71

Year ended 30 June	Commonwealth payments								Patient contribution on general benefit prescriptions	Per cent increment on previous year	Total cost[4]	Per cent increment on previous year
	Prescription benefits				Hospitals and miscellaneous services[3]	Per cent increment on previous year	Total payments	Per cent increment on previous year				
	General[1]	Per cent increment on previous year	Pensioner[2]	Per cent increment on previous year								
	$'000		$'000		$'000		$'000		$'000		$'000	
1962	44,632	..	18,195	..	7,552	..	70,380	..	13,008	..	83,388	..
1963	47,093	5.5	19,831	9.0	9,986	32.2	76,910	9.3	14,742	13.3	91,653	9.9
1964	46,461	−1.3	20,602	3.9	11,776	17.9	78,839	2.5	15,574	5.6	94,412	3.0
1965	48,930	5.3	21,564	4.7	11,708	−0.6	82,203	4.3	16,841	8.1	99,044	4.9
1966	53,078	8.5	24,071	11.6	14,635	25.0	91,784	11.7	17,481	3.8	109,265	10.3
1967	56,656	6.7	29,280	21.6	15,344	4.8	101,281	10.4	18,347	5.0	119,628	9.5
1968	56,800	0.3	32,115	9.7	16,219	5.7	105,134	3.8	18,504	0.9	123,639	3.4
1969	64,025	12.7	36,609	14.0	17,739	9.4	118,373	12.6	20,129	8.8	138,503	12.0
1970	73,228	14.4	41,069	12.2	22,422	26.4	136,718	15.5	21,942	9.0	158,660	14.6
1971	88,176	20.4	45,181	10.0	26,918	20.1	160,275	17.2	24,384	11.1	184,659	16.4

[1] Benefits supplied to persons other than those eligible to receive pensioner pharmaceutical benefits.

[2] Benefits supplied to persons eligible to receive pensioner benefits.

[3] These figures do not include adjustments for hospital progress payments.

[4] Apparent minor errors in totals are due to rounding.

Source: Compiled from Table 37, Annual Report of Commonwealth Director General of Health.

TABLE II

PAYMENTS FOR PHARMACEUTICAL BENEFITS SUPPLIED[1]

(a) by Royal Flying Doctor Service and Queensland Ambulance Transport Brigade;

(b) by Colostomy and Ileostomy Associations;

(c) in Public, General and Mental Hospitals.

Year	a	b	c[2]
	$'000	$'000	$'000
1961–62	10.4	..	8,393
1962–63	19.8	3.3	9,866
1963–64	22.6	10.9	10,374
1964–65	21.3	17.6	12,233
1965–66	26.1	22.8	12,444
1966–67	27.9	29.0	14,180
1967–68	29.2	40.0	16,630
1968–69	39.3	42.3	19,619
1969–70	24.8	55.7	20,067
1970–71	27.2	71.2	20,365

[1] Other miscellaneous payments excluded from this table include haemodialysis in the home, bush nursing centre supplies and other payments under Section 100 of the National Health Act.

[2] These figures do not coincide with Table I due to adjustments of progress payments to hospitals.

Source: Compiled from Tables 8, 9 and 10 of submission by Commonwealth Department of Health.

TABLE III

NUMBER AND AVERAGE COST OF PHARMACEUTICAL BENEFIT PRESCRIPTIONS

1961–62 to 1970–71

Year ended 30 June	Number of benefit prescriptions						Average cost per prescription		
	General benefits	Percentage increase over previous year	Pensioner benefits	Percentage increase over previous year	Combined benefits	Percentage increase over previous year	General benefits	Pensioner benefits	Combined benefits
	'000		'000		'000		$	$	$
1962	26,050	27.1	11,664	8.7	37,714	20.8	2.22	1.56	2.01
1963	29,518	13.3	12,674	8.7	42,192	11.9	2.09	1.57	1.93
1964	31,040	5.2	13,317	5.1	44,357	5.1	2.00	1.55	1.86
1965	33,714	8.6	13,841	3.9	47,556	7.2	1.95	1.56	1.83
1966	35,085	4.1	14,908	7.7	49,993	5.1	2.01	1.61	1.89
1967	36,751	4.8	16,936	13.6	53,687	7.4	2.04	1.73	1.94
1968	37,053	0.8	18,370	8.5	55,423	3.2	2.03	1.75	1.94
1969	40,453	9.2	19,954	8.6	60,408	9.0	2.08	1.83	2.00
1970	44,071	8.9	21,504	7.8	65,575	8.6	2.16	1.91	2.08
1971	48,971	11.1	22,515	4.7	71,487	9.0	2.30	2.01	2.21

Source: Table 5 of the submission by the Commonwealth Department of Health.

TABLE IV

NUMBER OF PRESCRIPTIONS AND COST PER HEAD OF POPULATION FOR PHARMACEUTICAL BENEFIT PRESCRIPTIONS

1961–62 to 1970–71

Year ended 30 June	Cost per head of population			Prescriptions per head of population		
	General benefits	Pensioner benefits	Combined benefits	General benefits	Pensioner benefits	Combined benefits
	$	$	$			
1962	5.92	23.08	7.20	2.65	14.80	3.56
1963	6.12	23.95	7.48	2.95	15.45	3.90
1964	6.10	24.38	7.51	3.05	15.91	4.02
1965	6.47	25.88	7.93	3.24	16.35	4.23
1966	6.68	26.45	8.25	3.32	16.38	4.36
1967	7.06	28.68	8.95	3.46	16.59	4.61
1968	6.95	29.40	9.01	3.42	16.82	4.65
1969	7.62	32.30	9.92	3.67	17.61	4.96
1970	8.43	35.68	10.95	3.90	18.68	5.27
1971	9.80	37.59	12.43	4.26	18.73	5.63

Source: Table 6 of the submission by the Commonwealth Department of Health.

TABLE V

DISSECTION OF BENEFIT PRESCRIPTION COSTS INTO INGREDIENT COST AND APPROVED SUPPLIERS' REMUNERATION[1]

1961–62 to 1970–71

Year ended 30 June	Cost of ingredients and containers[2]	Suppliers' remuneration[3]	Total Cost[4]
	$'000	$'000	$'000
1962	46,714	29,121	75,835
1963	49,113	32,553	81,666
1964	49,398	33,239	82,637
1965	52,139	35,197	87,336
1966	57,293	37,337	94,630
1967	63,676	40,608	104,284
1968	66,662	40,758	107,420
1969	75,314	45,450	120,764
1970	85,821	50,418	136,238
1971	99,366	58,375	157,741

[1] Excludes costs in relation to hospitals and miscellaneous services.

[2] Cost of ingredients and containers includes payments to suppliers for wastage on broken quantities of ready prepared items.

[3] Remuneration includes mark-up on wholesale price and professional fees but does not include discount allowed to suppliers by wholesalers and manufacturers.

[4] Apparent minor errors in totals are due to rounding.

Source: Table 40 of the Annual Report of the Commonwealth Director General of Health.

TABLE VI

NUMBER OF PRESCRIPTIONS AND COST OF MORE FREQUENTLY PRESCRIBED THERAPEUTIC GROUPS[1]

Drug group	1961–62[2]		1970–71[2]		Increase			
					Value		Volume	
	$'000	'000	$'000	'000	$'000	Per cent	'000	Per cent
Broad spectrum antibiotics	15,304	3,508	18,954	6,678	3,650	24	3,170	90
Penicillins	7,231	2,643	15,045	5,724	7,814	108	3,081	117
Analgesics	5,980	4,203	12,849	6,017	6,869	115	1,814	43
Diuretics (N.M.)	5,812	1,610	11,227	3,289	5,415	93	1,679	104
Hypnotics	3,706	3,344	5,789	5,440	2,083	56	2,096	63
Blood vessels—drugs acting on	4,454	2,005	13,583	3,627	9,129	205	1,622	81
Anti-histamines	2,077	1,161	8,357	4,554	6,280	302	3,393	292
Sulphonamides	2,491	1,703	1,102	813	−1,389	−46	−890	−52
Antacids	2,392	2,223	3,694	2,457	1,302	54	234	11
Expectorants and cough suppressants	1,784	1,483	1,761	2,081	−23	−1	598	40
Tranquillisers	3,371	1,663	4,726	1,480	1,355	40	−183	−11
Anti-diabetics	1,158	246	2,947	712	1,789	154	466	189
Anti-cholinergics	1,692	320	3,592	1,098	1,900	112	778	243
Urinary antiseptics	962	463	3,409	747	2,447	254	284	61
Bronchial spasms	431	409	5,313	2,012	4,882	1,113	1,603	392
Anti-depressants[3]	..	..	5,460	1,750	5,460	..	1,750	..

[1] Excludes benefit prescriptions dispensed by hospitals and miscellaneous services.

[2] Cost includes the patient contribution on prescriptions available to the general public.

[3] Anti-depressants were first listed during 1965–66. Between 1966–67 and 1970–71 the volume has risen 136 per cent whilst the value has increased nearly 1,600 per cent.

Source: Compiled from Appendix 8 of Commonwealth Health Department submission.

TABLE VII

SELECTED DRUG GROUPS WITH COMPARATIVELY HIGH AVERAGE COST PER PRESCRIPTION

Drug group	Average cost per prescription 1969-70	Prescription volume			Average cost per prescription 1970-71	Prescription volume		
		1961–62	1969–70	Percentage increase		1961–62	1970–71	Percentage increase
	$	'000	'000		$	'000	'000	
Broad spectrum antibiotics	2.78	3,508	6,395	82.3	2.84	3,508	6,678	90.4
Penicillins	2.28	2,643	4,958	87.6	2.63	2,643	5,724	116.6
Diuretics	3.49	1,610	3,068	90.6	3.41	1,610	3,289	104.3
Drugs acting on blood vessels	3.65	2,005	3,508	75.0	3.74	2,005	3,627	80.9
Anticholinergics	3.28	320	1,046	228.9	3.27	320	1,098	243.1
Urinary antiseptics	3.75	463	908	96.1	4.56	463	747	61.3
Anti-diabetics	3.81	246	695	182.5	4.14	246	712	189.4

Source: Table 29 of the submission by the Commonwealth Department of Health.

TABLE VIII

COST OF DRUGS IN MAIN THERAPEUTIC AREAS

Category	1965–66 cost	Per cent of total cost	1966–67 cost	Per cent of total cost	1967–68 cost	Per cent of total cost	1968–69 cost	Per cent of total cost	1969–70 cost	Per cent of total cost	1970–71 cost	Per cent of total cost
	$'000		$'000		$'000		$'000		$'000		$'000	
Drugs used mainly in the treatment of—												
Infections	29,942	31.6	27,348	26.2	27,682	25.8	31,548	26.1	35,237	25.9	40,051	25.5
Heart complaints and high blood pressure	16,331	17.3	19,053	18.3	21,412	19.9	23,451	19.4	25,985	19.1	27,548	17.5
Rheumatism	3,267	3.5	6,917	6.6	6,453	6.0	7,439	6.2	8,676	6.4	10,139	6.5
Disorders of the digestive tract	5,072	5.4	5,829	5.6	6,819	6.3	7,210	6.0	8,077	5.9	8,664	5.5
Allergic conditions	4,707	5.0	5,223	5.0	5,828	5.4	6,707	5.6	7,798	5.7	8,357	5.3
Respiratory complaints	1,950	2.1	2,376	2.3	2,357	2.2	3,458	2.9	4,666	3.4	7,075	4.5
Skin conditions	430	0.5	498	0.5	596	0.5	608	0.5	1,664	1.2	2,739	1.7
Psychotropic drugs (Drugs affecting human behaviour, tranquillisers, anti-depressants, hypnotics and sedatives)	10,305	10.9	10,894	10.4	12,177	11.3	13,336	11.0	14,435	10.6	18,238	11.6

Source: Appendix 9 of the submission by the Commonwealth Department of Health.

TABLE IX

DETAILS OF THE NUMBER OF APPROVALS TO SUPPLY PHARMACEUTICAL BENEFITS AND RELATIONSHIP WITH POPULATION GROWTH

Year ended 30 June	Approved persons	Index	Approved persons per 100,000 head of population	Index	Prescriptions per approved person	Total payment per approved person
						$
1962	5,027	102*	46.8	100.2*	7,579	15,240
1963	5,184	105	47.3	101.3	8,263	15,994
1964	5,328	108	47.7	102.1	8,439	15,722
1965	5,459	111	47.9	102.6	8,816	16,191
1966	5,582	113	48.1	103.0	9,055	17,140
1967	5,719	116	48.4	103.6	9,500	18,454
1968	5,807	118	48.3	103.4	9,617	18,640
1969	5,887	120	47.9	102.6	10,331	20,654
1970	5,960	121	47.5	101.7	11,071	23,002
1971	5,994	122	47.2	101.1	11,926	26,391

* 1961 = 100

Source: Tables 30 and 31 of the submission by the Commonwealth Department of Health.

TABLE X

THE PROPORTION OF READY PREPARED ITEMS AND EXTEMPORANEOUSLY PREPARED ITEMS TO TOTAL PRESCRIPTIONS

Year ended 30 June	All preparations			Ready prepared				Extemporaneous			
	Number of prescriptions	Average cost per prescription	Per cent variation	Number of prescriptions	Per cent of total	Average cost per prescription	Per cent variation	Number of prescriptions	Per cent of total	Average cost per prescription	Per cent variation
	'000	$		'000		$		'000		$	
1962	37,681	2.01		28,933	76.8	2.29		8,748	23.2	1.04	
1963	42,157	1.93	−4.0	33,182	78.7	2.16	−5.6	8,975	21.3	1.04	..
1964	44,318	1.86	−3.6	35,864	80.9	2.04	−2.0	8,454	19.1	1.01	−2.9
1965	47,514	1.83	−1.6	39,079	82.2	2.00	+2.0	8,435	17.8	0.99	−2.0
1966	49,951	1.89	+3.3	42,229	84.5	2.04	+2.0	7,722	15.5	1.00	+1.0
1967	53,556	1.94	+2.7	45,822	85.6	2.08	−0.5	7,734	14.4	1.01	+1.0
1968	55,301	1.94	..	48,052	86.9	2.07	+2.9	7,249	13.1	1.01	..
1969	60,148	2.00	+3.1	52,759	87.7	2.13	+3.3	7,389	12.3	1.05	+4.0
1970	65,304	2.08	+4.0	58,219	89.2	2.20	−1.4	7,085	10.9	1.04	−1.0
1971	71,190	2.21	+6.3	64,457	90.5	2.32	+5.5	6,733	9.5	1.13	+8.7

Source: Appendix 7 of the submission by the Commonwealth Department of Health.

TABLE XI

EFFECT OF ADDITIONS TO THE LIST OF BENEFITS ON TOTAL COST AND THE AVERAGE COST PER PRESCRIPTION

Year ended 30 June	Number of items added	Cost in year of listing	Cost in first full year after listing	Cost in 1969–70	Average cost per prescription	
					Items listed since commencement of 1960–61	All benefit items
		$'000	$'000	$'000	$	$
1962	35	137	1,026	7,364	3.04	2.01
1963	46	759	3,795	3,204	1.55	1.93
1964	20	799	3,306	9,242	3.94	1.86
1965	29	225	1,540	4,927	1.92	1.83
1966	13	625	6,313	9,663	4.56	1.89
1967	35	548	2,071	5,317	2.31	1.94
1968	17	412	1,638	2,436	3.30	1.94
1969	43	1,946	5,249	5,249	2.51	2.00
1970	26	916	916	916	2.50	2.08

Source: Appendix 5 of the submission by the Commonwealth Department of Health.

TABLE XII

ESTIMATED ANNUAL VALUE OF SAVINGS EFFECTED IN THE YEARS 1963–64 TO 1970–71

Year ended 30 June	Amount
	$'000
1964	5,400
1965	5,000
1966	4,800
1967	3,700
1968	1,400
1969	1,200
1970	303
1971	−721

Source: Table 12 of the submission by the Commonwealth Department of Health.

TABLE XIII

ESTIMATED ANNUAL VALUE OF SAVINGS EFFECTED IN THE YEAR FOR NEW LISTINGS AND CHANGES TO LISTING

Year ended 30 June	New listings	Changes to listing
	$'000	$'000
1969	1,289	121
1970	715	5,777
1971	572	1,196

Source: Table 13 of the submission by the Commonwealth Department of Health.

TABLE XIV

REQUESTS BY MANUFACTURERS FOR PRICE INCREASES FOR PHARMACEUTICAL BENEFITS

Year ended 30 June	Accepted	Rejected	Total
1965*	7	..	7
1966	34	7	41
1967	11	3	14
1968	5	5	10
1969	2	2	4
1970	28	2	30
1971	110	33	143

Source: Table 14 of the submission by the Commonwealth Department of Health.

* January 1965.

APPENDIX II

Generic Prescribing

Generic names may be described as abbreviated chemical names of the therapeutically active ingredients in the drugs. The brand name is the registered name used by a manufacturer to differentiate between his product and that of others in the same generic group. It is usually shorter than the generic name.

Generic names are used in the *British Pharmacopoeia* and in all articles in medical journals.

The Australian Medical Association recently rescinded a resolution passed in 1962 in favour of generic prescribing. The reason given was that the profession was ignoring its advice and was prescribing by brand names.

Some views put forward by doctors on this topic were:

(a) generic names are difficult to remember;

(b) doctors become used to prescribing by brand name where only one is available, rather than the generic name of the drug;

(c) if doctors do not know the generic names of the drugs they are prescribing there is a greater possibility that drugs of the same generic group will be duplicated or that drugs with unfavourable interaction will be prescribed;

(d) in some cases it is essential to prescribe a specific brand as real differences exist, for example, certain brands do not measure up to the efficacy of others; variations in particle size and different filler substances change the reaction times of absorption, desorption, blood levels, etc.;

(e) the doctor becomes used to prescribing a particular product, knows its responses as well as its shortcomings. He considers he has more control over his patient's treatment knowing the patient is getting the exact drug he prescribed;

(f) it is safer to assume non-equivalence until it is proven otherwise and brand name prescribing should be continued until present objections are met or overcome;

(g) the range available in generic drugs usually covers only those in high demand and in the common dosages. It aims mainly at the bulk and high volume market;

(h) the generic producer rarely undertakes any research.

The Department of Health witnesses appeared to generally support the notion that there were differences between substances in the same generic group. They said it was generally known that some doctors obtained better results with a particular brand than they had with another and that the Department was not in a position to dispute these preferences.

Academic doctors generally said that many of the supposed differences between products were only of a marginal nature in almost all products and even where differences existed the doctor was not necessarily skilled enough or in a position to test objectively.

Some research is being conducted into bio-availability, absorption, desorption, etc. As techniques for testing develop, more accurate estimates of comparative efficacy can be expected.

Although admitting that subtleties in formulations could have marginal effects, witnesses from the Pharmaceutical Benefits Advisory Committee said that where better

absorption rates are claimed by some manufacturers as heralding a major breakthrough, these claims are generally rather hollow when examined. Complaints are received by the Pharmaceutical Benefits Advisory Committee that certain brands are not doing as well as claimed and these are examined. If the formulation differs to a degree affecting its therapeutic action it is referred to the National Biological Standards Laboratory.

From an economic point of view, generic prescribing has the potential of reducing the cost of the Pharmaceutical Benefits Scheme. At the Committee's request the Department of Health made a study of the probable savings from generic prescribing, which indicated a potential saving of $2.7 million.

Areas of probable savings by a change to generic prescribing are:

(a) in the stocks which must be held by the wholesaler and the pharmacist;

(b) reduction in competitive advertising extolling the virtue of one brand against another brand of the same generic substance;

(c) more specialising by one company, leading to longer production runs and reduced cost.

A study of savings in the United States indicated a potential saving of around 2 per cent. This ties in with the savings indicated by the Department of Health.

The Australian Pharmaceutical Manufacturers Association held that generic prescribing would be false economy as the quality loss would well off-set any savings. It stated that competitive bidding in Canada by generic names, results in supplies being purchased from the least competent and least scrupulous suppliers.

Supplies of drugs for Australian hospitals are obtained by calling tenders for generic named products to ensure competition. Many of their actual purchases are of brand name substances because in some instances there is only one supplier (patented products) or a brand name is the lowest bidder. In most hospitals doctors are required to prescribe generically, or, where a brand name is prescribed, the hospital chemist has the right to supply the generic equivalent. Evidence was received from the Royal Brisbane Hospital that there were few, if any, complaints from the medical staff regarding this requirement. The tender system of purchase for bulk packs results in enormously reduced prices and therefore savings to the hospitals, compared with prices paid under the Pharmaceutical Benefits Scheme. These savings are very much higher for unpatented products. With patented products prices are generally around the wholesale level. Prices for unpatented products can be misleading because in many cases they result from marginal pricing (covering little more than the direct cost of manufacture). Any company attempting to produce at the same price for the retail market would run into serious losses.

If the arguments for brand name prescribing are all valid then it is difficult to see how doctors are able to live with the system of generic prescribing required in hospitals. Oversight by the hospitals' drug committees and the hospitals' chemists may tend to offset some objections by providing for selective acceptance of tenders according to experience.

There appear to be sound arguments in favour of generic prescribing from the viewpoints of cost reduction and consistency of nomenclature, whilst from product quality and equivalency aspects—brand name prescribing appears desirable.

APPENDIX III

Available Drug Information

The Monthly Index of Medical Specialities was stated to be written objectively. It is a resumé of manufacturers advice about the properties of their products. It is revised monthly to include new preparations; systematically lists therapeutic groups; gives descriptive monographs in a standard form; is fairly brief but shows basic information relevant to the prescriber's needs. It is financed from advertising revenue and is distributed free to all doctors and hospital chemists. A survey disclosed that it is used by doctors on an average of twice a day. The publication does not make value judgments as does *The Prescribers' Journal*. Plans were disclosed of possible extension in scope to provide the doctor with more reliable information than is currently available on pharmacology and therapeutics. It was criticised for its extreme briefness, the fact that the information on the products of advertising clients was in bold type; information on National Health Scheme products did not include prices; that it was difficult to sort through because it was full of advertising and that its only source of information was drug manufacturers.

The Australian Physician's Index is an annual publication and has no advertising. It includes monographs of each drug but includes no evaluation or judgment articles. Information is obtained only from manufacturers. It is sold to members of the profession and only 2,600 of the recent edition were sold. Some doctors may not purchase a new edition every year and group practices would tend to purchase only one copy. It seems to be a more complete version of *The Monthly Index of Medical Specialities*.

New Ethicals has a professionally qualified staff who attempt to retrieve, evaluate and compile information in an unbiased and objective manner. Publications include a monthly journal called *New Ethicals*; an annual drug compendium and several other large drug indices. In addition, the firm publishes international publications which include no advertising. The local publications are issued free of charge and are said to be read by 82 per cent of doctors in Australia. The monthly publication reports on new drugs; gives review articles on groups of drugs and treatment for specific diseases; and provides abstracts of worthwhile or significant contributions. Advertising is the sole source of income and this sometimes causes problems, especially where articles of a critical nature are published about advertised drugs.

It was stressed that *New Ethicals* was not an edited version of the material provided by manufacturers but an evaluation of published literature to date. Its system of retrieval of drug information was stated to be unique.

The Department of Health indicated its approval of *New Ethicals* as the type of publication the Department feels is most useful for doctors. A survey was carried out by the Committee (with the co-operation of the firm) of those witnesses who were critical of available drug information and most of these gave their approval of the group of publications circulated by New Ethicals Pty Limited. However, there are still objections that the firm is reliant on the goodwill of advertisers and that its publications contain too many advertisements.

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APPENDIX IV

Survey of Prescribing in General Practice by the Royal Australian College of General Practitioners

A. Scope of the Survey

Surveys were carried out by the Royal Australian College of General Practitioners for 1969-70 and 1970-71. In 1969-70 the panel of doctors taking part in the survey consisted of 55 full-time recorders (recording every contact, every day for a year) and 367 part-time recorders (recording every contact, every day for a week each quarter).

The quarterly response from participating doctors varied from 95 per cent to 84 per cent for full-time recorders and from 75 per cent to 70 per cent for part-time recorders, showing a tendency for responses to fall off in the final quarter.

In 1970-71 the survey was expanded and recording made easier; 932 volunteers were obtained by writing to all general practitioners and recording was carried out for one week only per year. Comparisons of 1969-70 and 1970-71 show very similar diagnostic levels and a similar prescribing pattern.

The College believes that the survey is representative. However, there is a possibility that by using volunteers that the survey results would be biased towards showing more conscientious prescribing habits, as the recorders were probably more conscientious that the average prescriber.

B. The Method

A triplicate copy of the usual pharmaceutical benefit, or repatriation prescription, was inserted into the doctor's pad. Details of the patient's age, sex, status, when and where seen, and the illness leading to the consultation were recorded in areas provided. Diseases were coded and data about seasonal and geographical factors were included in the coding of the card. Where no prescription was written for a patient an identical blank card was filled in giving the same patient data.

Reports were produced each quarter, in two volumes, showing illnesses and treatment (Volume I) and drugs and their uses (Volume II). Quarterly and cumulative figures appeared in each volume.

C. Main Results

(i) *Leading Causes of Morbidity:*

Illness class	Percentage total all disease contacts
Respiratory	21.83
Circulatory	11.66
Mental and psychoneurotic	10.21
Supplementary class (including Pap-Smear)	8.02
Musculo skeletal	6.19
C.N.S. (including Otitis Media)	6.09

It was found that the male-female ratio varied from illness to illness, thus females exceeded males in urinary diseases ratio 4:1; in mental and psychoneurotic disorder 2:1; and in circulatory disorders 1.7:1. Males exceeded females in accidents, etc., 1.6:1. There was nothing in the survey to indicate that men and women received different treatment, by virtue of their sex, but the varying number of women:men suffering different illnesses caused apparent differences in levels of treatment.

(ii) *Leading Morbidity and Drugs:*

Drug group	Percentage all drugs		Illness group	Percentage all illnesses
Antibiotics	17.9			
Antiasthmatics	2.7	25.3	Respiratory	21.83
Cough and cold preparations	4.7			
Cardiovascular	5.8			
Diuretics	3.6	9.8	Circulatory	11.66
*Sedatives	0.4			
Psychotropics	5.2	7.7	Mental and psycho-neurotic	10.21
*Sedatives	2.5			
*Sedatives and hypnotics (minus those transferred to Class VII and Class V)	9.8 2.9	6.9		

* Sedatives were divided between the major illness groups in which they are used.

The College claimed that the degree of parallelism between the three main drug and illness groups pointed to treatment that was rationally based.

(iii) In 33 per cent of all contacts with the doctor no drug was prescribed at all.

(iv) Special studies were carried out into antibiotic prescribing and the prescribing of psychotropic and sedative drugs. In both studies it was claimed that prescribing appeared to be rationally based.

APPENDIX V—TABLES ON PRICING

TABLE I

COMPARISON OF AUSTRALIAN, UNITED KINGDOM, UNITED STATES AND CANADIAN PRICES RECEIVED BY MANUFACTURERS OF SELECTED ITEMS

Item	Australia		United Kingdom		Australia Per cent U.K.	United States		Australia Per cent U.S.	Canada		Australia Per cent Canada
	Pack	Price	Pack	Price		Pack	Price		Pack	Price	
		$A		$A			$A			$A	
Tetracycline with Nystatin caps . 250 mg	150	7.49	100	5.84	85	100	11.53	43	100	15.22	33
	100*	4.99									
Tetracycline (buffered) caps . . 250 mg	150	7.49	100	3.85	130	100	11.23	44	100	10.95	46
	100*	4.99									
Tetracycline caps . . . . 250 mg	150	7.49	100	2.80	178	100	3.38	148	N/A	..	..
	100*	4.99									
Penicillin Phenoxymethyl tabs . 250 mg	150	6.18	100	1.84	224	100	6.73	61	50	4.30	48
	100*	4.12							100*	8.60	
Indomethacin caps . . . 25 mg	100	3.40	100	3.54	96	100	6.24	54	50	2.56	66
									100*	5.12	
Methyldopa tabs . . . . 250 mg	100	3.72	100	3.51	106	100	5.36	69	50	2.43	76
									100*	4.86	
Phenethicillin caps . . . 250 mg	150	6.18	100	3.94	105	100	10.40	40	N/A	..	..
	100*	4.12									
Frusemide tabs . . . . 40 mg	50	3.07	50	2.55	120	100	6.32	97	50	3.66	84
						50*	3.16				
Cholorathiazide tabs . . . 500 mg	100	3.40	100	2.65	128	100	4.51	75	100	2.97	114
Dexchlorpheniramine sust. rel. tabs 6 mg	50	1.82	N/A	..	..	100	4.51	81	100	3.15	115
						50*	2.26		50*	1.58	
Erythromycin caps . . . 250 mg	150	13.32	100	7.64	116	100	19.63	45	100	16.44	54
	100*	8.88									
Bendrofluazide tabs . . . 5 mg	50	1.50	100	1.40	214	100	4.82	62	100	3.17	95
	100*	3.00									
Amitriptyline tabs . . . 25 mg	100	1.99	100	1.74	114	100	6.43	31	100	5.07	39
Trifluoperazine tabs . . . 1 mg	100	1.88	100	1.42	132	100	5.03	37	100	3.88	48
Penicillin Phenoxymethyl paediatric suspension . . . . 125 mg per 5 ml	100 ml	0.83	100 ml	0.65	127	N/A	..	..	100 ml	1.35	61
Penicillin Phenoxymethyl suspension 250 mg per 5 ml	100 ml	1.48	100 ml	1.22	121	N/A	..	..	N/A	..	..
Erythromycin paediatric suspension 125 mg per 5 ml	100 ml	1.67	100 ml	1.00	156	N/A	..	..	100 ml	2.23	75

(a) All prices are shown in Australian dollars and were calculated from the following rates obtained from the Reserve Bank:

(i) £1 Sterling = $2.16 Australian
(ii) $1 Australian = $1.1088 U.S.
(iii) $1 Australian = $1.1331 Canadian

(b) All prices shown are price to wholesaler and have been calculated on the following basis:

(i) United Kingdom—price to chemist less 15 per cent
(ii) United States—price to chemist less 16.67 per cent
(iii) Canada—price to chemist less 15 per cent
(iv) Australia—price to chemist less 20 per cent, except for diuretics, ampicillin, erythromycin and tetracyclines where 15 per cent wholesale discount applies.

(c) Figures indicated with an asterisk (*) are theoretical because they have been calculated from the standard pack sizes which are available in the particular countries.

(d) Source of price information:

(i) Australian Prices—Department of Health.
(ii) United Kingdom Price—Chemist and Drugist Price List.
(iii) United States Prices—Department of Health, Education and Welfare, U.S.A.
(iv) Canadian Prices—Pharmaceutical Manufacturers Association of Canada.

Source: Commonwealth Department of Health submission.

TABLE II

PRICE HISTORY INDEX OF THE TOP SELLING PRESCRIPTION MEDICINES IN AUSTRALIA

Product name	Patent status	Price at introduction	APRIL											
			1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971
Abocillin V	Nil	100	100	73	73	73	59	59	49	43	43	37	37	34	34
Achromycin	Patent expired between April 63 and April 69	100	..	..	..	100	100	77	54	54	42	35	35	23	23
Aldomet	*Patented*	100	..	..	..	..	..	100	100	100	95	95	95	95	90
Alupent	Patented	100	..	..	..	..	..	100	95	90	90	81	81	88	88
Amytal	Nil	100	100	100	..	100	100	71	61	61	48	48	48	48	48
Aprinox	Patented	100	..	..	..	100	100	90	85	85	79	74	74	74	74
Betnovate	Patented	100	..	..	..	..	..	100	100	100	100	100	85	85	80
Butazolidin	Patent expired in 1964	100	100	92	92	80	80	70	64	57	57	55	52	49	49
Chlotride	Patented	100	100	100	100	85	71	59	55	55	51	51	51	51	51
Debendox	No Australian patent	100	100	100	100	100	100	100	100	100	100	100	100	70	70
Eromycin	Patented	100	..	..	..	..	..	69	64	64	54	54	49	38	36
Erythrocin	Patent expired	100	81	81	81	68	68	50	48	48	35	35	32	24	23
Furadantin	Patented	100	100	100	93	93	87	80	80	80	80	80	80	80	80
Hygroton	Patented	100	..	..	100	94	94	94	94	94	94	94	94	94	94
Ilosone	Patented	100	..	100	85	85	85	59	51	51	44	44	39	30	29
Indocid	Patented	100	..	..	..	..	..	..	..	100	100	94	94	94	90
Intal	Patented	100	..	..	..	..	..	..	..	..	..	..	100	96	96
Ismelin	Patented	100	..	..	100	100	100	111	111	119	119	119	130	130	137
Lasix	Patented	100	..	..	..	..	..	..	100	100	100	100	95	95	102
Librium	Patented	100	..	100	100	100	100	100	100	100	100	100	100	100	100
Lincocin	Patented	100	..	..	..	..	..	..	..	100	100	95	95	81	68
Melleril	Patented	100	..	..	100	100	100	90	90	90	90	90	90	90	90
Mylanta	*Nil*	*100*	..	..	..	..	..	..	*100*	*125*	*95*	*95*	*95*	*95*	*95*
Mysteclin V	Patent expired March 69	100	..	100	95	86	86	63	45	43	33	26	26	17	17
Negram	Patented	100	..	..	..	..	..	100	92	92	92	92	88	88	88
Neo-synephrine	Nil	100	..	100	100	100	107	107	107	118	120	120	120	120	129
Panadeine	Patented	100	..	..	..	..	..	..	100	100	100	100	100	100	106

PRICE HISTORY INDEX OF THE TOP SELLING PRESCRIPTION MEDICINES IN AUSTRALIA—*continued*

Product name	Patent status	Price at introduction	APRIL												
			1959	1960	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971
Panadol	Nil	100	100	100	100	100	93	93	60	60	60	60	60	60	60
Penbritin	Patented	100	..	..	..	..	100	74	74	59	51	51	48	27	27
Phisohex	Nil	100	100	100	83	83	83	83	83	83	93	93	93	93	93
Polarmine	Patented	100	..	100	100	100	100	100	90	90	81	81	81	81	81
Rastinon	Patented	100	100	100	100	100	95	88	88	88	88	88	88	88	95
Randixin	Nil	100	80	80	66	66	56	47	47	47	47	47	47	47	47
Stelazine	Patented	100	..	100	89	89	75	75	67	67	63	63	63	62	62
Tetrex	Patented	100	..	..	..	..	..	88	68	68	53	42	42	27	27
Tofranil	Nil	100	..	100	100	100	90	90	90	90	90	90	90	78	69
Tryptanol	Nil	100	..	..	100	100	63	63	63	63	63	63	63	63	52
Urolucosil	Patent expired in 1965	100	100	100	100	100	100	100	100	100	100	100	100	100	90
Valium	Patented	100	..	..	..	..	100	100	100	100	100	100	100	100	71
Vibramycin	Patented	100	..	..	..	..	..	..	..	..	..	88	88	78	78
Zyloprim	Patented	100	..	..	..	..	..	..	..	..	100	88	88	88	76

Source: Australian Pharmaceutical Manufacturers Association.

TABLE III

SUMMARY OF TABLE II, APPENDIX V

Percentage of original listed price	Range of	
	Patented products	Unpatented products
21– 30	3	..
31– 40	1	1
41– 50	..	2
51– 60	1	2
61– 70	2	2
71– 80	6	..
81– 90	6	..
91–100	4	2
101–110	2	..
111–120	..	..
121–130	..	1
131–140	1	..
Total	26*	10*

* Excludes the five products on which the patent had expired during the period.

Source: Australian Pharmaceutical Manufacturers Association

APPENDIX VI

Financial Questionnaire

The Committee's terms of reference required it to inquire into all factors contributing to the cost of the Scheme. The Committee, therefore, resolved to issue a financial questionnaire to the major manufacturers of pharmaceutical benefits products.

The Australian Pharmaceutical Manufacturers Association co-operated with the Committee in the issue and collection of questionnaires.

Questionnaires were sent to forty-nine firms, including some non-member firms of the Australian Pharmaceutical Manufacturers Association and Commonwealth Serum Laboratories. There were forty-three completed questionnaires, some of which covered amalgamations of two of the firms canvassed. Several small firms were excused from completing the questionnaire because they lack adequate records. Commonwealth Serum Laboratories returned its questionnaire but it was received after the data had been tabulated and could not be included.

There are some limitations in the figures:

(a) allocations of costs and funds employed had to be made by firms between pharmaceutical benefits products and other medicines as well as other non-medical products in some instances on an arbitrary basis;

(b) pharmaceutical benefits products include products which can also be purchased or prescribed other than through the Scheme;

(c) the questionnaire was answered on the basis of annual audited accounts so that figures are consolidated from differing accounting dates ending in the year shown. However, years ending 30 June predominated;

(d) assets, liabilities, costs and sales were accepted at book value;

(e) 1971 figures were not available for many firms at the time of completing the questionnaire so that the figures include estimates or pro-rata extensions of, for example, six months' figures. However, the total result agrees with the apparent trend.

The questionnaire data has been analysed by grouping firms with similar sales results for the last two years. Each group includes firms within $1 million of sales:

Group	$ million	Number of firms in group
1	Up to $1	13
2	Between $1 and $2	14
3	Between $2 and $3	6
4	Between $3 and $4	5
5	Over $4	5

To preserve anonymity a minimum of five firms is included in each group. Sales fluctuated for some firms over the last two years. It was necessary, therefore, to include two firms in group 4 which had sales in at least one year slightly over $4 million.

Sales

The following sales, although excluding Commonwealth Serum Laboratories, are estimated to cover around 95 per cent of the total sales of pharmaceutical benefits products.

Local sales of pharmaceutical benefits per annum from 1968 to 1971 and total sales increased at 10.8 per cent per annum. Exports rose at 44.9 per cent per annum and were responsible for the 0.5 per cent higher rate of growth of overall sales.

	Group	1968	1969	1970	1971	Increase	Annual rate of increase
		$'000	$'000	$'000	$'000	$'000	Per cent
Local sales	1	5,731	6,683	7,557	8,363	2,632	12.4
	2	13,213	15,325	17,967	19,267	6,054	12.3
	3	12,200	13,700	14,437	13,879	1,679	4.1
	4	11,845	12,825	15,926	18,334	6,489	14.7
	5	23,282	25,921	30,016	30,889	7,607	9.2
Total	..	66,271	74,454	85,903	90,732	24,461	10.3
Exports	..	179	1,315	1,584	1,832	1,653	44.9
Total sales	..	66,450	75,769	87,487	92,564	26,114	10.8

Group 4 had the highest rate of growth at 14.7 per cent per annum whilst group 3 had the lowest rate at 4.1 per cent per annum.

The average sales (including exports) in each group were:

Group	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
1	441	514	581	643	202	12.4
2	944	1,105	1,294	1,387	443	12.5
3	2,033	2,288	2,406	2,313	280	4.1
4	2,375	2,794	3,193	3,678	1,303	14.4
5	4,686	5,184	6,282	6,504	1,818	10.7
Total	1,545	1,762	2,035	2,153	608	10.8

The proportion of local sales supplied by each group was rather stable overall but group 3 lost around 3 per cent of the market and group 4 gained over 2 per cent.

Group	Number of firms in group	1968	1969	1970	1971
		Per cent	Per cent	Per cent	Per cent
1	13	8.7	9.0	8.8	9.2
2	14	20.0	20.5	20.9	21.2
3	6	18.4	18.4	16.7	15.3
4	5	17.9	17.3	18.6	20.2
5	5	35.0	34.8	35.0	34.1
Total	43	100.0	100.0	100.0	100.0

Thus in the lower groups twenty-seven firms shared around 30 per cent of the market whilst in the top group five firms shared around 35 per cent of the market.

Cost of Sales and Profits

The total cost of sales, including manufacturing, administration, selling and distribution expenses, rose between 1968 and 1971 at 12.3 per cent per annum compared with 10.8 per cent per annum on total sales. This varied for individual groups as follows:

Group	1968	1969	1970	1971	Increase	Annual rate of *increase*
	$'000	$'000	$'000	$'000	$'000	Per cent
1	5,035	5,985	6,660	7,563	2,528	13.4
2	11,762	13,526	16,265	17,702	5,940	13.4
3	9,606	10,841	11,445	11,817	2,211	6.7
4	9,381	10,430	12,550	14,372	4,991	14.2
5	18,612	21,685	26,500	27,822	9,210	13.0
Total	54,396	62,467	73,420	79,276	24,880	12.3

The effects of costs rising faster than sales was to reduce the rate of growth of profits. This was reflected in most groups, while two groups had falling profits:

Group	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
1	786	822	994	937	151	5.7
2	1,528	2,214	2,029	2,021	493	8.4
3	2,598	2,863	2,997	2,068	—530	..
4	2,670	2,613	3,591	4,208	1,538	15.7
5	4,818	5,381	4,909	4,699	—119	..
Total	12,400	13,893	14,520	13,933	1,533	3.7

Net profits include income other than from sales. This other income rose from $346,000 in 1968 to $645,000 in 1971.

Average net profits per firm in each group were:

Group	1968	1969	1970	1971
	$'000	$'000	$'000	$'000
1	60	63	76	72
2	109	158	145	144
3	433	477	500	345
4	534	523	718	842
5	964	1,076	982	940
Total	288	323	338	324

Average net profits rose in total until 1970 but fell in 1971. Groups 2 and 5 average profits rose in 1969 but then showed a downward trend whilst groups 1 and 3 rose until 1970 and fell in 1971. Only group 4 showed an almost continuous rise in average profits.

The shares of total profits earned by each group were:

Group	Number of firms in group	1968	1969	1970	1971
		Per cent	Per cent	Per cent	Per cent
1	13	6.3	5.9	6.8	6.7
2	14	12.3	15.9	14.0	14.5
3	6	21.0	20.6	20.6	14.8
4	5	21.5	18.8	24.7	30.2
5	5	38.9	38.8	33.9	33.8
Total	43	100.0	100.0	100.0	100.0

Thus in the lower groups twenty-seven firms earned around 20 per cent of the industry's total profits whilst the top ten firms earned around 60 per cent.

Profits in 1970 were utilised to pay taxes, pay dividends and to retain as reserves and unappropriated profits as follows:

Group	Net profits	Tax	Net after tax profits	Remittances to parent company		Interest remitted	Other dividends	Transfers to reserves	Funds retained
				Dividend	Interest	Subsidiaries or associates overseas			
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent
1	187	87	100	38	6	3	6	−1	48
2	172	72	100	38	4	3	2	7	46
3	188	88	100	86	1	..	..	..	13
4	157	57	100	34	2	..	..	..	64
5	158	58	100	57	3	..	..	..	40
Total	169	69	100	53	3	1	1	1	41

Figures for 1970 have been used because many firms were uncertain of their 1971 dividend estimates.

Most firms re-invested over 40 per cent of their net after tax profits. Firms in group 3, however, remitted 86 per cent of their profits as dividends to parent companies, whilst other firms remitted between 34 per cent and 57 per cent.

Manufacturing Costs

Bulk Manufacture

Manufacturers were asked for details of production and sale of bulk materials used to manufacture pharmaceutical benefits products. Bulk manufacture and sales increased over the period as follows:

	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
Materials used	9,541	11,249	13,191	12,854	3,313	9.4
Labour	2,049	2,283	2,371	2,286	237	3.3
Expenses	2,745	3,094	3,020	2,926	181	2.0
Total	14,335	16,626	18,582	18,066	3,731	7.3
Bulk materials for resale	894	1,046	885	1,053	159	5.5
Other administrative selling and distribution	471	435	468	523	52	3.6
Total cost of goods	15,700	18,107	19,935	19,642	3,942	7.1
These were sold as:						
Exports	199	218	124	132	−67	13.2
Local Sales	4,144	4,537	5,067	5,394	1,250	9.6
or used further	11,996	14,096	15,526	15,221	3,225	7.6
Net Profit	639	744	782	1,105	466	19.0

The value of bulk material used slightly exceeds the value of materials used in producing finished goods because of stock fluctuations and other usage.

The proportions of total bulk manufacturing costs showed the following:

	1968	1969	1970	1971
	Per cent	Per cent	Per cent	Per cent
Materials used	60.8	62.1	66.2	65.4
Labour	13.1	12.6	11.9	11.6
Expenses	17.5	17.1	15.1	14.9
Purchases for resale	4.7	6.1	5.6	6.3
Other*	3.9	2.1	1.2	1.8
	100.0	100.0	100.0	100.0

* Includes stock adjustment.

As production and sales of bulk pharmaceuticals exclude some producers, including Commonwealth Serum Laboratories, it is estimated that production represents between 85 per cent and 90 per cent of the Australian total of bulk manufacture which is used to produce pharmaceutical benefits products. Most of the balance of sales would be made up of penicillins.

Finished Goods Manufacture—Materials

Materials are obtained from a firm's own bulk manufacture or are purchased from parent, subsidiary or associated companies and from non-related sources. There was a

trend towards purchasing materials from subsidiaries or associated companies over the period.

	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
Raw materials used from bulk manufacture	9,441	11,284	12,823	13,039	3,598	10.3
Purchases—						
Parent company	1,839	2,299	2,864	2,681	842	11.6
Subsidiaries or associates	6,040	7,081	9,407	11,710	5,670	22.1
Other	4,263	5,050	5,938	5,849	1,586	10.0
Stock adjustments	−167	−469	−1,555	−2,419	−2,252	..
Total	21,416	25,245	29,477	30,860	9,444	11.8

The cost of materials rose at a slightly higher rate than sales. Group usage of materials was as follows:

Group	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
1	1,179	1,353	1,593	1,713	534	12.2
2	3,228	3,815	4,437	3,736	494	4.3
3	3,878	4,277	4,635	4,787	909	6.9
4	2,817	2,885	4,032	4,696	1,879	17.4
5	10,314	12,915	14,780	15,928	5,614	13.9
Total	21,416	25,245	29,477	30,860	9,444	11.8

Other Manufacturing Costs

Other costs of manufacture include labour, factory overhead and contract work under varying manufacturing arrangements. The cost of labour rose at a rate of 13.1 per cent per annum compared with sales of 10.8 per cent per annum and overhead at 9.2 per cent per annum. There was a trend towards higher payments to other manufacturers which rose 14.6 per cent per annum.

	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
Factory labour	2,112	2,529	2,965	3,171	1,059	13.1
Factory expense	2,211	2,459	2,988	2,940	729	9.2
Payments to other manufacturers	1,077	1,328	1,707	1,714	637	14.6
Total	5,400	6,316	7,660	7,825	2,425	11.9

These other manufacturing costs for groups were:

Group	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
1	376	402	654	747	371	22.7
2	1,697	1,979	2,318	2,008	311	5.2
3	943	991	1,152	1,283	340	10.4
4	1,042	1,251	1,503	1,714	672	16.3
5	1,342	1,693	2,033	2,073	731	13.7
Total	5,400	6,316	7,660	7,825	2,425	11.9

Total Factory Costs and Other Purchases

Firms also purchased finished goods for sale, from various sources. These must be included with factory costs and adjusted for stock changes to obtain the cost of goods sold:

	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
Factory cost*	26,554	32,071	36,708	37,964	11,410	11.4
Purchases—						
Parent companies	4,124	4,696	4,628	7,020	2,896	18.9
Subsidiaries or associates	974	1,001	1,318	1,284	310	9.0
Others	248	321	268	268	20	2.4
Stock adjustments	−1,121	−2,236	−215	−767	354	..
Total cost of goods sold	30,779	35,853	42,707	45,769	14,990	12.9

* Adjusted for stock changes

The total cost by each group was:

Group	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
1	2,871	3,381	3,732	4,115	1,244	11.7
2	6,671	7,758	9,470	10,205	3,534	13.8
3	4,724	5,416	5,684	5,967	1,243	7.6
4	5,273	5,692	6,914	7,848	2,575	13.4
5	11,240	13,606	16,907	17,634	6,634	14.3
Total	30,779	35,853	42,707	45,769	14,990	12.9

Costs of Research, Advertising, Administration, etc.

Costs of research and development increased at a slower rate than sales, whilst advertising increased faster than sales and other administrative selling and distribution expenses and royalty payments rose at around the same rate as sales:

	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
Research and development	1,579	1,283	1,651	1,973	394	8.1
Advertising and promotion	10,182	12,081	13,613	14,997	4,815	12.6
Royalties	3,056	3,470	3,947	4,219	1,163	10.6
Administrative, selling and distribution	8,800	9,774	11,527	12,318	3,518	11.1
Total	23,617	26,608	30,738	33,507	9,890	11.5

Most research expenditure is made overseas and is included in the cost of the Australian product through materials costs or in royalty payments. Local research and development represented less than 3 per cent of total costs.

Local research and development expenditure showed differing patterns for each group; group 2 reduced its research expenditure whilst group 4 had a rise of 25.5 per cent per annum and group 1 increased at 29.3 per cent per annum.

Group	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
1	66	85	114	159	93	29.3
2	453	183	262	291	−162	..
3	411	365	429	430	19	1.6
4	281	267	410	574	293	25.5
5	368	383	436	519	151	11.8
Total	1,579	1,283	1,651	1,973	394	8.1

The proportions spent on each type of research changed between 1968 and 1971:

Group	Fundamental new products		Local clinical new products		New formulations		Techniques		Grants		Other	
	1968	1971	1968	1971	1968	1971	1968	1971	1968	1971	1968	1971
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent
1	66.5	..	7.7	19.0	14.1	59.7	7.1	15.1	4.6	6.2	..	..
2	..	7.4	32.5	46.9	17.5	13.2	6.4	4.0	16.9	19.1	26.7	9.4
3	3.8	1.7	50.8	58.8	2.8	4.1	2.5	2.0	17.4	6.6	22.7	26.8
4	6.4	..	29.9	14.6	..	..	13.3	4.9	12.8	11.2	37.6	69.3
5	7.2	3.6	18.3	21.2	16.9	22.3	7.4	8.1	16.3	14.7	33.9	30.2
Total	22.8	2.3	26.7	31.7	10.1	18.3	6.9	6.6	12.7	11.3	20.8	29.7

Fundamental new product research fell from 22.8 per cent to 2.3 per cent mainly due to the cessation of a project by a firm in group 1. This was offset by increases in other research for new products from 26.7 per cent to 31.7 per cent and formulations from 10.1 per cent to 18.3 per cent. Research grants to institutions fell slightly from 12.7 per cent to 11.3 per cent. Other research rose from 20.8 per cent to 29.7 per cent.

This pattern would alter if Commonwealth Serum Laboratories were added, because it spent almost $1 million in each of the last two years, over a third of which was on fundamental research into new products.

Advertising and Promotion

Advertising and promotion represented around 19 per cent of total expenditure. There was a consistently high rate of growth for all groups, ranging from 13.3 per cent to 15.5 per cent per annum except for group 3 which had a growth rate of only 5.1 per cent per annum.

Group	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
1	1,157	1,367	1,545	1,779	622	14.2
2	2,089	2,797	3,079	3,410	1,321	15.5
3	2,097	2,269	2,406	2,447	350	5.1
4	2,342	2,748	3,155	3,514	1,172	13.3
5	2,497	2,900	3,428	3,847	1,350	14.2
Total	10,182	12,081	13,613	14,997	4,815	12.6

The proportions spent on various types of advertising and promotion were:

Group	Representatives		Literature		Journal advertising		Administration of sales promotion		Samples		Other	
	1968	1971	1968	1971	1968	1971	1968	1971	1968	1971	1968	1971
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent
1	46.7	48.3	6.2	6.6	6.5	6.2	7.7	10.1	10.8	8.1	22.1	20.2
2	48.7	43.5	10.9	13.2	8.7	12.3	4.1	6.7	10.3	10.4	17.3	13.9
3	40.6	44.3	20.8	18.3	8.0	10.0	7.6	8.6	8.7	6.7	14.3	12.1
4	46.5	45.0	9.3	9.1	6.0	7.2	17.9	19.4	8.4	6.9	11.9	12.4
5	30.2	27.6	11.0	7.7	14.7	14.9	6.1	8.2	12.2	8.2	25.7	33.4
Total	43.1	42.0	11.8	11.0	8.6	10.2	8.6	10.5	10.0	8.3	17.9	18.0

The cost of company representatives was over 40 per cent of total advertising and promotion costs for all groups except for group 5 where it fell from 30.2 per cent in 1968 to 27.6 per cent in 1971. Group 5 concentrated its expenditure on other unspecified activities. Expenditure of most groups was fairly evently distributed between literature, journal advertising, samples and administration of sales promotion, at around 10 per cent each, whilst other activities were under 20 per cent.

Royalties

Group	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
1	74	81	142	187	113	31.1
2	533	607	638	771	238	12.5
3	710	759	796	771	61	2.7
4	42	39	37	38	−4	..
5	1,697	1,984	2,334	2,452	755	11.9
Total	3,056	3,470	3,947	4,219	1,163	10.6

Royalties are amounts paid under licensing agreements for the right to produce and sell patented products. Most of these payments would be made to overseas firms.

Royalties showed an erratic growth pattern between the various groups. However, group 5 represented over half of total payments and stabilised total royalties with sales increases. These payments represented over 5 per cent of total costs.

Administrative, Selling and Distribution Expenses

Group	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
1	867	1,045	1,127	1,323	456	13.9
2	2,016	2,181	2,816	3,025	1,009	13.4
3	1,664	2,032	2,130	2,202	538	8.9
4	1,443	1,704	2,059	2,398	955	16.8
5	2,810	2,812	3,395	3,370	560	6.0
Total	8,800	9,774	11,527	12,318	3,518	11.1

In total these expenses rose slightly faster than sales. Group 5 had the slowest rate at 6 per cent per annum while group 4 was the highest at 16.8 per cent per annum. These payments represented around 16 per cent of total costs.

Combined Costs

Because manufacturing was divided into bulk and finished goods, a clear division for the total of each element of cost cannot be seen. Some bulk materials are sold as such whilst the rest is used in further production. This has been adjusted on an arbitrary basis to show the following figures:

	1968		1969		1970		1971	
	$'000	Per cent	$'000	Per cent	$'000	Per cent	$'000	Per cent
Materials	22,250	40.9	25,904	41.5	31,314	42.7	34,217	43.2
Labour	3,310	6.1	3,949	6.3	4,465	6.1	4,651	5.9
Expense	3,860	7.1	4,389	7.0	4,928	6.7	4,830	6.1
Payments to other manufacturers	1,070	2.0	1,328	2.1	1,707	2.3	1,714	2.2
Research and development	1,586	2.9	1,311	2.1	1,651	2.3	2,000	2.5
Advertising and promotion	10,210	18.8	12,104	19.4	13,626	18.6	15,000	18.9
Royalties	3,160	5.8	3,538	5.6	3,998	5.5	4,280	5.4
Administration, selling and distribution	8,950	16.5	9,944	15.9	11,731	16.0	12,584	15.9
Total cost of sales	54,396	100.0	62,467	100.0	73,420	100.0	79,276	100.0

It will be seen that:

(a) materials represent over 40 per cent of total cost;
(b) labour represents around 6 per cent of total cost;
(c) factory expense and payments to other manufacturers represent around 9 per cent of total cost;
(d) research represents around 3 per cent of total cost;
(e) advertising represents around 19 per cent of total cost;
(f) royalties represent over 5 per cent of total cost;
(g) administrative, selling and distribution expenses represent around 16 per cent of total cost.

However, materials are bought at various stages of manufacture and also include some of the other elements of cost. Also, there may be some double counting as sales by one firm may be reflected in purchases of goods for further manufacture, for packaging or for resale. In addition, the figures for Commonwealth Serum Laboratories are omitted. However, because much of their production is for other firms and not for direct retail sale, much of the duplication is probably offset by omitting the sales of some firms and of Commonwealth Serum Laboratories.

Funds Employed

During the period 1968 to 1971, funds employed in producing pharmaceutical benefits products increased at a faster rate than sales:

	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
Current assets—						
Stocks	19,075	20,469	24,737	28,362	9,287	13.4
Debtors	12,946	15,239	19,450	20,621	7,675	15.0
Other	7,508	7,895	8,116	8,907	1,399	5.8
Total	39,529	43,603	52,303	57,890	18,361	12.7
Less current liabilities—						
Creditors	9,557	11,881	15,886	17,772	8,215	19.9
Other	10,123	10,339	12,111	12,639	2,516	7.4
Total	19,680	22,220	27,997	30,411	10,731	14.3
Working capital	19,849	21,383	24,306	27,479	7,630	10.9
Fixed assets—						
Land and Buildings	16,516	18,488	20,892	21,933	5,417	9.3
Plant and Machinery	6,607	6,875	9,382	9,545	2,938	12.1
Other	3,869	4,071	5,561	8,256	4,387	26.9
Total	26,992	29,434	35,835	39,734	12,742	12.9
Total Funds	46,841	50,817	60,141	67,213	20,372	12.1

It is estimated that these represent between 90 per cent and 95 per cent of total funds employed in producing pharmaceutical benefits products.

In calculating funds employed, intangible assets such as goodwill have been excluded. Inter-company loans between related firms and bank loans have been treated as a source of funds and are excluded from current liabilities. Assets are generally at book value less provisions for depreciation and are based upon audited annual accounts. 1971 funds were estimated by some firms where figures were not yet available when the questionnaire was being completed. In the absence of estimates, 1970 funds have been used to complete the tables.

Working capital rose at 10.9 per cent per annum whilst fixed assets increased at 12.9 per cent per annum.

These funds were financed from:

	1968	1969	1970	1971	Increase	Annual rate of increase
	$'000	$'000	$'000	$'000	$'000	Per cent
New Capital	18,321	18,954	21,440	22,287	3,966	6.5
Reserves	3,792	4,484	4,869	5,027	1,235	9.1
Other retained profits	12,219	13,455	13,297	13,818	1,599	4.0
Bank loans	1,987	2,072	3,421	3,266	1,279	15.9
Other loans	10,522	11,852	17,114	22,815	12,293	26.3
Total	46,841	50,817	60,141	67,213	20,372	12.1

From 1968 to 1971 two-thirds of the increase in funds was financed from loans whilst 19 per cent came from subscribed capital and 14 per cent from retained profits. Much of the loan money is dividends retained in the business. These loans increased at 26.3 per cent per annum over the period compared with new capital of 6.5 per cent per annum.

In 1971 funds were financed 33 per cent from new capital, 7 per cent from reserves, 21 per cent from other retained profits, 5 per cent from bank loans and 34 per cent from other loans.

The spread of assets between groups was:

Group	1968			1971			Increase	Annual rate of increase
	Working capital	Fixed assets	Total	Working capital	Fixed assets	Total		
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	Per cent
1	1,387	1,940	3,327	3,416	3,094	6,510	3,183	21.9
2	3,348	2,769	6,117	5,416	4,668	10,084	3,967	16.3
3	4,334	7,791	12,125	4,425	8,204	12,629	504	1.4
4	3,900	5,734	9,634	4,629	7,786	12,415	2,781	8.4
5	6,880	8,758	15,638	9,593	15,982	25,575	9,937	16.6
Total	19,849	26,992	46,841	27,479	39,734	67,213	20,372	12.1

Relationships between Profits, Sales, Funds

The rates of gross profit to sales showed a downward trend over the four years although some groups went against this trend:

Group	1968	1969	1970	1971
	Per cent	Per cent	Per cent	Per cent
1	49.9	49.0	50.6	50.8
2	49.5	49.2	47.7	47.4
3	61.3	60.4	60.6	57.0
4	55.6	51.5	56.8	57.5
5	52.0	51.9	46.2	45.8
Total	53.7	52.6	51.2	50.6

Group 5 had the lowest gross margin of 45.8 per cent in 1971 whilst groups 3 and 4 had the highest with 57 per cent.

Net profit to sales also fell over the period for almost all groups:

Group	1968	1969	1970	1971	Australian* Average	
					1968	1970
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent
1	13.7	12.3	13.2	11.2	..	..
2	11.6	14.3	11.2	10.4	..	..
3	21.3	20.9	20.8	14.9	..	..
4	22.5	18.7	22.5	22.9	..	..
5	20.6	20.8	15.6	14.4	..	..
Total	18.7	18.3	16.6	15.1	7.8	8.4

* Page 53, Tariff Board Report 1970–71.

Group 4 had the highest return on sales in most years with around 23 per cent whilst group 2 had the lowest return and fell from 11.6 per cent to 10.4 per cent over the period. Only group 4 showed a slight gain over the four years despite a fall in 1969.

The industry had a much higher return on sales than the Australian average but this was reduced over the period as the trends went in opposite directions.

The return on funds employed also showed a downward trend:

Group	1968	1969	1970	1971	Australian* Average	
					1968	1970
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent
1	23.6	20.4	18.0	14.4	..	..
2	25.0	28.1	24.1	20.0	..	..
3	21.4	24.0	24.0	16.4	..	..
4	27.7	24.7	30.5	34.0	..	..
5	30.8	32.8	22.3	18.4	..	..
Total	26.5	27.3	24.1	20.8	11.4	13.0

* Page 53, Tariff Board Report, 1970–71.

This falling trend was quite marked in all groups except group 4. Group 5 fell from 30.8 per cent to 18.4 per cent due to a rise of 64 per cent in funds employed whilst profits actually fell over the four years to 1971.

Employment

Employment in the production of medicines rose by 799 to 7,961 over the two year period to 1971. Of this number, 6,225 were employed in producing pharmaceutical benefits products in 1971. In addition, Commonwealth Serum Laboratories employed over 900 staff during the period.

Group	Employees	Average number per firm
1	1,265	97
2	1,413	101
3	790	132
4	1,391	278
5	1,366	273
Total	6,225	145

This was divided between categories of employment:

Group	Direct production	Supervision	Quality control	Research	Selling	Administration	Other	Total
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent
1	29.1	4.5	5.6	3.3	28.5	18.8	10.2	100.0
2	28.6	3.3	4.2	1.8	31.1	18.8	12.2	100.0
3	27.8	3.8	5.3	1.8	31.3	20.8	9.2	100.0
4	17.8	6.5	2.8	1.9	24.8	15.7	30.6	100.0
5	32.6	5.5	5.9	2.9	24.5	14.6	14.1	100.0
Total	27.1	4.8	4.7	2.4	27.7	17.4	15.9	100.0

The variations between groups is probably due to the varying extent to which firms in each group bulk manufacture, tabletise or formulate and package their products. The first three groups had very similar patterns of employment whilst group 4 had an unusually high proportion employed in unspecified activities and a low proportion for direct production.

The increase in employment on the production of pharmaceutical benefits was 591 over the two years. This increase was distributed:

	Increase number	Per cent
Direct production	184	12.3
Supervision	24	8.8
Quality control	65	28.6
Research	−13	−8.1
Selling	116	7.2
Administration	109	11.2
Other	106	12.0
Total	591	10.5

While most of the increase in labour was for direct production, the largest proportionate rise of 28.6 per cent was in quality control.

Comparison between Pharmaceutical Benefits Products and Other Medicines

Sales of pharmaceutical benefits products represented around 60 per cent of total medicine sales of the firms answering the questionnaire. This, of course, excludes many large producers of aspirin and other non-ethicals. The individual firms varied considerably in the proportions of their sales and this is reflected in the following group proportions of sales of pharmaceutical benefits products to total medicine sales:

Group	1968	1969	1970	1971
	Per cent	Per cent	Per cent	Per cent
1	27.7	30.8	31.7	31.9
2	51.8	53.0	51.4	51.2
3	61.0	63.4	61.4	60.3
4	57.2	61.5	63.1	63.8
5	87.0	87.9	88.7	87.6
Total	58.4	60.8	61.1	60.5

Costs of producing pharmaceutical benefits products were also around 60 per cent of the total cost of producing medicines, however, in every year costs were slightly below the sales proportions:

Group	1968	1969	1970	1971
	Per cent	Per cent	Per cent	Per cent
1	26.4	29.8	30.4	31.6
2	52.0	53.4	51.4	51.0
3	61.6	63.9	62.7	62.7
4	56.0	58.1	60.4	61.7
5	85.8	87.0	87.9	87.8
Total	56.8	59.3	60.1	59.8

This resulted in net profits (before tax) on pharmaceutical benefits products being above 60 per cent of total profits on all medicines in each year:

Group	1968	1969	1970	1971
	Per cent	Per cent	Per cent	Per cent
1	38.7	41.7	45.5	35.4
2	50.7	53.8	52.0	54.5
3	56.7	60.2	54.9	47.5
4	63.8	66.0	76.0	73.0
5	90.8	91.2	89.8	83.0
Total	64.9	67.1	66.8	63.0

Alternatively, funds employed were much lower for pharmaceutical benefits products at around 45 per cent of funds employed in producing all medicines:

Group	1968	1969	1970	1971
	Per cent	Per cent	Per cent	Per cent
1	23.7	23.9	27.3	30.9
2	34.9	39.1	33.0	36.0
3	52.9	51.9	51.4	49.0
4	53.9	58.3	59.2	59.1
5	57.6	58.1	46.6	43.0
Total	47.1	47.7	44.0	43.3

The return on funds for pharmaceutical benefits products was, therefore, much higher than for other medicines. This is shown by the following comparison which, however, also covers production other than medicines (including veterinary etc. production for some firms):

	Other production including other medicines	Pharmaceutical benefits production	Total
	Per cent	Per cent	Per cent
1968	18.9	26.5	22.4
1969	16.0	27.3	21.4
1970	14.1	24.1	18.5
1971	13.7	20.8	16.7

APPENDIX VII

HEALTH COMMITTEES

A. The Pharmaceutical Benefits Advisory Committee (P.B.A.C.)

The Pharmaceutical Benefits Advisory Committee is established under Section 101 of the Pharmaceutical Benefits Act to advise the Minister for Health on the listing of benefits.

The nine members of the Committee include:

(a) six medical practitioners appointed by the Minister for Health from ten medical practitioners nominated by the Federal Council of the Australian Medical Association;

(b) a pharmaceutical chemist appointed by the Minister from among three pharmaceutical chemists nominated by the Pharmacy Guild of Australia;

(c) a pharmacologist appointed by the Minister for Health;

(d) a pharmacist officer of the Commonwealth Department of Health appointed by the Director-General of Health.

Names of the members of the Committee were not published until June 1970.

The P.B.A.C. meets in March, July and November of each year and the Commonwealth Department of Health provides a secretariat service for it.

The P.B.A.C. considers additions to, or deletions from the list, in maximum quantities, number of repeats, and amendment, removal or introduction of restrictions.

No drug is considered for listing as a pharmaceutical benefit until it has been cleared by the Australian Drug Evaluation Committee and the National Biological Standards Laboratories.

The cost of a drug is only considered when comparing drugs of approximately equal therapeutic value.

The main guidelines used by the P.B.A.C. when considering drugs are;

(a) a drug must be therapeutically active and of minimal toxicity in therapeutic doses;

(b) new drugs are listed if they are:

  (i) used for diseases or abnormal conditions not already covered, or inadequately covered by the existing list;

  (ii) of more than equal efficacy, or less toxic than a drug already listed;

  (iii) as effective and safe as a drug already listed;

(c) drugs in fixed formulation are rarely acceptable;

(d) where it is advisable, appropriate restrictions on the use of the drug will be recommended;

(e) where it is thought necessary a new drug may be placed on the 'Hospital Only' list until an assessment is made as to its therapeutic value and safety;

(f) where possible the maximum quantity of a drug allowed is that which would provide treatment for the normal course of an acute condition;

(g) in chronic conditions the maximum quantity should provide for one month's treatment and two repeats;

(h) the Committee seeks expert opinion from professional bodies where thought advisable;

(i) no drug is placed on the list simply to relieve individual hardship;

(j) the listing of certain drugs such as anaesthetics, etc., is regarded as a Commonwealth policy decision;

(k) drugs will be removed from the list when a more effective or equally effective but less toxic drug is found; when the toxicity or the suspected toxicity outweighs the therapeutic value; and when it has fallen into disuse.

The P.B.A.C. has no facilities for evaluating drugs and sometimes requests that tests be made by research institutions such as the McCallum Institute. The P.B.A.C. commented on the shortage of pharmacological facilities.

It often takes a long time to have a drug put on the list. The procedure is that the Department of Health secretariat provides members with a detailed description of each drug, all drug company literature and information on adverse effects and advantages. Each drug is then considered at the next meeting and in some cases is referred to a Society or College for an opinion. This takes 3 to 4 months or longer.

There is a communications gap between the P.B.A.C. and the medical profession because reasons for its decisions are rarely published. As medicine is always subject to debate, every decision published by the P.B.A.C. would be stoutly contested by people who had opposite views. Reasons are sometimes given to the various societies if they have applied to have a drug listed and it has been rejected. However, it would be difficult to give reasons for every drug listed; up to 300 applications may be considered at each session.

Although doctors recognise that there are problems involved in disclosure, they said that secrecy causes frustration and stops discussion or appraisal of these decisions. If reasons were disclosed, doctors would be more co-operative and, as well, there would be an educational effect.

Several medical organisations, including the Society of Hospital Pharmaceutical Chemists of Australia and the Australian and New Zealand College of Psychiatrists,

suggested that they should have representation on the P.B.A.C. These representatives would have ready access to opinions within their colleges and could convey them to the P.B.A.C. This would raise the membership of the P.B.A.C. to between twenty and thirty. The P.B.A.C. claims that when in doubt it does ask for opinions from medical organisations

The Royal Australasian College of Physicians considered that there is a need for more assistance for the P.B.A.C. because the large number of drugs in use is subject to rapid change. It was suggested that specialist sub-committees along the lines of those used by the Food and Drug Administration (U.S.A.) be established to look in depth at drugs and new drug applications within their own field of expertise. They would then consist of specialists involved in clinical practice, together with clinical pharmacologists to advise on the interpretation of scientific data including animal and toxicity studies and the adequacy of experimental design. These sub-committees could then advise the P.B.A.C.

B. Australian Drug Evaluation Committee (A.D.E.C.)

The Australian Drug Evaluation Committee was established in 1963 following the thalidomide disaster of the early 1960s. It was established under Regulation 19 of the Therapeutic Goods Regulations.

Between six and eight members are appointed by the Minister for Health and are re-appointed every three years. Membership must consist of not less than four eminent medical practitioners including at least three specialists in clinical medicine. There must be at least two pharmacologists or persons with degrees specialising in pharmaceutical science.

The functions of the A.D.E.C. are:

(a) to make medical and scientific evaluations of such goods for therapeutic use referred by the Minister, or considered necessary by the Committee;

(b) to advise the Minister on the importation and distribution of goods for therapeutic use that have been the subject of evaluations made by the Committee.

In general, the A.D.E.C. advises on matters of quality, safety and efficacy of imported drugs.

There are four ways the A.D.E.C. can investigate drugs:

(a) new, imported drugs—for a period of three years a new drug remains under 'new drug status' when any amendments to the prescribing information and packaging inserts must be submitted to the Department for approval;

(b) if the Director-General is concerned about the value of an old drug he designates the drug 'a new drug', and he can have the A.D.E.C. look at it;

(c) a drug can be referred by a State Government—drugs produced locally are subject to State controls and, while there is not a uniform system, the State Governments co-operate in this field;

(d) there is a feed-back of toxicity information from physicians under the drug surveillance scheme and druggists associated with toxicity. When this occurs the A.D.E.C. will examine it, irrespective of the source.

The A.D.E.C. meets roughly every 8 to 10 weeks and considers new drugs or new forms of drugs, as well as all adverse reactions reported in the intervening period, including a report on adverse reactions presented by the Adverse Drug Reactions Advisory Sub-committee. Once the A.D.E.C. has decided a drug is safe the Committee informs the Commonwealth Government that in its opinion it can become available for therapeutic purposes.

Companies are required to provide the Department of Health with information concerning adverse effects associated with the drug, quarterly during the first year of marketing, six monthly during the second year and yearly thereafter.

The basis of judgment is sometimes imperfect as reliance is placed upon data submitted by the marketing company. However, if there have been properly conducted trials, the degree of objectivity of information can be established. Also, information from any source has to conform to a prescribed standard.

Witnesses commented upon the need for properly conducted and controlled clinical trials which the A.D.E.C. has not the resources to carry out except when considering drugs for marketing. There was also criticism that the tests they set up are limited to techniques which were the only ones available ten years ago, and that members of the A.D.E.C. are not always right up with current techniques, including electron-microscopy which has made a vast difference in biological and pharmacological work.

The A.D.E.C. is principally concerned with imported new drugs and prior to any of these being approved for marketing, prescribing information and package inserts are subject to the approval of the Committee.

For the period of three years that a drug remains under 'new drug status' any amendments to the prescribing information and package inserts must be submitted to the Department of Health for approval.

C. Reporting on Adverse Drug Reactions

Following the thalidomide tragedy, a Registry of Adverse Reactions to Drugs was established in 1964. Medical practitioners and dentists were requested to report on a voluntary basis and, recently, chemists have been invited to participate and report reactions to non-prescription drugs. Reports are also received from other sources, including pharmaceutical companies.

To enable more detailed evaluation of adverse reaction reports and increase feed-back activities, a sub-committee of the A.D.E.C. known as the Adverse Drug Reactions Advisory Sub-committee was formed in May 1970.

Initially, emphasis was placed on the development of an early warning system and it was requested that reports be made on all reactions to new drugs and any severe or previously unreported reactions to established drugs. This has changed to requests for reporting of all reactions, however trivial, as even the extent of the most common drug reactions are not known in Australia. Available information indicates that less than 10 per cent of reactions are actually reported.

Cumulative lists of reported drug reactions have been circulated in booklet form and there are plans to circulate briefing notes on particularly interesting drug reactions.

Advice is sought from medical colleges, societies and experts and information is exchanged with a number of overseas countries. Australia is established in the *World Health Organisation international drug monitoring programme.*

D. Therapeutic Goods Advisory Committee

This Committee, which is being established, will provide a chance for interested and professional and commercial people to place their views on drug standards before the Minister for Health. More emphasis will be placed on economic rather than scientific factors.

E. Therapeutic Goods Standards Committee

This Committee, also being established, will inquire into, and advise the Minister for Health, on standards of any goods for therapeutic use and labelling and packaging requirements.

F. National Standing Control on Drugs of Dependence

This Committee, under the Chairmanship of the Comptroller-General, Customs and Excise, is developing a national drug education programme and providing films,

television shorts, literature and training courses. Legislation has been reviewed and measures introduced to prevent drug trafficking.

G. National Health and Medical Research Council (N.H.M.R.C.)

The National Health and Medical Research Council inquires into and makes recommendations concerning:

(a) public health legislation, administration, etc., relating to health, medical and dental care and research;

(b) applications for grants under the Medical Research Endowment Fund;

(c) expenditure on medical research and medical research projects;

(d) the merits of reputed cures or treatment methods advanced for recognition.

Membership of the N.H.M.R.C. includes:

Director-General of Health;
Two officers of the Commonwealth Department of Health appointed by the Minister;
A representative of Commonwealth Serum Laboratories appointed by the Minister;
The Directors-General (or equivalent) of the six States and the Territory of Papua and New Guinea;
Nine members appointed by the Minister for Health on the nomination of the Australian universities and medical schools (appointed for three years);
An eminent man and an eminant woman, neither of whom is a medical or dental practitioner, appointed by the Minister for Health.

Grants from the N.H.M.R.C. have recently represented 20 per cent of specific funds spent on medical research in Australia. These grants go mainly to institutions, providing the basic equipment and facilities for research. These grants, therefore, assist much more than 20 per cent of the total research work.

Project grants are made to institutions to support scientific investigations proposed by one of the institution's staff.

Travelling fellowships covering stipends, travel and family allowance and fares, enable graduates to study overseas for up to two years in the field of medical research and public health.

Scholarships are awarded to university departments and individuals engaged in research and training in medical and dental specialties, to enable graduates to obtain additional training to gain research skills.

General scientific grants are given for other important scientific activities such as publishing scientific works.

Grants are aimed at supplementing other sources of financial support for medical research and are not intended to control or direct but to assist the investigations.

Committees and sub-committees of the Council are concerned with the use of drugs in medical practice. Uniform Commonwealth/State policies and practices are a major responsibility of the Council as well as to give specific advice to the A.D.E.C. and the P.B.A.C.

These committees and sub-committees include:

Antibiotics Committee
Child Health Committee
Epidemiology Committee
Mental Health Committee
Tropical Medicine and Health Committee
Veterinary Public Health Committee
Pesticides and Agricultural Chemicals Sub-committee
Poisons Schedule Sub-committee.

APPENDIX VIII

LIST OF WITNESSES, REFERENCES AND EXHIBITS

List of Witnesses

ALDERSON, DR B. S., Deputy Chairman of Council, Royal Australian College of General Practitioners, Victoria.

ARNOLD, DR P. C., President, General Practitioners' Society in Australia, New South Wales.

AVERY, MR G. S., Editor-in-Chief, New Ethicals Pty Limited, and Australian Drug Information Services Pty Ltd, New South Wales.

BAILEY, DR H. R., Consultant Psychiatrist, New South Wales.

BLACKET, PROFESSOR R. B., Professor of Medicine, University of New South Wales.

BLANDY, DR R. J., Economic Research Associate, South Australia.

BLOOMFIELD, MR A. J., Federal President, Australian Dental Association, New South Wales.

BROWN, MR E. R., President, Pharmaceutical Society of New South Wales.

BURNET, SIR MACFARLANE F., Professor of Experimental Medicine, University of Melbourne.

BURNSTOCK, PROFESSOR G., Professor and Chairman of Department of Zoology and Associate Dean of Biological Sciences, University of Melbourne.

CLAMPETT, MR R. B., General Secretary, Pharmaceutical Association of Australia, South Australia.

CLARKE, DR M. V., Member, Pharmaceutical Benefits Advisory Committee.

DAL BON, MRS K., Executive Officer, Commonwealth Department of Health, Australian Capital Territory.

DAVIES, MR R. J., President, Australian Pharmaceutical Manufacturers Association, New South Wales.

DE LA LAND, PROFESSOR I. S., Member, Pharmaceutical Benefits Advisory Committee.

DOYLE, PROFESSOR A. E., Professor of Medicine, University of Melbourne.

DUNLOP, MR D. G., First Assistant Director-General, Establishments and Finance Division, Commonwealth Department of Health, Australian Capital Territory.

EDMONSON, DR K. W., First Assistant Director-General, National Health Division, Commonwealth Department of Health, Australian Capital Territory.

EDWARDS, DR R. G., Medical Practitioner, South Australia.

FEEHAN, MR H. V., Secretary Pharmaceutical Society of Victoria.

FREW, MR R. L., Chairman, National Health Committee of Pharmacy Guild of Australia.

GEFFEN, DR L. B., Teacher, Department of Physiology, Monash University, Victoria.

GIBBS, DR W. T., Executive Director, Australian Pharmaceutical Manufacturers Association, New South Wales.

HALL, DR G. V., Chairman, Therapeutics Advisory Committee, Royal Australasian College of Physicans, New South Wales.

HARRIS, MR K., Managing Director, Drug Houses of Australia Limited, Victoria.

HASSALL, DR J. E., Secretary, Therapeutics Advisory Committee, Royal Australasian College of Physicians, New South Wales.

HECKER, DR R., Consulting Physician and Director, Gastro-Enterology Unit, Royal Adelaide Hospital.

HETZEL, PROFESSOR B. S., Professor of Social and Preventive Medicine, Monash University, Melbourne

HOBBS, MR A. K., Managing Director, Sigma Co. Limited, Victoria.

HODGE, DR R. L., Reader in Human Physiology and Pharmacology, University of Adelaide.

HUGHES, MR D. B., Economic Research Associate, South Australia.

HUGHES, MR W. W., Director, New Ethicals Pty Limited, New South Wales.

HUTCHINSON, DR J. M., Member, Royal Australian College of General Practitioners, New South Wales.

JUDSON, MR F. C., Publisher, *The Australian Physician's Index*, New South Wales.

KEITH, MR N. F., Member, Federal Council of the Pharmacy Guild of Australia, Victoria.

KELLEHER, MR J. G., Assistant Director-General, Pharmaceuticals, Commonwealth Department of Health, Australian Capital Territory.

KELLY, MR N. R., General Manager, Wholesale Drug Co. Pty Ltd, New South Wales.

KLEINERT, MR K., Management Accountant, Sigma Co. Limited, Victoria.

LANE, DR W. R., Director, Commonwealth Serum Laboratories, Victoria.

LIPTON, DR G. L., Honorary Federal Secretary, Australian and New Zealand College of Psychiatrists, Victoria.

LLOYD, MR A. I. K., Vice-President, Pharmaceutical Association of Australia, South Australia.

LOVELL, PROFESSOR R., Department of Medical Research, Royal Melbourne Hospital; Member, Association of University of Clinical Professors of Australia.

MALLEN, SIR LEONARD, Chairman, Pharmaceutical Benefits Advisory Committee, Adelaide.

MANNING, DR W. K., Medical Practitioner, Waterfall, New South Wales.

MASHFORD, DR M. L., Reader in Applied Pharmacology, University of Melbourne.

MCKENZIE, MR, W. A., Secretary, Friendly Societies Dispensaries Association of Australia, Western Australia.

MEARES, DR A., Psychiatrist, Victoria.

MERRINGTON, DR H. N., President, Royal Australian College of General Practitioners, New South Wales.

MILLER, MR B. R., Federal Secretary, Society of Hospital Pharmaceutical Chemists of Australia, Victoria.

MILLNER, MR J. S., Chairman and Managing Director, Washington H. Soul Pattinson & Co. Ltd, New South Wales.

MORROW, SIR WILLIAM, Chairman, Australian Drug Evaluation Committee.

NEWTON, MR J. M., Federal Secretary, Australian Dental Association, New South Wales.

NICHOLS, DR J. J., Psychiatrist, New South Wales.

NORTON, DR H. G., Representative, Australian Medical Association, New South Wales.

O'CONNOR, MR B. T., Chief Pharmacist, Calvary Hospital, South Australia.

OLIVER, DR R. G., Research Fellow, Department of Social and Preventive Medicine, Monash Medical School, Victoria.

PARGITER, DR R. A., Federal Councillor, Australian and New Zealand College of Psychiatrists, Victoria.

PHELPS, MR K. G., President, Friendly Societies Dispensaries Association of Australia, Western Australia.

PIPER, PROFESSOR D. W., Medical Practitioner, New South Wales.

RADFORD, DR J. G., President-Designate, Royal Australian College of General Practitioners, New South Wales.

RAND, PROFESSOR M. J., Professor of Pharmacology, University of Melbourne.

REED, DR C. S. H., Member of the Branch Council of New South Wales, Australian Medical Association, New South Wales.

REFSHAUGE, SIR WILLIAM D., Director-General of Health, Commonwealth Department of Health, Australian Capital Territory.

ROBERTSON, DR T. I., Member, Australian Drug Evaluation Committee.

SCAMMEL, MR W. F., Managing Director, F. H. Faulding & Co. Ltd, South Australia.

SCOTT, SIR ERIC, President, Pharmacy Guild of Australia, Victoria.

SEARLE, MR R. H., Assistant Director-General, Automatic Data Processing Branch, Commonwealth Department of Health, Australian Capital Territory.

SHAW, MR J. W., Director, Pharmaceutical Services Branch, Commonwealth Department of Health, Australian Capital Territory.

SMITH, PROFESSOR D. D., Associate Professor of Bacteriology, Prince of Wales Hospital, New South Wales.

SPAFFORD, MR R. N., President, Pharmaceutical Association of Australia, South Australia.

STEVENS, DR J. A., Member, Royal Australian College of General Practitioners, Tasmania.

STOCKS, MR C. N. R., Executive Chairman, Drug Houses of Australia Limited, Victoria.

THOMAS, DR J., Associate Professor of Pharmaceutical Chemistry, University of Sydney.

THOMSON, DR E. F., Secretary-General, Australian Medical Association, New South Wales.

TIMBS, MR S. J., Managing Director, Monthly Index of Medical Specialities Pty Ltd, New South Wales.

WADE, DR D. N., Member, Therapeutics Advisory Committee, Royal Australasian College of Physicians, New South Wales.

WALSHE, DR A. M., Secretary, Australian Drug Evaluation Committee and Assistant Director-General, Therapeutic Substances Branch, Commonwealth Department of Health, Australian Capital Territory.

WATSON, PROFESSOR T. R., Professor of Pharmaceutical Chemistry, University of Sydney.

WIENHOLT, DR L. J., Deputy Director-General, Commonwealth Department of Health, Australian Capital Territory.

WILCOCK, MR R. S., General Manager (Development), Sigma Co. Ltd, Victoria.

WILHELM, MRS E. V., President, Family Planning Association of Australia, New South Wales

WILLING, DR R. L., Consultant Physician, South Australia.

WILSON, MR A. G., Managing Director, Eclipse Drug Co. Pty Ltd, New South Wales.

WILSON, MR R. E. MACDONALD, Assistant Director-General, Pharmaceutical Services Branch, Commonwealth Department of Health, Australian Capital Territory.

WINTON, DR R., Editor, *Medical Journal of Australia*, New South Wales.

WOODS, MR R. G., Federal Councillor, Australian Dental Association, New South Wales.

YOUNG, MR P. R., Executive Director, Family Planning Association of Australia, New South Wales.

YUILLE, DR D., Chairman, General Practitioners' Society in Australia (South Australian Branch), South Australia.

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29. Sample copies of National Health Scheme prescription forms.
30. Sample of four dispensing bottles.
31. List of increased prices of raw materials.
32. Flow chart showing the research and development of a compound from the initial stages, following its discovery to the lodging of a new drug application, **Australian Pharmaceutical Manufacturers Association.**
33. 'Notes regarding submission to Select Committee which is reviewing Pharmaceutical Benefits', **Washington H. Soul Pattinson and Co. Ltd** and **Soul-Pattinson (Newcastle) Pty Ltd.**
34. Chart showing company structure, **The Wholesale Drug Co. Ltd.**
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19442/72—4

HOUSE OF REPRESENTATIVES SELECT COMMITTEE ON
PHARMACEUTICAL BENEFITS

MINUTES OF PROCEEDINGS

Minutes of Proceedings

4 OCTOBER 1970

Deliberative meeting held at Parliament House Canberra

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Mr R. V. Garland, M. P., Dr R. T. Gun, M.P.

ESTABLISHMENT OF COMMITTEE

Extracts from the Votes and Proceedings of the House of Representatives No. 52 dated 16 September and No. 62 dated 13 October 1970 relating to the establishment of the Committee were read by the Acting Clerk of the Committee and Dr M. Mackay was asked to take the chair.

The Chairman welcomed the Committee and made some introductory remarks.

Agreed that the Committee Clerk should write to the Minister Assisting the Treasurer requesting the payment of the usual fees and allowances.

ADVERTISING

Agreed that advertisements be placed in the daily press throughout Australia inviting submissions from the public as soon as possible.

***Agreed* that the Department of Health be invited to make an oral submission to the** Committee.

ADVISERS

Agreed that the Chairman write to the Director-General of Health asking him to make an officer available to assist the Inquiry. It was further agreed to write to Public Service departments seeking their co-operation in the conduct of the Inquiry.

PROGRAMME

Agreed that though a Public Hearing in 1970 may be difficult to arrange, the Committee should plan to hear the Department of Health initially and then consider its further programme at a deliberative meeting in the first or second week of December 1970.

RESIGNATION OF MR LUCOCK

The Chairman announced that Mr Lucock had applied to the Prime Minister for permission to withdraw from the Committee and that Mr I. Robinson would accept nomination to fill the vacancy.

PRESS RELEASE

The Committee considered and agreed on the text of a statement to be released to the press when the question of appointments to the Committee was resolved.

The Secretariat was asked to procure the following:

(a) Copies of the book *In a few hands, a study of monopoly power in U.S.A.;* and

(b) Satchels for the Committee.

The Committee adjourned to a date to be fixed.

Confirmed.

8 DECEMBER 1970

New South Wales Legislative Council Chamber, Sydney

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Mr R. V. Garland, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr I. L. Robinson, M.P.

Private Meeting

MINUTES

The Minutes of Proceedings of the meeting held on 4 October 1970, were read and confirmed.

The Committee deliberated on the following matters:

(a) Questioning procedure to be followed at the public hearings.
(b) The procedure for introducing witnesses for today's hearing.
(c) Schedule of today's hearing.
(d) Parts of the Commonwealth Department of Health submission to be examined.
(e) The possibility of the Committee receiving a lecture type talk with illustrations by Professor Thorp at the Sydney University on 14 December 1970, in the afternoon.
(f) The next hearing of the Committee—agreed that the next hearing of the Committee be held on 14 December 1970, commencing at 10.00 a.m. in the New South Wales Legislative Council Chamber, Sydney. All members indicated that they would be able to be present.

Brief cases were distributed to members requiring them and members were informed that transparent folders were available as requested.

The meeting closed at 9.58 a.m. and members proceeded to the public hearing.

Public Hearing

The public hearing commenced at 10.00 a.m.

The Chairman formally declared the Inquiry open with a short statement.

The witnesses were called and sworn:

Sir William Refshauge—Director General of Commonwealth Department of Health.
Dr L. J. Weinholt—Deputy Director General of Commonwealth Department of Health.
Dr K. W. Edmondson—First Assistant Director General, National Health Division.
Mr D. Dunlop—First Assistant Director General, Management Services Division.
Mr J. G. G. Kelleher—Assistant Director General, Pharmaceutical.
Dr A. N. Walsh—Assistant Director General, Therapeutic Substances.
Mr J. Shaw—Director Pharmaceutical (Administration).

Sir William Refshauge read an introductory submission, was examined and later withdrew.

Following a motion for incorporation of the main submission of the Commonwealth Department of Health in the transcript of evidence, the remaining Departmental witnesses were examined.

The witnesses withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

ADJOURNMENT

The Chairman adjourned the hearing at 5.00 p.m. until 10.00 a.m. on Monday, 14 December 1970. The hearing to continue at the New South Wales Legislative Council Chamber, Parliament House, Macquarie Street, Sydney.

Confirmed.

14 DECEMBER 1970

New South Wales Legislative Council Chamber, Sydney

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. M. Berinson, M. P., Mr N. A. Brown, M.P., Mr R. V. Garland, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr I. L. Robinson, M.P.

Public Hearing

The public hearing commenced at 10.00 a.m.

The Chairman formally continued the hearing on the Commonwealth Department of Health submission which had been adjourned from 8 December 1970.

The witnesses from the Commonwealth Department of Health who were already sworn—

Dr L. J. Wienholt—Deputy Director General.

Dr A. N. Walsh—Assistant Director General, Therapeutic Substances.

Dr K. W. Edmondson—First Assistant Director General, National Health Division.

Mr D. Dunlop—First Assistant Director General, Management Services Division.

Mr J. G. Kelleher—Assistant Director General, Pharmaceutical.

Mr J. Shaw—Director Pharmaceutical (Administration).

were examined.

The witnesses withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the ***Parliamentary Papers Act*** 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

ADJOURNMENT

The Chairman adjourned the hearing at 2.50 p.m. to a date to be advised.

Confirmed.

4 AND 5 FEBRUARY 1971

Masonic Centre, 300 Albert Road, East Melbourne

4 February 1971

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. R. Berinson, M.P., Mr N. A. Brown, M.P., Mr R. V. Garland, M.P., Mr I. L. Robinson, M.P.

APOLOGIES: Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P

Private Meeting

MINUTES

The Minutes of Proceedings of the meetings held on 8 and 14 December 1970, were read and confirmed.

HEARING DATES

Committee discussed hearing dates and *resolved* that if necessary permission of the House should be sought for sitting whilst the House is in session and that there should be frequent meetings and hearings.

SUBMISSIONS

The Committee agreed that submissions should be discussed and a timetable should be made of hearings. It was *resolved* that the closing date for receiving submissions should be the end of March 1971.

GENERAL

The Committee discussed a possible meeting with Mr Bannerman of the Trade Practices Branch of the Attorney-General's Department and there was a general discussion on witnesses to be invited to give evidence

TERMS OF REFERENCE

There was a discussion as to the possible widening of the scope of the terms of reference to include the Repatriation Scheme.

ADVISORS

The Committee discussed the possible attachment from the Department of Health to the Committee, of Mr H. West, a senior officer of the Department. It was *resolved* that Mr West be asked to meet the Committee on 16 February 1971.

QUESTIONING OF WITNESSES

Committee discussed methods of questioning the witnesses and decided that each section of the submission should be taken separately. Committee also decided that the Chairman or a Committee member specialising in that particular section of the submission begin questioning and when completed the Chairman nominate members in order, around the table.

NEXT MEETING

The Committee decided to hold a deliberative meeting commencing at 10.00 a.m. on 16 February 1971, in Committee Room No. 58 of the Senate, Parliament House, Canberra, with a possible agenda as follows:

1. Submissions—summarised under brief topic headings.
2. A timetable for future meetings and hearings.
3. Meet Sir William Refshauge at 12.00 noon.
4. Lunch to be served in Committee room.
5. Meet Mr West.
6. Possible closure at 2.00 p.m.

The meeting closed at 10.50 a.m. and members proceeded to the public hearing.

Public Hearing

The Chairman opened the public hearing at 11.00 a.m. with introductory remarks.

Dr L. B. Geffen was called and made an affirmation. He made certain corrections to his submission. The Committee accepted these corrections and *resolved* that the submission be incorporated into the transcript of evidence.

Dr Geffen spoke on—

1. Doctor education;
2. Pharmacology teaching and facilities;
3. Overprescribing;
4. Generic and brand name prescribing;
5. Advertising;
6. Drug induced diseases—reporting

Dr Geffen withdrew at 1.00 p.m

At 2.00 p.m. Dr R. L. Hodge was called and made an affirmation.

The Committee *resolved* that Dr Hodge's submission be incorporated into the transcript of evidence.

Dr Hodge spoke on—

1. Doctor education;
2. Pharmacology teaching;
3. Scope of pharmacology;
4. Drug proliferation;
5. Efficaceous use of drugs·
6. Drug Evaluation Committee;
7. Generic and brand name prescribing.

Dr Hodge withdrew at 3.04 p.m.

At 3.05 p.m. Professor A. E. Doyle was called and made an affirmation. He made a correction to his submission. The Committee accepted the correction and resolved that the submission be incorporated into the transcript of evidence.

Professor Doyle spoke on—

1. Doctor education;
2. Pharmacology teaching;
3. Pharmacology facilities;
4. Prescribing habits of doctors;
5. Pharmaceutical Benefits Advisory Committee;
6. Adverse drug reaction—booklet.

Professor Doyle withdrew at 3.55 p.m.

Resolved: That pursuant to the power conferred by Section 2 (2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

ADJOURNMENT

The Chairman adjourned the hearing at 4.00 p.m. until 10.00 a.m. on Friday 5 February 1971.

5 FEBRUARY 1971

The hearing re-commenced at 10.05 a.m. on Friday, 5 February 1971, at the Masonic Centre, 300 Albert Street, East Melbourne.

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Mr R. V. Garland, M.P.

APOLOGIES: Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr I. L. Robinson, M.P.

Professor M. J. Rand and Dr M. L. Mashford were called and sworn.

Committee *resolved* that Professor Rand and Dr Mashford's submission be incorporated into the transcript of evidence.

The witnesses spoke on—

1. Doctor education;
2. Efficaceous use of drugs;
3. Drug induced diseases;
4. Reduction of the cost of the scheme;
5. The nature of pharmacology;
6. Generic and brand name prescribing;
7. Role of pharmacist;
8. Need for teaching pharmacology;
9. Research;
10. Development and production of drugs in Australia;
11. Prescribing habits of doctors;
12. Effects of drugs in the environment;
13. Need to educate public on drugs and pharmacology;
14. Adverse Drug Reaction Committee;
15. Statistics—drug monitoring;
16. Adverse reaction
    - reporting
    - awareness of doctors
    - awareness of patients
    - patient/doctor relationship;
17. Placebo effect;
18. Pharmacists role—education;
19. Research and research units.

Professor Rand and Dr Mashford withdrew at 12.45 p.m.

At 2.00 p.m. Dr A. Meares was called and sworn. Committee *resolved* that Dr Meares' submission be incorporated into the transcript of evidence

Dr Meares spoke on—

1. Placebo effects;
2. Psychological illnesses;
3. Overprescribing;
4. Prescribing habits of doctors;
5. Patient demand;
6. Psychological aspects of most diseases.

Dr Meares withdrew at 4.00 p.m.

Resolved: That pursuant to the power conferred by Section 2 (2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

ADJOURNMENT

The Chairman adjourned the hearing at 4.05 p.m. until 10.00 a.m. on Thursday 9 February 1971, at the New South Wales Legislative Council Chambers, Parliament House, Macquarie Street, Sydney.

Confirmed.

9 AND 10 FEBRUARY 1971

New South Wales Legislative Council Chambers, Parliament House, Macquarie Street, Sydney

9 FEBRUARY 1971

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P.

APOLOGIES: Mr R. V. Garland, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr I. L. Robinson, M.P.

Public Hearing

Professor R. Lovell was called and sworn at 10.00 a.m. The witness represented the Association of Clinical Professors, a professional group different from honorary physicians.

Professor Lovell spoke on—

1. Education of doctors;
2. Methods of teaching—use of advertising;
3. Prescribing habits of doctors;
4. Knowledge explosion;
5. Proliferation of drugs;
6. Drug evaluation by controlled trials and effects on prescribing habits;
7. Government role in drug evaluation:
8. Placebo effect;
9. Need for social worker—medico
10. Teaching of pharmacology;
11. Doctors unawareness of drug costs.

Professor Lovell withdrew at 12.17 p.m

At 2.00 p.m. Professor R. H. Thorp was called and sworn.

Professor Thorp spoke on—

1. Teaching of pharmacology to doctors;
2. Nature of pharmacology;
3. Overprescribing;
4. Need to educate doctors·
5. Need to educate the public·
6. Advertising by drug companies;

7. Research;
8. Drug evaluation of listed benefits·
9. Prescribing habits of doctors;
10. Proliferation of drugs;
11. Medical literature;
12. Range of drugs available under the Scheme;
13. Generic and brand name prescribing.

Professor Thorp withdrew at 3.30 p.m.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day

ADJOURNMENT

The Chairman adjourned the hearing until 10.00 a.m. on 10 February 1971.

10 FEBRUARY 1971

Public Hearing

At 10.00 a.m. Professor R. B. Blacket was called and sworn. Committee *resolved* that Professor Blacket's submission be incorporated into the transcript of the hearing.

Professor Blacket spoke on—

1. Doctor education;
2. Drug evaluation and effects on prescribing habits;
3. Scrutiny of prescribing—diagnosis shown;
4. Possible adverse reactions;
5. Overprescribing (geriatrics)·
6. Medicine as a subsidised profession
7. Statistics of diseases;
8. Drug induced diseases;
9. Honorary system;
10. Advertising;
11. Doctors unaware of drug costs·
12. Generic and brand name prescribing;
13. Cost of Scheme;
14. Pharmacology.

Professor Blacket withdrew at 12.25 p.m.

Dr K. W. Edmondson, previously sworn, and Mrs K. Dal Bon was sworn, at 2.00 p.m.

The witnesses were questioned about the use of the drug chloramphenicol and its side effects, mainly aplastic anaemia.

The witnesses spoke on—

1. Adverse drug reactions;
2. Overprescribing;
3. Need for scrutiny of prescribing.

The witnesses withdrew at 3.05 p.m.

Resolved: That pursuant to the powers conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

ADJOURNMENT

The Chairman adjourned the hearing to a date to be advised.

Confirmed.

10 FEBRUARY 1971

New South Wales Legislative Council Chambers, Parliament House, Macquarie Street, Sydney

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P.

Private Meeting

The Committee discussed:

1. The need to look at patterns appearing in the Inquiry with a view to the report, i.e. to look at headings under the Pharmaceutical Benefits Scheme.
2. Need to re-examine the Department of Health submission, especially tables showing statistical data.
3. Letter to be prepared for Dr Mackay to forward to Premier of New South Wales to request the attendance of State public servants, generally and specifically Dr Manning and possibly Hospitals Commission.
4. Approach Professor of Pharmacy, Sydney University, for a submission and College of General Practitioners—A.M.A.—Dr Mackay will approach and request submission. Look at further groups of witnesses who may be approached.
5. The submissions of witnesses were reviewed and the Committee decided that some of the submissions were not suitable to be heard whilst others could be heard and others may be heard if it was later considered desirable. These submissions are as follows:

I	*Name and Address*	*Major Points made in Submission*
	Mrs S. Gairn, 21 Netherlee St, Glen Iris, Victoria.	(i) Her son needs glutamic acid tablets to enable him to lead a normal life and therefore they should be on the Pharmaceutical Benefits listing. (ii) She needs priscol tablets to be able to walk without pain and as she is over 76 and a nonpensioner feels she should get these tablets free.
	Mrs E. Wallace, 90 Great West H/wy, Blaxland, N.S.W.	She objects to having to be referred by her local doctor to a specialist she has been attending for a number of years.
	Mr D. Linklater, Undersee Products, 578 Harris St, Ultimo, N.S.W.	(i) He was given massive doses of Amytal by his G.P. for gout and when he became doubtful of the treatment given him, presented himself to the Langton Clinic in Sydney. (ii) 'Free Health People' should work out 'a code system for computers accumulation and review by personal number' to control prescribing.
	Mr R. Roach 1113 Victoria Rd, West Ryde 2114.	His daughter died from the side effects of chloromycetin and he would like to have it made harder to secure under the Scheme.
	Senator R. J. D. Turnbull, Parliament House, Canberra, A.C.T.	The Committee should visit the pharmaceutical industry abroad to see the research work being done.
	Mr K. H. Hurst, Pharmacy 777, 777 Canning H/wy, Applecross, W.A. 6153.	(i) The Scheme should be evaluated on a cost/benefit approach. (ii) Pharmacists should be paid a fee in accordance with their professional standing.
	Mr M. C. H. Blackmore Blackmores Labs., 18 Whistler St, Manly, Sydney 2095.	(i) Products such as the simpler herbals or botanicals should be included in pharmaceutical benefits. (ii) They make these type of remedies and would like them to be included on pharmaceutical benefits listing.

Name and Address	*Major Points made in Submission*
Mrs D. Silva, 19 Deane St, Blackburn 3130.	If a dentist is able to prescribe drugs on the 'Free list', e.g. penicillin, they should be available under N.H.S.
Mr A. Endersby, 136 Nelson St, Wallsend, N.S.W.	(i) He is a chemist and reports a growing resentment of his colleagues against the Scheme. (ii) The government should be prepared to pay for the Scheme or else legislate it out of existence.
Mr P. Hastie, P.O. Box 257, Wagga Wagga.	The Pharmaceutical Benefits Act should be amended to include prescriptions written by registered dentists.
Mr W. Barber, Main Rd, Emerald 3782	The high cost of the N.H.S. is to be expected and value for the drug bill is good because: (i) cost will naturally increase each year; (ii) new drugs are expensive; (iii) dispensing is done by underpaid pharmacists; (iv) the prime consideration of the medical profession is what is in the best interest of the patient.
Mr D. O. Crompton, 104 Brougham Pl., Nth Adelaide	All bottles of drugs dispensed by chemists should have the name of the active ingredient on the label.
Mr A. G. Hayward, 32 Wilson St, Burnie, Tas.	He feels a major cost in the Scheme is the cost of running the Health Department.

Committee decided that the above submissions (I) need not be heard.

II *Name and Address*	*Major Points made in Submission*
Mr J. M. Newton, Fed. Secretary, Aust. Dental Assn, Sydney.	(i) There are cases when the interests and welfare of dental patients are well served by the judicious use of drugs. (ii) Dentists should be allowed to prescribe within the N.H.S.
General Practitioners Society in Australia, P.O. Box 192, Rose Bay 2029.	(i) they do not think doctors should be restricted in the drugs they prescribe; (ii) they are opposed to any regulation requiring generic prescribing; (iii) they would like a revision of the format of the 'Blue Book'; (iv) they feel G.P.s should be represented on the Drug Advisory Committee.
Mr A. J. Graham, 173 Springvale Rd, Nunawading.	(i) All items with a dispensed price of less than $1 be available to pensioners only under the Scheme. (ii) The 50c payment should be increased to 60c.
Mr E. A. Marsh, 'Treedene', French Rd, Petrie 4502.	The concession to Friendly Societies to charge only 10c to members who joined before 1964 should be taken away entirely.
Preventicare, 108 Parramatta Rd, Camperdown 2050.	(i) They are a firm in the field of computerised medical practice and have 400 doctors involved. (ii) Preventicare enables doctor to make early specific diagnosis. (iii) The computer stores medical histories and will pick up drug interactions, duplication of prescriptions, etc.
Mr K. Beehag, 3 Marie Dodd Cres., Blakehurst, N.S.W.	(i) Scheme is too broad but if it had been kept to the original concept of life saving drugs it would not have got out of hand. (ii) Should be restricted to pensioners, poor could use outpatients. (iii) The result of the Scheme has been an overuse of drugs.

Name and Address	*Major Points made in Submission*
Da Tel, 82 Flinders St, Melbourne.	(i) They deal with medical computing and its advantages. (ii) Some of their O/S honorary members may visit Australia during the inquiry or make specific submission through them.
Dr W. K. Manning, Garrawarra Hospital, Waterfall 2507	(i) As much as 75 per cent of drugs prescribed as pharmaceutical benefits are of no significant benefit. (ii) There is misleading and inadequate information on drugs supplied to doctors. (iii) Too many drugs of same type are listed as benefits. (iv) There should be general health education on drug resistance and side effects. (v) There should be more emphasis on common diseases in the medical courses. (vi) There should be a substantial increase in the 50c fee.

Committee decided that the above submissions (II) will be heard.

III

Name and Address	*Major Points made in Submission*
Dr A. F. Musso, 366 Hume H/wy, North Bankstown 2200.	(i) Excessive prescribing exists because the Scheme is so liberal and doctors do not know enough about drug indications and their effects. (ii) There should be a gradual reduction in the prescribable amounts of sedatives and hypnotics.
Dr J. J. Nichols, 20 Church Street,	(i) Pharmaceutical benefits book contains an over-abundance of psychotropic medications while (ii) major tranquilisers with little drug dependency properties are heavily restricted.
Mr J. S. Millner, Chairman and Managing Director, Washington H. Soul Pattinson & Co. Ltd, 158 Pitt St, Sydney.	(i) It is impossible to separate with any degree of accuracy the proportion of time spent by registered pharmacists on dispensing and on counter selling. (ii) Pharmacists have had no reasonable price increases on National Health dispensing for nine years. (iii) Retail pharmacy has been forced to subsidise the National Health Scheme and their company has not been able to increase their number of branches since 1940.
Dr D. N. Everingham, Commonwealth Parliament Offices, P.O. Box 604, Rockhampton 4700.	(i) Philosophical basis of chemotherapy expenditure on educating towards population control should accompany mass chemotherapy. (ii) There should be continuous, comprehensive, medical histories. (iii) The State should legislate for labelling by official names of all significant ingredients of prescribed medication. (iv) There should be individual wrapping of pills which can be used in overdose for suicide. (v) Generic prescribing.
Mr B. T. O'Connor, Chief Pharmacist, Calvary Hospital, 135 Penfold Rd, Wattle Park, S.A. 5066.	(i) An unfair situation exists as regards drugs on list for approved hospitals—when patient is discharged from hospital and if he still has repeats he has to pay the full amount. (ii) He outlined many administration problems with the Scheme as far as pharmacists are concerned. (iii) The public should be made aware of the cost of individual prescriptions.

Committee decided that the above submissions (III) are still under consideration.

Confirmed.

23 FEBRUARY 1971

Deliberative Meeting held at Parliament House, Canberra

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Mr R. V. Garland, M.P., Mr I. L. Robinson, M.P.

APOLOGIES: Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P.

MINUTES

Committee requested that Minutes be rewritten in less detail.

SUBMISSIONS

(a) Committee requested a schedule be prepared from time to time showing all submissions to date as listed, together with a list of new submissions since received.

(b) Four main headings of topics in submissions were considered to be:
1. Medical profession;
2. Pharmaceutical manufacturing industry;
3. Pharmaceutical marketing industry;
4. Role of the Government.

(c) An Index is to be prepared classifying topics under these four headings. Submissions received are to be listed under these headings.

(d) Submissions received in future are also to be listed with points made, as already provided to members.

TRANSCRIPT

Writers to be requested to provide as full and accurate reporting as possible, that no material evidence is to be omitted under any circumstances from the transcript.

POTENTIAL WITNESSES

(a) Those witnesses listed in agenda items (B) I-IX to be invited to make submissions to Committee, together with:
Dr S. Bell, University of New South Wales;
Professor D. Smith, Prince of Wales Hospital, Sydney;
Dr H. Bailey;
Royal Australian College of Physicians.

(b) List companies included under items X and XI for next meeting.

(c) Invite Commissioner of Trade Practices and Patents Commissioner to meet Committee in private at some future meeting.

WORK BEING DONE BY THE COMMITTEE STAFF

Members asked for details of work being done by the Committee staff.

Members will provide Chairman with written suggestions for work to be done by the staff.

FUTURE MEETINGS AND HEARINGS

Committee indicated a preference for Mondays and Tuesdays of sitting weeks. Mondays of first week were considered as good days for public hearings as a full day would be available and public hearing or Committee meeting could continue next morning.

A schedule of hearing dates would be discussed at next meeting.

Meeting adjourned at 12.12 p.m.

Confirmed.

25 FEBRUARY 1971

Deliberative Meeting held at Parliament House, Canberra

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Mr R. V. Garland, M.P., Mr W. G. Hayden, M.P.

APOLOGIES: Dr R. T. Gun, M.P.

MINUTES

The suitability of the Minutes was discussed and it was *resolved* to confirm the Minutes for public hearings and meetings on 4 and 5, 9 and 10 February and subject to an amendment, 23 February 1971—the amendment being that following the word 'possible', under the heading 'Transcript' the words 'that no material evidence is to be omitted under any circumstances from the transcript'.

TRANSCRIPT

It was resolved that the Committee ask an officer from Hansard to attend a meeting of the Committee to discuss the taking of transcripts of proceedings.

PROGRAMME FOR FUTURE MEETINGS AND HEARINGS

The Committee agreed to a full day hearing on the 8 March, continuing on the morning of the 9 March, commencing at 10.00 a.m. and the witnesses suggested by the Chairman, together with other suitable witnesses already listed, be invited to attend on these days. This hearing to be in Canberra.

It was *resolved* that the programme outlined in the agenda be agreed to as a tentative schedule of hearings and meetings but be subject to review from time to time. These hearings to be mainly held in Canberra.

ADVISOR TO COMMITTEE

The Committee *resolved* to appoint Mr Howard West as Adviser to the Committee and request him to attend the next public hearing.

The meeting adjourned at 10.15 a.m.

Confirmed.

8 MARCH 1971

Parliament House, Canberra

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr R. V. Garland, M.P., Dr R. T. Gun, M.P., Mr H. West (Adviser)

APOLOGIES: Mr N. A. Brown, M.P., Mr I. L. Robinson, M.P.

Public Hearing

Dr W. K. Manning was called and sworn at 10.00 a.m. Committee *resolved* that Dr Manning's submission be incorporated into the transcript of the hearing.

Dr Manning spoke on—

1. The prescribing habits of doctors:
   (a) overprescribing by doctors, especially antibiotics, antihistamines and hypnotics, as this was costly and allowed the development of resistance in patients;
   (b) patient pressure.
2. Exaggerated and misleading advertising and promotion by drug companies.
3. The need for an independent authority to test the efficacy of drugs as well as safety.
4. The need for objective information for doctors from the Commonwealth as the U.K. *Prescribers Journal* is useful but becoming less forthright.
5. The need for a body to conduct clinical trials and publicity reports.
6. On drugs included in the Pharmaceutical Benefits list.
7. On the proliferation of brand names.
8. The need for diagnoses to be specified by doctors.
9. The education of doctors, especially training in patient management.
10. The 50 cent patient contribution to be increased.

Dr Manning withdrew at 11.55 a.m.

At 12.00 p.m. Professor T. R. Watson and Dr J. Thomas were called and sworn. Committee *resolved* that Professor Watson and Dr Thomas' submission be incorporated into the transcript of the hearing. An amendment to page 3 was accepted.

The witnesses spoke on—

1. Education of pharmacist to fulfil his role.
2. The ownership and financing of pharmacies.
3. Discretion under the Pharmacy Act.
4. Skills required in dealing with stock.
5. Advice to patients and doctors on the use of drugs.
6. The role of hospital pharmacists.
7. Training of detailers—or use of pharmacy graduates as detailers.
8. The relation between pharmacists and clinical pharmacologists.
9. Generic prescribing.
10. Research.

Professor Watson and Dr Thomas withdrew at 3.00 p.m.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

IN CAMERA HEARING

MR R. M. Bannerman spoke to the Committee on trade practices aspects of the inquiry.

Dr A. D. Speares advised the Committee on computerised preventive medicine.

ADJOURNMENT

The Chairman adjourned the hearing until 10.00 a.m. on 9 March 1971.

9 MARCH 1971

Committee Room No. 2, House of Representatives, Parliament House, Canberra, at 10.00 a.m.

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. M. Berinson, M.P., Dr R. T. Gun, M.P., M. I. L. Robinson, M.P. Mr H. West (Adviser).

APOLOGIES: Mr N. A. Brown, M.P., M. R. V. Garland, M.P., Mr W. G. Hayden, M.P.

IN CAMERA HEARING

Mr Searle spoke to the Committee on the automatic data processing activities of the Department of Health and their relationship to the Pharmaceutical Benefits Scheme.

The hearing closed at 11.00 a.m.

15 MARCH 1971

Parliament House, Canberra

Private Meeting

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr R. V. Garland, M.P., Dr R. T. Gun, M.P., Mr H. West (Adviser).

APOLOGIES: Mr N. A. Brown, M.P., Mr W. G. Hayden, M.P., Mr I. L. Robinson, M.P.

MINUTES

The Committee *resolved* that the Minutes for the public and in camera hearings on 8 and 9 March 1971, be confirmed.

ITEMS DISCUSSED

The Committee discussed the following subjects:

1. The possibility of an interim report being prepared.
2. The possibility of an overseas tour.

3. Future meetings:
   (a) Deliberative meeting to be held at 9.30 a.m. on 29 March 1971, in the New South Wales Legislative Council Chambers, Parliament House, Macquarie Street, Sydney, before the public hearing commences.
   (b) The programme for 19 March 1971, for the public hearing to be held at 10.00 a.m. in the New South Wales Legislative Council Chambers was approved.
   (c) The public hearing to continue at 10.00 a.m. on 30 March 1971, in Canberra.
   (d) Future public hearings to include organisations of the medical profession so that this sector of the Inquiry could be finalised. For example:
   The Australian Medical Association;
   The Royal College of General Practitioners;
   The Royal College of Physicians;
   might be heard as soon as possible, if necessary without submissions but that copies of transcripts be forwarded to these organisations and a submission requested as soon as possible.

The meeting closed at 10.45 a.m.

IN CAMERA HEARING

PRESENT: Dr M. G. Mackay, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr R. V. Garland, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr H. West (Adviser).

APOLOGIES: Mr N. A. Brown, M.P., Mr I. L. Robinson, M.P.

WITNESSES

The following witneses from the Department of Health spoke on price negotiations betwen the Department and pharmaceutical manufacturers: Mr J. G. Kelleher; Mr R. E. M. Wilson; Mr J. W. Shaw; and Mr N. J. Clarke.

The in camera hearing closed at 12.30 p.m.

Confirmed.

20 APRIL 1971

Deliberative meeting held, Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr I. L. Robinson, M.P., Mr H. West (Adviser).

APOLOGIES: Mr R. V. Garland, M.P., Mr W. G. Hayden, M.P.

NEW CHAIRMAN

Mr A. A. Buchanan, the new Chairman of the Committee, took the chair.

MINUTES

The Committee resolved that the Minutes for the meeting and in camera hearing on the 15 March 1971, be confirmed.

VICE CHAIRMAN

The Chairman decided that it was not appropriate to appoint a vice-chairman but that where necessary, he would appoint a deputy chairman from time to time as required.

DIRECTION OF INQUIRY

There was a discussion on the direction that the inquiry had taken to date.

A discussion was held about the procedure for hearing submissions and it was decided that in general submissions would be taken as read, provided members had had an opportunity of reading the submissions.

SUBMISSIONS

Submissions not yet heard were discussed and it was decided that only those submissions which the Committee should hear, avoiding duplication if possible, should be listed for hearing.

FUTURE HEARING DATES

1. Future hearing dates were discussed and it was decided to hold the next public hearing at the New South Wales Legislative Council Chambers, Sydney, on 30 April 1971, at 9.30 a.m. to clear as many as possible of the submissions relating to the medical profession.

2. It was also decided that where possible hearing weeks should be on a four day basis. The possibility was discussed of commencing these weeks of hearings on 17 May 1971, in Adelaide but it was decided to defer decision until a future meeting at 3.30 p.m. on Tuesday, 27 April 1971.

3. It was decided that hours of hearing be from 9.30 a.m. and if necessary, continuing to 5.30 p.m.

TOPICS OF HEARINGS

It was decided that a precis of topics already covered by the Committee be prepared and distributed as each section becomes available.

The meeting adjourned at 4.50 p.m.

27 APRIL 1971

Deliberative meeting held in Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Mr R. V. Garland, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr I. L. Robinson, M.P., Mr H. West (Adviser).

MINUTES

Moved by Mr Berinson: That the Minutes for the meeting on 20 April 1971, be confirmed.

PROGRAMME OF HEARINGS

A programme of hearings was decided upon, to commence at 9.30 a.m. on 17 May 1971 in Melbourne.

17 and 18 May	Melbourne
19 and 20 May	Adelaide
7, 8, 9 10 June	Sydney
29, 30 June, 1, 2 July	Melbourne

It was decided that a factory visit be fitted into the programme on Tuesday afternoon 18 May 1971, and Sigma Co. Ltd, a wholesale manufacturer was considered suitable.

PUBLIC SERVANTS AS WITNESSES

A reply was received from the Premier of New South Wales concerning the hearing of New South Wales public servants.

The Committee decided on the basis of the letter to write to the Health Ministers in each State requesting that he following information be supplied:

1. The prices of the 25 most popular drugs;
2. the methods of price negotiation;
3. the extent to which the 20 per cent premium over cost paid by the Commonwealth on drugs available under the National Health Scheme, covers costs of dispensing etc.

The meeting adjourned at 5.00 p.m.

Confirmed.

30 APRIL 1971

Public hearing held in the New South Wales Legislative Council Chambers, Parliament House, Macquarie Street, Sydney

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Dr R. T. Gun, M.P., Mr W. G. Hayden, Mr I. L. Robinson, M.P., Mr H. West (Adviser).

APOLOGIES: Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Mr R. V. Garland, M.P.

MINUTES

Moved by Dr Gun: That the Minutes for the meeting held on 27 April 1971, be confirmed.

CHAIRMAN

The Chairman made an opening statement regarding his taking over of the chairmanship of the Committee from Dr Mackay, following the latter's appointment to the Ministry.

EVIDENCE

Dr J. Nichols was called and sworn. Committee *resolved* that Dr Nicholls's submission be incorporated into the transcript of the hearing.

The witness was examined and withdrew at 10.15 a.m.

Professor D. Smith (Associate Professor of Bacteriology, The Prince of Wales Hospital, Randwick) was called and sworn. Committee *resolved* that Professor Smith's submission be incorporated into the transcript of evidence. The witness made an additional statement regarding evidence given by witnesses at previous hearings.

The witness was examined and withdrew at 11.15 a.m.

Dr H. Bailey (psychiatrist) was called and sworn. The witness made a statement but did not present a written submission.

The witness was examined and withdrew at 12.07 p.m.

Dr R. Winton (Editor of the *Medical Journal of Australia*) was called and sworn. Committee *resolved* that Dr Winton's submission be incorporated into the transcript of evidence.

The witness was examined and withdrew at 12.45 p.m.

Professor D. W. Piper (Associate Professor of Medicine, Royal North Shore Hospital of Sydney) was called and sworn. Committee *resolved* that Professor Piper's submission be incorporated into the transcript of evidence. The witness made an additional statement, was examined and withdrew at 2.35 p.m.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The hearing closed at 2.40 p.m.

Confirmed.

17 MAY 1971

Commonwealth Parliament Offices, 400 Flinders Street, Melbourne

PRESENT: Mr A. A. Buchanan M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr I. L. Robinson, M.P., Mr H. West (Adviser).

Public Hearing

The hearing opened at 9.30 a.m. Mr Barrie Raymond Miller, Chief Pharmacist, Preston and Northcote Community Hospital, Preston, Victoria and Federal Secretary, Society of Hospital Pharmaceutical Chemists of Australia, Melbourne, Victoria, was called and sworn.

Resolved that the submission made by the Society of Hospital Pharmaceutical Chemists of Australia be taken as read and incorporated in the transcript of evidence.

The witness was examined and withdrew.

Professor Geoffrey Burnstock, Professor and Chairman of Department of Zoology, University of Melbourne, Gratton Street, Parkville, Victoria, was called and sworn.

Resolved that the submission made by Professor Burnstock be taken as read and incorporated in the transcript of evidence.

The witness was examined and withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The hearing adjourned at 12.30 p.m.

Private Meeting

The Committee deliberated and *resolved:*

1. That the Committee visit Brisbane to study the State system of centralised purchasing and distribution in Brisbane hospitals.
2. That the Committee visit Commonwealth Serum Laboratories and invite Commonwealth Serum Laboratories to prepare a submission including comment on the possibility of the Laboratories extending its range of production.
3. That a staff paper be prepared on the possible need to obtain from individual pharmaceutical manufacturers financial data including manufacturing, trading and profit and loss accounts, funds and costs etc.
4. That the Committee consider at some future time the advisability of recommending an overseas visit by some members and staff.

The meeting closed at 1.05 p.m.

The Committee visited Sigma Co. Ltd's warehouse and factory on an inspection tour during the afternoon.

18 MAY 1971

Commonwealth Parliament Offices, 400 Flinders Street, Melbourne

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr I. L. Robinson, M.P., Mr H. West (Adviser)

Public Hearing

Mr Alan Keith Hobbs, Managing Director; Mr Randolph Sydney Wilcock, General Manager (Development); and Mr Keith Kleinert, Management Accountant; of Sigma Company Limited, 589-605 Collins Street, Melbourne, Victoria, were called and sworn.

Resolved that the submission made by Sigma Company Limited be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Professor Basil Stuart Hetzel, Professor of Social and Preventive Medicine, Monash University, Commercial Road, Prahran, Victoria; and Dr Robert Graham Oliver, Research Fellow, Department of Social and Preventive Medicine, Monash Medical School, Alfred Hospital, Prahran, Victoria, were called and sworn.

Resolved that the submission made by Professor Hetzel and Dr Oliver be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Dr George Lucien Lipton, Honorary Federal Secretary; and Dr Russell Ashby Pargiter, Federal Councillor; of The Australian and New Zealand College of Psychiatrists, 'Maudsley House', 107 Rathdowne Street, Carlton, Victoria, were called and sworn.

Resolved that the submission made by The Australian and New Zealand College of Psychiatrists be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The hearing was adjourned at 3.30 p.m. until 9.30 a.m. on 19 May 1971 in Adelaide.

Confirmed.

19 MAY 1971

The Superior Court (Federal), 1 King William Street, Adelaide

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr H. West (Adviser).

Public Hearing

Mr Rex Netherton Spafford, President; Mr Alistair Ian Kingswell Lloyd, Vice President; and Mr Richard Blackmore Clampett, General Secretary; all of the Pharmaceutical Association of Australia, South Australia; Mr Esmond Ross Brown, President, Pharmaceutical Society of New South Wales; and Mr Harold Victor Feehan, Secretary, Pharmaceutical Society of Victoria; were called and sworn.

Resolved that the submission made by the Pharmaceutical Association of Australia be taken as read and incorporated in the transcript of evidence.

Mr Spafford made a further statement.

The witnesses were examined and withdrew.

Mr Kevin Phelps, General Manager; and Mr William Albany McKenzie, Secretary; both of the Friendly Societies Dispensaries Association of Australia, Adelaide, South Australia; were called and sworn.

Resolved that the submission made by the Friendly Societies Dispensaries Association of Australia be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Mr William Faulding Scammell, Managing Director, F. H. Faulding & Co. Ltd, Adelaide, South Australia; was called and sworn.

Resolved that the submission made by F. H. Faulding & Co. Ltd be taken as read and incorporated in the transcript of evidence.

The witness was examined and withdrew.

Sir Leonard Mallen, Chairman; Sir Maurice Vivian Clarke, Member; and Professor Ivan Stanley de la Land, Member; all of the Pharmaceutical Benefits Advisory Committee, were called and sworn.

Sir Leonard Mallen informed the Committee on the background of the Pharmaceutical Benefits Advisory Committee.

The witnesses were examined on the activities of the Pharmaceutical Benefits Advisory Committee and withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

Confirmed.

20 MAY 1971

The Superior Court (Federal), 1 King William Street, Adelaide

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr H. West (Adviser)

Public Hearing

Dr Duncan Yuille, Chairman, the General Practitioners' Society in Australia, South Australian Branch, Wayville, South Australia; was called and sworn.

Resolved that the submission made by the General Practitioners' Society in Australia, South Australian Branch, be taken as read and incorporated in the transcript of evidence.

The witness made a statement in addition to the submission, was examined and withdrew.

Dr Robert George Edwards, Head of the Division of Biochemistry, Institute of Medical and Veterinary Science, Adelaide, South Australia; was called and sworn.

Resolved that the submission made by Dr Edwards be taken as read and incorporated in the transcript of evidence.

Dr Richard Lyell Willing, Physician, Royal Adelaide Hospital, Adelaide, South Australia; was called and sworn.

The witness read his opening letter to the Committee.

Resolved that the remainder of Dr Willing's submission be taken as read and incorporated in the transcript of evidence.

The witness was examined and withdrew.

Dr Robert Hecker, Director of Gastroenterology Unit, Royal Adelaide Hospital, Adelaide, South Australia; was called and sworn.

Resolved that the submission made by Dr Hecker be taken as read and incorporated in the transcript of evidence.

Dr Hecker made statements in addition to his submission, was examined and withdrew.

Mr Brian Thomas O'Connor, Chief Pharmacist, Pharmacy Department, Little Company of Mary, Calvary Hospital, North Adelaide, South Australia; was called and sworn.

Resolved that the submission made by Mr O'Connor be taken as read and incorporated in the transcript of evidence.

The witness was examined and withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The public hearing adjourned at 4.00 p.m.

Private Meeting

The Committee deliberated and *resolved:*

(i) To invite Sir Macfarlane Burnet and the Family Planning groups to make a submission to the Committee.
(ii) To invite Commonwealth Serum Laboratories to make a submission.
(iii) To ask the Drug Evaluation Committee (Sir William Morrow, Chairman) to appear in Sydney on 10 June.
(iv) To accept a revised programme for public hearings from 7 to 10 June 1971 in Sydney.
(v) To meet in Melbourne on 28 and 29 June to hear the Pharmacy Guild of Australia and to visit the Commonwealth Serum Laboratories.
(vi) To meet in Sydney on 30 June, if there are submissions to be heard.
(vii) To visit Brisbane on 1 July to study the hospital system of purchasing and distribution.

Confirmed.

7 JUNE 1971

New South Wales Legislative Council Chambers, Parliament House, Macquarie Street, Sydney

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr R. V. Garland, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr I. L. Robinson, M.P.

Public Hearing

The Chairman made an opening statement.

Dr Edgar Frederick Thomson, Secretary General; Dr Horace George Norton, Representative; and Dr Con Scott Hathoway Reed, Member, Branch Council of New South Wales; all of the Australian Medical Association, 77-79 Arundal Street, Glebe, New South Wales, were called and sworn.

Dr Thomson asked the Committee to accept some amendments to the Association's submission.

Resolved that the submission made by the Australian Medical Association, as amended, be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Dr Harvard Northcroft Merrington, President; Dr John Goulburn Radford, President Designate; Dr Bernard Selwyn Alderson, Deputy Chairman of Council; Dr John Alfred Stevens, Member; and Dr John Martin Hutchinson, Member; all of the Royal Australian College of General Practitioners, 43 Lower Fort Street, Sydney, New South Wales, were called and sworn.

Resolved that the submisssion made by the Royal Australian College of General Practitioners, be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Resolved: That pursuant to the power conferred by section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

Private Meeting

The public hearing adjourned until the following day and the Committee deliberated.

MINUTES

Minutes of proceedings of 30 April and 17, 18, 19, 20 May 1971, were read and confirmed.

The meeting adjourned at 5.35 p.m.

Confirmed.

8 JUNE 1971

New South Wales Legislative Council Chamber, Parliament House, Macquarie Street, Sydney

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr R. V. Garland, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr I. L. Robinson, M.P.

Public Hearing

Mr Russell John Davies, President; and Dr Wylie Talbot Gibbs, Executive Director, both of the Australian Pharmaceutical Manufacturers Association, 45 Macquarie Street, Sydney, New South Wales; were called and sworn.

Resolved that the submission made by the Australian Pharmaceutical Manufacturers Association be taken as read and incorporated in the transcript of evidence.

Dr Gibbs made an additional statement. The witnesses were examined and withdrew.

Private Meeting

The public hearing adjourned and the Committee deliberated.

The private meeting adjourned.

Public Hearing

The public hearing resumed at 2.15 p.m. and the witnesses appearing on behalf of the Australian Pharmaceutical Manufacturers Association were further examined.

The witnesses withdrew, to be called to appear before the Committee at a future time.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The hearing adjourned at 5.30 p.m.

Confirmed.

9 JUNE 1971

New South Wales Legislative Council Chamber, Parliament House, Macquarie Street, Sydney

PRESENT: Mr A. A. Buchanan M.P. (Chairman), Mr J. M. Berinson, M.P., Mr R. V. Garland, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr I. L. Robinson, M.P.

Private Meeting

The Committee deliberated and agreed:

(a) on the content of a questionnaire to be issued by the Australian Pharmaceutical Manufacturers Association to obtain confidential data from manufacturers;

(b) that the Chairman, Clerk and Adviser discuss the contents and administrative details of the questionnaire with the Secretary of the Australian Pharmaceutical Manufacturers Association.

Public Hearing

Dr George Vincent Hall, Chairman; and Dr John Everard Hassall, Secretary; and Dr Denis Newell Wade, Member; all of the Therapeutics Advisory Committee of the Royal Australasian College of Physicians, Sydney, New South Wales, were called and sworn.

Resolved that the submission made by the Royal Australasian College of Physicians be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Mr James Sinclair Millner, Chairman and Managing Director, Washington H. Soul Pattinson & Company Limited, Sydney, New South Wales, was called and sworn.

Resolved that the submission made by Washington H. Soul Pattinson & Company Limited be taken as read and incorporated in the transcript of evidence.

The witness was examined and withdrew.

Mr Norman Roy Kelly, Managing Director, Wholesale Drug Company Limited, Sydney, New South Wales, was called and sworn.

Resolved that the submission made by the Wholesale Drug Company Limited be taken as read and incorporated in the transcript of evidence.

The witness was examined and withdrew.

Sir Arthur William Morrow, Chairman; and Dr Thomas Inglis Robertson, Member; both of the Australian Drug Evaluation Committee, were called and sworn.

Dr Annette Maria Walshe, Secretary, The Australian Drug Evaluation Committee, previously sworn, was called.

Sir William Morrow gave an outline of the Australian Drug Evaluation Committee activities. The witnesses were examined and withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The hearing adjourned at 5.00 p.m.

Confirmed.

28 JUNE 1971

Commonwealth Serum Laboratories, Parkville, Melbourne

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr W. G. Hayden, M.P.

INSPECTION

The Committee inspected the Commonwealth Serum Laboratories and held an informal discussion with Dr Lane, Director of Commonwealth Serum Laboratories.

Confirmed.

29 JUNE 1971

Commonwealth Parliament Offices, 400 Flinders Street, Melbourne

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr W. G. Hayden, M.P.

Public Hearing

Sir Eric Scott, President; Mr Rupert Lindsay Frew, Member of the Federal Council; and Mr Norman Francis Keith, Member of the Federal Council all of the Pharmacy Guild of Australia, Melbourne, Victoria, were called and sworn.

Sir Eric Scott made an additional statement.

Resolved that the submission made by the Pharmacy Guild of Australia, together with the reports by the Economic Research Associates, be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The hearing adjourned at 5.05 p.m. after resolving that the submission made by the Pharmacy Guild of Australia be further heard at a future time.

Private Meeting

MINUTES

The minutes of Proceedings of the public hearings held on 7, 8 and 9 June 1971, were read and confirmed.

PHARMACEUTICAL MANUFACTURERS QUESTIONNAIRE

The Committee deliberated and *resolved* that a letter be forwarded to the Australian Pharmaceutical Manufacturers Association informing the Association of the Committee's decisions regarding the proposed questionnaire to be completed by manufacturers of pharmaceutical products in Australia.

VISIT TO BRISBANE

The Committee decided that the Chairman and Mr Hayden represent the Committee at discussions with the management of the Royal Brisbane Hospital and the inspection tour of the Hospital's bulk dispensing and distribution system on 1 July 1971.

CANCELLATION

It was decided to cancel the public hearing on 30 June 1971, owing to lack of a quorum.

The meeting adjourned at 5.55 p.m.

Confirmed.

27 JULY 1971

Deputy Crown Solicitor's Office, Courtroom No. 1, Third Floor, 119 Phillip Street, Sydney

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Dr R. T. Gun, M.P.

Public Hearing

Dr Peter Chester Arnold, President, General Practitioners Society in Australia, Sydney, N.S.W., was called and made an affirmation.

Resolved that the submission made by the General Practitioners Society in Australia, be taken as read and incorporated in the transcript of evidence.

The witness was examined.

Dr Arnold then presented a personal submission.

Resolved that the submission made by Dr P. C. Arnold, be taken as read and incorporated in the transcript of evidence.

The witness was examined on his submission and withdrew.

Mr Sylvester James Timbs, Publisher, Monthly Index of Medical Specialities Pty Ltd, Sydney, N.S.W., was called and sworn.

Resolved that the submission made by Monthly Index of Medical Specialities Pty Ltd, be taken as read and incorporated in the transcript of evidence.

The witness was examined and withdrew.

Mr Graeme Seton Avery, Editor-in-Chief; and Mr William Wynne Hughes, Director both of New Ethicals Pty Ltd, Sydney, N.S.W., were called and sworn.

Resolved that the submission made by New Ethicals Pty Ltd, be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Mr Francis Carter Judson, Publishing Consultant, Physicians Index, Sydney, N.S.W., was called and sworn.

Resolved that the submission made by Mr F. C. Judson, be taken as read and incorporated in the transcript of evidence.

The witness was examined and withdrew.

Mr Alfred George Wilson, General Manager, Eclipse Drug Co. Ltd, Sydney, N.S.W., was called and sworn.

The witness was examined and withdrew.

Mr Cyril Norman Reeve Stocks, Executive Chairman; and Mr Keith Harris, Managing Director; both of Drug Houses of Australia Limited, Melbourne, Victoria, were called and sworn.

Resolved that the submission made by Drug Houses of Australia Limited be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the ***Parliamentary Papers Act*** 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The hearing adjourned at 4.55 p.m.

Private Meeting

MINUTES

The Minutes of Proceedings of the public hearings held on 29 June 1971, together with Minutes of Proceedings of the visit to Commonwealth Serum Laboratories on 28 June 1971, were read and confirmed.

FACTORY VISITS

The Committee decided that the Chairman and Dr Gun represent the Committee when visiting the plant of Merck Sharpe and Dohme at South Granville and at Knoll Laboratories Pty Ltd in Arncliffe on 29 July 1971.

The Committee deliberated.

The meeting adjourned at 6.00 p.m.

Confirmed.

28 JULY 1971

Deputy Crown Solicitor's Office, Courtroom No. 1, Third Floor, 119 Phillip Street, Sydney

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P.

Public Hearing

Sir Eric Scott, President; Mr Rupert Lindsay Frew, Member of the Federal Council; and Mr Norman Francis Keith, Member of the Federal Council; all of the Pharmacy Guild of Australia, Melbourne, Victoria, previously sworn, were called.

Sir Eric Scott presented two additional submissions.

Resolved that the two additional submissions to the original submission made by the Pharmacy Guild of Australia, be incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Mr Russell John Davies, President; and Dr Wylie Talbot Gibbs, Executive Director; both of the Australian Pharmaceutical Manufacturers Association, 45 Macquarie Street, Sydney, New South Wales, previously sworn, were called.

Dr Gibbs read a supplementary submission.

Resolved that the supplementary submission, together with table, made by the Australian Pharmaceutical Manufacturers Association, be incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The hearing adjourned.

Confirmed.

25 AUGUST 1971

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr I. L. Robinson, M.P.

Private Meeting

WELCOME:

The Chairman welcomed Mr L. H. Irwin as a member of the Committee, replacing Mr R. V. Garland who has been appointed Minister of Supply.

MINUTES:

The Minutes of Proceedings of 27 and 28 July 1971, were read and confirmed.

The Committee deliberated.

The meeting adjourned.

Confirmed.

6 SEPTEMBER 1971

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr L. H. Irwin, M.P.

Public Hearing

Mr Allan John Bloomfield, Federal President; Mr Robin George Woods, Federal Councillor; and Mr John Mansfield Newton, Federal Secretary; all of the Australian Dental Association, Sydney, New South Wales, were called and sworn.

Resolved that the submission made by the Australian Dental Association, be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The hearing adjourned.

Private Meeting

The Committee deliberated.

The meeting adjourned.

Confirmed.

28 SEPTEMBER 1971

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Public Hearing

Mrs Eileen Viny Wilhelm, President; and Mr Peter Raymond Young, Executive Director; both of the Family Planning Association of Australia, Chippendale, New South Wales, were called and sworn.

Resolved that the submission made by the Family Planning Association of Australia, be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Sir Frank Macfarlane Burnet, O.M., Professor of Experimental Medicine, University of Melbourne, Victoria, was called and sworn.

Resolved that the submission made by Sir Macfarlane Burnet, be taken as read and incorporated in the transcript of evidence.

The witness was examined and withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The hearing adjourned.

Private Meeting

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

MINUTES

The Minutes of Proceedings of 25 August and 6 September 1971 were read and confirmed.

WELCOME

The Chairman welcomed Mr B. Lloyd as a member of the Committee, replacing the Hon. I. L. Robinson who has been appointed Assistant Minister to the Postmaster-General.

The Committee deliberated.

The meeting adjourned.

Confirmed.

29 OCTOBER 1971

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Dr R. T. Gun, M.P., Mr L. H. Irwin, M.P.

Public Hearing

Sir William Dudley Refshauge, Director-General of Health, Commonwealth Department of Health, A.C.T., previously sworn, presented a further submission.

Resolved that the submission from Sir William Refshauge dated September 1971, be taken as read and incorporated in the transcript of evidence.

The witness was examined and withdrew.

Dr Louis John Wienholt, Deputy Director-General of Health; Dr Annette Maria Walshe, Assistant Director-General, Therapeutic Substances Branch; Dr Kenneth William Edmondson, First Assistant Director-General, National Health Division; Mr David George Dunlop, First Assistant Director-General, Establishments and Finance Division; and Mr John William Shaw, Director, Pharmaceutical Services Branch; all of Commonwealth Department of Health, Canberra, previously sworn, were called; and Mr Richard Euan MacDonald Wilson, Assistant Director-General, Pharmaceutical Services Branch, Commonwealth Department of Health, Canberra, was called and sworn.

Resolved that the submission from the Commonwealth Department of Health dated September 1971, be taken as read and incorporated in the transcript of evidence.

The witnesses were examined and withdrew.

Dr William Reid Lane, Director, Commonwealth Serum Laboratories, Melbourne, was called and sworn.

Resolved that the submission from Commonwealth Serum Laboratories be taken as read and incorporated in the transcript of evidence.

The witness was examined and withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The hearing adjourned.

Confirmed.

3 NOVEMBER 1971

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Private Meeting

MINUTES

The Minutes of Proceedings of 28 September and 29 October 1971, were read and confirmed.

The Committee deliberated.

The meeting adjourned until 3.30 p.m. on 4 November 1971.

Confirmed.

4 NOVEMBER 1971

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Dr R. T. Gun, M.P., Mr L. H. Irwin, M.P.

Private Meeting

MINUTES

The Minutes of Proceedings of 3 November 1971, were read and confirmed.

The Committee deliberated and agreed:

(a) that a public hearing be held on 23 November 1971, in Canberra at 9.30 a.m. to hear Messrs Blandy and Hughes, Economists to the Pharmacy Guild of Australia;

(b) that a framework of the Committee Report be prepared for 9 November 1971;

(c) that the completed questionnaire from Commonwealth Serum Laboratories was received too late for inclusion in the analysis and tables.

The meeting adjourned.

Confirmed.

10 NOVEMBER 1971

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Private Meeting

MINUTES

The Minutes of Proceedings of 4 November 1971, were read and confirmed.

The Committee deliberated and agreed to:

(a) guidelines for drafting the Committee Report;

(b) the circulation of summaries of evidence to Committee members.

The meeting adjourned.

Confirmed.

23 NOVEMBER 1971

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Public Hearing

Dr Richard John Blandy; and Mr Desmond Barry Hughes; both of Economic Research Associates, Adelaide, were called and sworn.

The witnesses presented a submission on pharmacists' remuneration.

The witnesses were examined and withdrew.

Resolved: That pursuant to the power conferred by Section 2(2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of the evidence given before it at public hearings this day.

The Committee adjourned.

Confirmed.

24 FEBRUARY 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Private Meeting

MINUTES

The Minutes of Proceedings of 10 and 23 November 1971, were read and confirmed.

SUMMARY OF EVIDENCE

The Committee deliberated on the summary of evidence and discussed findings and recommendations for the Committee report.

The meeting adjourned until 3.30 p.m. on 1 March 1972.

Confirmed.

1 MARCH 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P. Dr R. T. Gun, M.P., Mr B. Lloyd, M.P.

Private Meeting

MINUTES

The Minutes of Proceedings of 24 February 1972, were read and confirmed.

SUMMARY OF EVIDENCE

The Committee further deliberated on the summary of evidence and discussed findings and recommendations for the Committee report.

The meeting adjourned until 3.00 p.m. on 2 March 1972.

2 MARCH 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P., (Chairman), Mr J. M. Berinson, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Private Meeting

SUMMARY OF EVIDENCE

The Committee deliberated further on the summary of evidence and discussed findings and recommendations for the Committee report.

The Committee adjourned until 3.30 p.m. on Wednesday, 8 March 1972.

Confirmed.

8 MARCH 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Private Meeting

MINUTES

The Minutes of Proceedings of 1 and 2 March 1972, were read and confirmed.

First Section of First Draft Report

The Committee deliberated on draft material for the Committee report.

The Committee adjourned until 3.30 p.m. on Tuesday, 21 March 1972.

21 MARCH 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Private Meeting

MINUTES

The Minutes of Proceedings of 8 March 1972 were read and confirmed.

FIRST SECTION OF DRAFT REPORT

The Committee further deliberated on draft material for the Committee report.

The Committee adjourned until 3.30 p.m. on Wednesday, 22 March 1972.

Confirmed.

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22 MARCH 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Dr R. T. Gun, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Private Meeting

FIRST SECTION OF FIRST DRAFT REPORT

The Committee further deliberated on draft material for the Committee report.

The Committee adjourned until 3.30 p.m. on Wednesday, 29 March 1972.

Confirmed.

29 MARCH 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Private Meeting

MINUTES

The Minutes of Proceedings of 21 and 22 March 1972, were read and confirmed.

FIRST SECTION OF FIRST DRAFT REPORT

The Committee completed deliberations on the First Section of the First Draft Report.

The Committee adjourned until 3.30 p.m. on Wednesday, 12 April 1972.

Confirmed.

12 APRIL 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Dr R. T. Gun, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Private Meeting

MINUTES:

The Minutes of Proceedings of 29 March 1972, were read and confirmed.

The Committee deliberated on its report.

The Committee adjourned until 3.30 p.m. on Thursday, 13 April 1972.

Confirmed.

13 APRIL 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Private Meeting

The Committee deliberated on its report.

The Committee adjourned until 3.30 p.m. on Wednesday, 19 April 1972.

Confirmed.

19 APRIL 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Dr R. T. Gun, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

Private Meeting

MINUTES:

The Minutes of Proceedings of 12 and 13 April 1972, were read and confirmed.

The Committee deliberated on its report.

The Committee adjourned until 2.30 p.m. on Thursday, 20 April 1972.

Confirmed.

20 APRIL 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Dr R. T. Gun, M.P., Mr B. Lloyd, M.P.

Private Meeting

MINUTES

The Minutes of Proceedings of 19 April 1972, were read and confirmed.

The Committee deliberated on its report.

The Committee adjourned until 3.30 p.m. on Tuesday, 9 May 1972.

Confirmed.

9 MAY 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

The Minutes of Proceedings of 20 April 1972, were read and confirmed.

The Committee proceeded to the consideration of the Chairman's draft Report.

Paragraphs 1-6, by leave, taken together. Dr Gun moved the following amendment, by leave:

Omit paragraphs 1-6 and insert the following paragraphs in place thereof:

1. The House of Representatives Select Committee on Pharmaceutical Benefits was formed on the resolution of the House of Representatives on 16 September 1970. The resolution of appointment required the Committee to inquire into and make recommendations on all aspects of the provision of, and arrangements for the supply of, pharmaceutical benefits under the *National Health Act* 1953-1970, with particular reference to:

(a) the scope of the Scheme;

(b) all factors contributing to the cost of the Scheme; and

(c) the effects of the Scheme on the health and welfare of the community.

2. The circumstances of the appointment of the Committee were exceptional in that the initiative for its formation was taken by the Government. There was no prior suggestion in the Parliament that the Committee be set up. The Committee has been unable to determine whether the move was initiated at a Departmental or a political level.

3. The motives behind the establishment of the Committee are therefore not clear. It would appear a reasonable speculation, however, that there was concern at the rising cost of the Pharmaceutical Benefits Scheme. The Government and the Commonwealth Department of Health have endeavoured to contain the cost of the Scheme by pegging the dispensing fees of pharmacists and by effecting price reductions in pharmaceuticals on the manufacturers supplying the Scheme. This has resulted in protests from pharmacists and manufacturers that they were caught in a 'cost-price squeeze'. Thus there was probably pressure on the Government to increase dispensing fees and drug prices in the face of the rising cost of an already expensive Scheme. No doubt there was a temptation to increase prescription charges above the level of 50c, so as to deter overuse of the Scheme and to recover some of the costs.

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4. If the purpose of the Committee was intended to be the public justification of the changes foreshadowed above, the Committee's existence has been made superfluous by changes made since September 1970. In November 1971 prescription charges were raised from 50c to one dollar. The drug manufacturers off-loaded part of their cost-price squeeze by reducing discounts. More recently the pharmacists have been granted an increase in dispensing fees of 7c per prescription.

5. Notwithstanding the above, the Committee believes that the inquiry has provided an insight into the Scheme, and all concerned with it, from the manufacturer through to the consumer.

Drugs and the Community

6. The great increase in the use of drugs is cause for concern. The Committee believes that the fundamental answers to this problem are not to be found in an examination of the Pharmaceutical Benefits Scheme. It is not only the medical use of drugs which is increasing. The use of alcohol and tobacco has risen manifold in recent years (Hetzel). The increasing non-medical use of drugs has been the subject of a separate inquiry by a Select Committee of the Senate. The cause and cure of the problem of the increased use of drugs can only be found by a searching examination of society itself, and the temptation to find scapegoats (e.g. the Pharmaceutical Benefits Scheme, cigarette advertising, 'permissiveness') must be resisted.

6A. An even more fundamental matter is the question of the very place of drugs. Different religions place strictures on differing drugs. Some forbid the medical use of drugs, some forbid alcohol, others forbid the use of even the amount of caffeine in a cup of tea. Clearly then, one's conclusions as to the nature and extent of the drug problem are heavily dependent on one's basic assumptions on the nature of man.

6B. An example of the importance of such considerations is the question as to whether psychotropic drugs are overprescribed, a question given a lot of attention during the Inquiry. The use of tranquillisers is for many people an indispensable prop to prevent the stresses of living from becoming intolerable. Yet the same people may regard the use of alcohol for the same objective as being undesirable. Similarly the non-medical use of certain drugs for this purpose is widely denounced because they lead to loss of drive, and a state of mind which, if widespread, would lead to a 'decline in our civilisation'. Such varying attitudes to varying drugs make very difficult the objective appraisal of whether or not those psychotropic drugs prescribed by doctors should or should not be used less.

6C. It would appear logical to regard all psychotropic drugs, whether used legally or illegally, as potentially affecting the user's attitude to life, possibly adversely. On the other hand, such drugs may be suppressing other forms of deviant social behaviour (such as violent crime), which might become manifest if access to drugs were limited, by such measures as reduced prescribing of prescription drugs. Drugs have the potential to do harm, but their use may suppress other evils. Society should therefore seek to remove those basic causes which motivate people to take drugs.

6D. Possible factors in the social environment responsible for increased drug use have been suggested by the Senate Select Committee on Drug Trafficking and Drug Abuse. They include:

(a) the stresses of modern life. For example, technological change has been too rapid for man to adapt to it;

(b) life in large cities;

(c) population density.

It is thus in the social and physical environment that the cause of increased drug use is to be found. Environmental stimuli are probably also responsible for the increased use of drugs other than the psychotropic drugs. For example, the three groups of drugs whose use under the Pharmaceutical Benefits Scheme increased most in the period 1961-62 to 1969-70 were antihistamines (a quadrupling), bronchodilators (quadrupling) and anticholinergics (trebling). It does not seem too far-fetched to hypothesise that the increased use of these drugs is related to such factors as, for example, psychological stress (causing asthma and peptic ulcers) and air pollution (causing asthma). (See Appendix)

6E. The real answer to the problems of the cost of the Pharmaceutical Benefits Scheme and its effect on the health and welfare of the community are therefore not to be found in the Scheme itself. The answer, if indeed there is an answer, lies in fundamental changes to the modern capitalist system. Nevertheless, the Committee believes that pursuant to its findings from the Inquiry, certain changes should be made to the Scheme. These changes would be beneficial, but they would be 'once-and-for-all' changes, and would only be peripheral to the whole problem of drug use and abuse, of which the increased cost of the Scheme is merely a symptom.

6F. In other words, the essential need is for preventive medicine. The preventive measures may, in many cases, be as much social and political as medical. For example, if it can be shown that psychoneurotic and psychosomatic disorders are a condition of overcrowding or of large cities, radical town-planning measures would seem desirable. Increasing attention is being given to the subject of social engineering, which is based on the theory of 'architectural determinism'.

6G. In this sense, it is also a preventive medical measure to endeavour to alter the 'rat-race' attitudes of society. It is certainly a plausible theory that much mental and physical illness is caused by the stresses of living in a competitive, acquisitive and materialistic society. In this respect the questions of economic growth, the artificial sustaining of consumer demand and the international arms race should come under critical scrutiny.

6H. The increased use of certain drugs may be traced back to another side effect of industrialisation—pollution. For example, air pollution is undoubtedly contributing to increased respiratory disease. Thus if the use of drugs to treat respiratory disease is to be reduced, an attack on the problem of air pollution will be far more fruitful than amendments to the Pharmaceutical Benefits Scheme'.

Amendment—put

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
Mr Hayden	Mr Brown
	Mr Buchanan
	Mr Irwin
	Mr Lloyd

And so it was negatived.

Paragraphs 1-2 agreed to.

Paragraph 3 withdrawn, by leave.

Paragraphs 4-6 amended and agreed to.

Table VI, Appendix I considered, by leave, amended and agreed to.

Paragraph 7 agreed to.

Paragraph 8 amended and agreed to.

Paragraphs 9-19 agreed to.

Paragraph 20 amended and agreed to.

Paragraph 21 agreed to.

Paragraph 22 Dr Gun moved the following amendment, by leave:

Omit the paragraph and insert the following paragraphs in place thereof:

22. The main factors responsible for the increased costs of the Scheme do not lie within the Pharmaceutical Benefits Scheme itself, but are related to the pattern of sickness in the Community. They are involved in the consideration of public health and preventive medicine.

22A. Another factor external to the Scheme but affecting its cost, is the prescribing habits of doctors. This involves consideration of the organisation of medical and other services for the delivery of health care, and is discussed in Section C of this Report.

22B. Factors actually within the Scheme affecting its cost include:

(a) scope of the Scheme;
(b) the cost of the drugs. The unit costs have not increased unduly. In fact the cost per prescription over the last nine years has risen at a slower rate than the Consumer Price Index;
(c) rate of chemist remuneration and the cost of distribution;
(d) maximum quantity and other restrictions on prescribing;
(e) population growth.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Berinson	Mr Brown
Dr Gun	Mr Buchanan
Mr Hayden	Mr Irwin
	Mr Lloyd

And so it was negatived.

Paragraph 22 amended and agreed to.

Paragraphs 23-28 agreed to.

Paragraph 29 amended and agreed to.

Paragraph 30 agreed to.

The Committee adjourned until 3.30 p.m. on Wednesday, 10 May 1972.

Confirmed.

10 MAY 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

The Committee resumed its consideration of the Chairman's draft Report:

Paragraphs 31-38 by leave, taken together. Dr Gun moved the following amendment, by leave:

Omit paragraphs 31-38 and insert the following paragraphs in place thereof:

31. The Committee heard varying claims as to whether overprescribing occurs. It is impossible to make an objective judgment as to how much prescribing may occur before *overprescribing* can be said to exist. As mentioned earlier in the report, individual judgments vary as to the place of drugs. For example, some doctors claim that counselling or psychotherapy is more appropriate treatment for certain psychoneurotic conditions than treatment by drugs; whereas other doctors would claim that drug therapy is more effective than the best counselling.

32. Nevertheless the Committee finds cause for concern at the level of prescribing for a number of reasons:

(a) the greatly increased rate of prescribing itself;
(b) the incidence of drug-induced disease and other associated problems.

33. Estimates were given that between 5 per cent and 15 per cent of all patients entering hospitals suffer from some drug-induced disease. These are, in many cases, caused by interaction between drugs; excessive medication with the drug used; treatment with the wrong drug; or adverse reactions where correct treatment has been applied.

34. It was claimed that many patients were seen who had been prescribed for without any compelling reasons or who were suffering from unnecessary over-exposure to drugs. This over-exposure takes the form of the use of more than one drug when one drug would do, or the treatment of several complaints with different drugs without giving sufficient consideration to the interaction of the drugs prescribed.

35. Another type of overprescribing is where drugs are prescribed for precautionary reasons. For example, drugs may be prescribed against the possibility of bacterial infection following viral infection (although this was estimated to occur in only 5 per cent of cases). Antibiotics were given as examples of drugs commonly prescribed in this way. Prescribing as a precautionary measure poses serious problems. Not only can it render valuable drugs useless by developing resistant strains but also by destroying harmless organisms, the overgrowth of disease-producing organisms can occur.

36. The Committee believes that many cases of unnecessary prescribing, such as the case of antibiotics mentioned in the previous paragraph, result from the fact that clinical pharmacology as a science is in its infancy. The doctor prescribing an antibiotic as a prophylaxis against bacterial infection secondary to a viral infection knows that the antibiotic is superfluous in most cases. Nonetheless he prescribes it because he does not wish any secondary infection to occur which might be attributed to his neglect. It is thus not likely that mere exhortations to prescribe less, or claims that secondary infection is uncommon, will induce doctors to refrain this practice. It is necessary for the doctor to know the statistical likelihood of the outcome of each case, if the antibiotic is or is not used.

37. The Committee recommends:

(a) that studies be undertaken and statistics be compiled of the common illnesses, particularly the infections, indicating the history of the illness with and without different kinds of drug therapy, together with statistics of the incidence of untoward effects of the use of the drugs concerned;

(b) this information should be gathered in a manner similar to that used by the Royal Australasian College of General Practitioners in its morbidity survey and study of prescribing habits of doctors;

(c) financial support for gathering of such information should be given to bodies such as the College of General Practitioners and to university departments of medicine able and willing to carry out the surveys;

(d) up-to-date information arising from the surveys should be made available to all doctors to assist them in the judicious use of drugs;

(e) as sufficient statistical information is available to warrant it, consideration should be given to the installation of computer terminals in clinics, hospitals and health centres, giving information enabling the doctor to prescribe therapy which is statistically the most likely to be successful in each case.

The Placebo Effect

38. When a doctor prescribes medication, the patient usually improves. This is due to one of three factors, or combination of them.

(a) the patient's improvement is part of the natural history of the illness;

(b) the placebo effect of the drug. Even though the drug exerts no physiological effect, the patient's belief that he is receiving treatment for his illness has a psychological effect which is beneficial;

(c) the patient improves as a result of the action of the drug.

In the majority of cases the patient ascribes his improvement to cause (c). However, this is no reason for the doctor to do the same.

38A. The Committee believes that prescribing habits would improve if doctors had more information on the proven efficacy of the drugs prescribed. The use of antihistamines may be taken as an example. These are frequently prescribed for respiratory infection as an act of hope rather than an act of faith, and in preference to telling the patient that there is no known cure for his illness but that he will get better anyway. If doctors were squarely confronted with the fact that antihistamines have little proven clinical value in such cases, their use would be more honestly acknowledged as a placebo, and they would probably be used less.

38B. The Committee finds that many drugs are prescribed in cases where, even though a physiological effect is known from *in vitro* or *in vivo* studies, their clinical efficacy is not proven. The Committee believes that an effort should be made to obtain as much knowledge on this subject and make it available to doctors.

38c

(a) The Committee recommends that the combined resources of the Australian Drug Evaluation Committee and the Pharmaceutical Benefits Advisory Committee (see Section K) be expanded to collect all available information from Australia and overseas on the clinical efficacy of drugs, particularly that information elicited from properly controlled double-blind clinical trials.

(b) The Committee further recommends that the Government give active encouragement to the carrying out of double-blind clinical trials of those drugs most frequently prescribed under the Pharmaceutical Benefits Scheme.

(c) Statistical data on (a) and (b) should be made available regularly to doctors'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
Mr Hayden	Mr Buchanan
	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraph 31 agreed to.

Paragraph 32 amended and agreed to.

Paragraph 33 amended and agreed to.

Paragraph 34 amended and agreed to.

Paragraph 35 agreed to.

Paragraph 36 agreed to.

Paragraph 37 agreed to.

Paragraph 38 (a)-(c) amended and agreed to.

Paragraph 38 (d) withdrawn, by leave.

Paragraph 38 (d) Mr Hayden moved the following amendment, by leave:

That a new sub-paragraph be inserted as 38 (d) as follows:

'38 (d) *Consideration be given to the installation of computer systems to assist* doctors in prescribing therapy which is statistically the most likely to be successful in each case.'

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
Mr Hayden	Mr Brown
	Mr Buchanan
	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraph 39 agreed to.

Paragraph 40 agreed to.

Paragraph 41 amended and agreed to.

Paragraph 42 agreed to.

Paragraphs 43-52 by leave, taken together. Dr Gun moved the following amendment, by leave:

Omit paragraphs 43-52 and insert the following paragraphs in place thereof:

'43. More adequate instruction in pharmacology and therapeutics could be expected to produce direct economies both by reducing the cost of drugs prescribed unnecessarily or ineffectually, and by lowering the incidence of disease induced by drugs.

44. Professional and academic opinion was unanimous in supporting a change in the emphasis of medical education towards this end. At the under-graduate level it was suggested that there is ample scope to reduce the content of anatomy instruction, for example, replacing the time made available in this way by increased training in pharmacology and therapeutics. Ideally, separate departments of clinical pharmacology should be established in all major teaching centres.

45. The paucity of undergraduate education in these fields carries through to the post-graduate level. At present there is no post-graduate diploma in pharmacology in Australia, although such diplomas are available in Canada, the U.S.A. and the United Kingdom. Present post-graduate education and re-education of practising doctors is predominantly carried out, where it exists at all, by the professional societies.

46. Post-graduate activities available to practising doctors through societies such as the Royal Australasian College of Physicians and the Royal Australian College of General Practitioners, include symposiums, workshops in clinical pharmacology, seminars and courses in country and urban areas. The Royal Australian College of General Practitioners did have post-graduate fellows (senior well-informed general practitioners) in each State, organising educational discussion groups and generally acting as education agents for their colleagues. Through lack of finance this system has lapsed in every State except in New South Wales where the State Government has given financial assistance. The Royal Australian College of General Practitioners has a vocational training plan for the College entrance examinations.

47. There is, however, the problem of attracting the interest of most practising doctors in continuing education. It may be necessary to require participation by doctors in such a continuing education programme. There are associated difficulties in obtaining sufficient finance to allow post-graduate courses to operate on a regular basis. Possibly the most useful type of continuing education in clinical pharmacology is medical audit, or peer-review. Ideally, each doctor's prescribing habits would be subject to audit by local committees of doctors, in the presence of a clinical pharmacologist and/or a post-graduate fellow of the Royal Australian College of General Practitioners. Medical audit has been practised in certain hospitals in Australia for some years. It is also an integral part of extra-hospital practice in certain overseas centres. In giving evidence to the Committee, the Director-General of Medical Services said he thought that medical audit would take a long time to develop, but he thought it was an ultimate aim.

48. At present the doctor is frequently under great pressure from his patient to prescribe drugs. The only counter-pressure to this is the occasional visit from a pharmacist from the Commonwealth Department of Health to inform the doctor of how his prescribing habits compare with those of his colleagues. The Committee believes that peer-review would be more effective and much less bureaucratic.

49. The Committee found that there is an urgent need to completely review the content of medical courses which do not at present fully equip graduates to deal with the proliferation of modern drugs.

50. The Committee recommends that tied grants be made available by the Commonwealth, either directly or through the Australian Universities Commission, for the establishment of departments of clinical pharmacology in all Australian medical schools.

51. The Committee recommends that the Commonwealth Government give financial assistance to the Royal Australian College of General Practitioners to appoint a post-graduate fellow to assist in post-graduate teaching programmes.

52. The Committee recommends that, as a condition of Commonwealth reimbursement for prescribed drugs, it require all teaching hospitals to establish review committees of doctors for the purpose of medical audit, with particular reference to prescribing habits.

52A. The Committee recommends that the Commonwealth initiate the establishment of review committees of doctors in each locality for the purpose of medical audit, with particular reference to prescribing habits; that such committees should sit, where possible, in the presence of a post-graduate fellow of the Royal College of General Practitioners, and or a clinical pharmacologist. That the Commonwealth Department of Health provide each committee with the figures on the prescribing habits of each doctor in that locality; that each committee meet every alternate month; and that attendance at not less than three meetings per year of his or her local review committee be a pre-requisite for continued accreditation to prescribe under the National Health Act'

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Brown
Mr Hayden	Mr Buchanan
	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraph 43 agreed to.
Paragraph 44 agreed to.
Paragraph 45 amended and agreed to.
Paragraph 46 withdrawn, by leave.
Paragraph 47 amended and agreed to.
Paragraph 48 amended and agreed to.
Paragraph 49 amended and agreed to.
Paragraph 50 amended and agreed to.
Paragraph 51 withdrawn, by leave.
Paragraph 52 withdrawn, by leave.
Paragraph 53 withdrawn, by leave.
Paragraph 54 amended and agreed to.
Paragraph 55 agreed to.
Paragraph 56 amended and agreed to.
Paragraph 57 amended and agreed to.
Paragraph 58 amended and agreed to.
Paragraph 59 agreed to.
The Committee adjourned until 11.00 a.m. on Thursday, 11 May 1972.

Confirmed.

11 MAY 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

The Committee resumed its consideration of the Chairman's draft Report.
New paragraphs 30A-30C agreed to.
Paragraph 60 agreed to.
Paragraph 62 amended and agreed to.
Paragraph 63 amended and agreed to.
Paragraph 64 agreed to.
Paragraph 65 agreed to.
Paragraphs 66-67 by leave, taken together, amended and agreed to.
Paragraph 68 agreed to.

Paragraph 69 agreed to.
Paragraph 70 withdrawn, by leave.
Paragraph 71 agreed to.
Paragraph 72 amended and agreed to.
Paragraph 73 amended and agreed to.
Paragraph 74 Dr Gun moved the following amendment, by leave:

Omit the paragraph and insert the following paragraph in place thereof:

'74. The Committee also recommends that the scope of *The Prescribers' Journal* be made more comprehensive, and that it be published two-yearly as a compendium of the various drug groups, indicating all data including dosages, contra-indications, interactions with other agents, etc., and that a monthly supplement be issued also.'

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
	Mr Buchanan
	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraph 75 amended and agreed to.
Paragraph 76 withdrawn, by leave.
Paragraph 77 amended and agreed to.
Paragraph 78 agreed to.
Paragraph 79 agreed to.
Paragraph 80 amended and agreed to.
Paragraph 81 agreed to.
Paragraph 82 amended and agreed to.
Paragraph 83 agreed to.
Paragraph 84 agreed to.
Paragraph 85 Dr Gun moved the following amendment, by leave:

Omit all words after 'found that' to the end of paragraph 85, and insert the following words in place thereof, 'many drugs are prescribed in cases where their clinical efficacies are not proven'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
	Mr Buchanan
	Mr Hayden
	Mr Irwin

and so it was negatived.

Paragraph 85—*Question:* That paragraph 85 stand part of the Report.

Question—put.

The Committee divided:

Ayes	*Noes*
Mr Berinson	Dr Gun
Mr Buchanan	
Mr Hayden	
Mr Irwin	

and so it was resolved in the affirmative.

19442/72—7

Paragraph 86 Dr Gun moved the following amendment, by leave:

Omit sub-paragraph 86 (b) and insert the following sub-paragraph in place thereof:

'86. (b) that the Pharmaceutical Benefits Advisory Committee and the Drug Evaluation Committee give urgent consideration to the views of the Australian and New Zealand College of Psychiatrists on the barbiturates, with a view to de-listing and withdrawing from sale all barbiturates, except for specific cases such as epilepsy, known barbiturate addiction, for general anaesthesia, etc.'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
	Mr Buchanan
	Mr Hayden
	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraph 86 amended and agreed to.

Paragraphs 87-94 by leave, taken together and agreed to.

Paragraph 95 amended and agreed to.

Paragraph 96 amended and agreed to.

Paragraph 97 withdrawn, by leave.

New Paragraphs 97A-97D by leave, taken together. Dr Gun moved the following amendment, by leave:

That the following paragraphs be inserted following paragraph 96:

'97A. The Committee gave some attention to the problems associated with the present fee-for-service system of paying for medical services in Australia. Under this system, whereby each medical service bears its own fee, there is an in-built temptation for the doctor to over-use the system. This is undesirable in that it leads to excessive cost and it does not motivate the doctor to practise preventive medicine. On the other hand, certain pre-paid systems of health care, such as the Kaiser scheme in the U.S.A., have resulted in considerable savings in medical costs and in hospital costs. Although figures are not available on savings in drug costs, the Committee believes that the emphasis on preventive medicine would militate towards reduced drug costs and reduced drug-induced disease.

97B. Furthermore, opinions were expressed that under a fee-for-service medical system, a doctor may prescribe a drug for no reason other than that the patient desires it; the doctor may fear loss of clientele if he does not prescribe.

97C. Under the fee-for-service system, the doctor is rewarded more for a greater throughput of patients. Consequently there may be a financial inducement to prescribe a medicine rather than give counselling which though more appropriate in certain cases, is more time-consuming.

97D. The Committee therefore recommends that the present fee-for-service system be replaced as far as possible by a salaried medical service. That the Commonwealth implement this by establishing a salaried service to work in parallel with the fee-for-service system, and that the conditions of service in the salaried service be made sufficiently attractive to induce doctors to join it'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
Mr Hayden	Mr Brown
	Mr Buchanan
	Mr Irwin
	Mr Lloyd

and so it was negatived.

New paragraph 97 Dr Gun moved the following amendment, by leave:

That the following paragraph be inserted following paragraph 96:

'97. The Committee recommends that the Commonwealth give encouragement to the establishment of health centres, where the work of doctors is integrated with that of social workers, nurses, dieticians, physiotherapists and other para-medical personnel, so that alternatives to drug therapy are readily available'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Berinson	Mr Irwin
Mr Brown	Mr Lloyd
Mr Buchanan	
Dr Gun	
Mr Hayden	

and so it was resolved in the affirmative.

Paragraph 98 agreed to.

Paragraph 99 amended and agreed to.

New paragraph 99A Dr Gun moved the following amendment, by leave.

That the following paragraph be inserted following paragraph 99:

'99A. In some hospitals generic equivalent dispensing is practised, whereby the doctor prescribes either generically or by brand name; the chemist may substitute a generically equivalent drug of suitable quality unless the prescriber specifically insists on that brand. This eliminates the need for stocking excessive different brands, or excessively expensive brands where they are prescribed by a doctor merely because he does not know the generic name of a drug or where he prescribes a particular brand merely from habit'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Berinson	Mr Buchanan
Mr Brown	Mr Irwin
Dr Gun	Mr Lloyd
Mr Hayden	

and so it was resolved in the affirmative.

Paragraph 100 Dr Gun moved the following amendment, by leave:

'Omit all words after "progress" to the end of paragraph 100'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Brown	Mr Berinson
Dr Gun	Mr Buchanan
Mr Hayden	Mr Irwin
	Mr Lloyd

and so it was negatived.

Question: That the paragraph stand part of the Report.

Question—put.

The Committee divided:

Ayes	*Noes*
Mr Berinson	Dr Gun
Mr Brown	Mr Hayden
Mr Buchanan	
Mr Irwin	
Mr Lloyd	

and so it was resolved in the affirmative.

Paragraph 101 Mr Hayden moved the following amendment, by leave:

Insert the word 'and' between the words 'effectiveness' and 'It is' and omit all words after 'years' to the end of paragraph 101, insert the following words in place thereof:

'Objective measurement of these factors is well nigh impossible and conclusions on these matters necessarily subjective and giving the earlier comments on the influence of drug promotion and advertising in successfully moulding doctors' attitudes more emphasis. Accordingly many attitudes on these matters are highly questionable and only rarely, and then often by chance, based on fact'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Buchanan
Mr Hayden	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraph 101 amended and agreed to.

New paragraph 101A Dr Gun moved the following amendment, by leave:

That the following paragraph be inserted after paragraph 101:

'101A. However, the Committee was not convinced that variations in brands are significant when compared with variations in patients (e.g. the dose of antibiotics for a small female weighing 50kg is usually the same as that given a 100kg male), or in variations in the one patient at different times (how long after food, presence of bowel disorder, other therapy, etc.)'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
	Mr Brown
	Mr Buchanan
	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraphs 102-103 by leave, taken together. Dr Gun moved the following amendment, by leave:

Omit paragraphs 102 and 103 and insert the following paragraphs in place thereof:

'102. The Committee found that there are not many cases in which doctors' brand preferences can be defended on genuine grounds of quality or bio-availability.

103. The Committee recommends that studies of comparative bio-availability be carried out on the most commonly-prescribed drug groups by the Drug Evaluation Committee, co-opting the assistance of the university departments of pharmacology and pharmacy.

103A. The Committee recommends:

(a) that doctors be permitted to prescribe either generically or by brand name;

(b) that chemists be required, except under conditions set out in (c) of this paragraph, to dispense the cheapest or one of the cheapest generic equivalent drug of any prescribed brand, provided that the brand be approved for use in the Pharmaceutical Benefits Scheme.

(c) that the doctor may insist on a particular brand being dispensed by encircling the brand name on the prescription and initialling it;

(d) that in the event of medical review committees being established, attention be given to doctors' brand preferences, in order to reconcile doctors' prejudices towards or against certain brands with the known facts about those brands'

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
	Mr Brown
	Mr Buchanan
	Mr Irwin
	Mr Lloyd

and so it was negatived

Paragraph 102:

Question: That paragraph 102, as amended, stand part of the Report

Question—put.

The Committee divided·

Ayes	*Noes*
Mr Berinson	Dr Gun
Mr Buchanan	Mr Hayden
Mr Irwin	

and so it was resolved in the affirmative.

Paragraph 103 Mr Hayden moved the following amendment, by leave:

Omit all words following 'recommends that' to the end of paragraph 103, and insert the following words in place thereof: 'doctors be required to prescribe generically'

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Hayden	Mr Berinson
	Mr Buchanan
	Dr Gun
	Mr Irwin

and so it was negatived.

Question: That the paragraph, as amended, stand part of the Report.

Question—put.

The Committee divided:

Ayes	*Noes*
Mr Berinson	Mr Hayden
Mr Buchanan	
Mr Irwin	

and so it was resolved in the affirmative.

Paragraphs 104-118 by leave, taken together and withdrawn.
Paragraph 119 amended and agreed to.
Paragraph 120 agreed to.
Paragraph 121 agreed to.
Paragraph 122 agreed to.
Paragraph 123 agreed to.
Paragraph 124 amended and agreed to.

New paragraph 124A Dr Gun moved the following amendment, by leave:

That the following new paragraph be inserted following paragraph 124:

'124A. The Committee recommends that only non-lethal quantities of anti-depressant drugs be dispensed at one time. The same quantities could be prescribed as at present, the patient receiving the amount in non-lethal increments, bringing his empty container back to the chemist for refills'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
	Mr Buchanan
	Mr Hayden
	Mr Irwin

and so it was negatived.

Paragraph 125 agreed to.
Paragraph 126 withdrawn, by leave.
Paragraph 127 withdrawn, by leave.
Paragraph 128 amended and agreed to.
Paragraph 129 agreed to.
Paragraph 130 amended and agreed to.
Paragraph 131 agreed to.
Paragraph 132 agreed to.
Paragraph 133 amended and agreed to.
Paragraph 134 agreed to.
Paragraph 135 agreed to.
Paragraph 136 agreed to.
Paragraph 137 agreed to.
Paragraph 138 agreed to.
Paragraph 139 agreed to.
Paragraph 140 amended and agreed to.
Paragraph 141 agreed to.
Paragraph 142 agreed to.

Paragraph 143 Mr Hayden moved the following amendment, by leave:

Omit the words 'The relevance of British experience to' in paragraph 143 and insert at the end of this paragraph the words:

'However, this trend could be explained easily by a number of factors not immediately apparent and it is accordingly wrong to ascribe a casual relationship to what, on the face of what is presented, is nothing more than a statistical relationship'

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
Mr Hayden	Mr Buchanan
	Mr Irwin

and so it was negatived

Paragraph 143 agreed to.

Paragraphs 144-162 by leave, taken together and agreed to.

Paragraph 163 amended and agreed to.

Paragraph 164 Mr Hayden moved the following amendment, by leave:

Omit the words 'but that' in paragraph 164 and insert the following words in place thereof:

'However, this deterrent effect should not be seen as a necessary one against patients alone who are largely dependent upon and trust in the prescribing habits of doctors'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Hayden	Mr Berinson
	Mr Buchanan
	Dr Gun
	Mr Irwin

and so it was negatived.

Paragraph 164 agreed to.

The Committee adjourned until 3.00 p.m. on Tuesday, 16 May 1972.

Confirmed.

16 MAY 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

The Committee resumed its consideration of the Chairman's draft Report:

Paragraph 165 Mr Hayden moved the following amendment, by leave:

Omit all words after 'recommends that' to the end of paragraph 165 and insert the words 'there be no patient contribution' in place thereof.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Berinson	Mr Brown
Dr Gun	Mr Buchanan
Mr Hayden	Mr Irwin
	Mr Lloyd

and so it was negatived.

New sub-paragraph 165 (b) by leave, new sub-paragraph added. Dr Gun moved the following amendment, by leave:

Omit the words 'beneficiaries of the Subsidised Medical Benefits Plan' and insert the following words in place thereof, 'while the Subsidised Health Benefits Plan continues to operate, beneficiaries of that Plan'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Berinson	Mr Brown
Dr Gun	Mr Buchanan
Mr Hayden	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraph 165 (a):

Question: That paragraph 165 (a), as amended, stand part of the Report.

Question—put.

The Committee divided:

Ayes	*Noes*
Mr Berinson	Mr Brown
Mr Buchanan	Mr Hayden
Mr Irwin	
Mr Lloyd	

and so it was resolved in the affirmative.

Paragraph 165 (b) agreed to.

Paragraphs 166-172 by leave, taken together and agreed to.

New paragraph 172A Dr Gun moved the following amendment, by leave:

Insert the following new paragraph after paragraph 172:

'172A. The Committee acknowledges that primary research and development into new pharmaceutical products in Australia would require enormous sums of capital. The Committee believes that as enormous expenditure is already occurring in this field in other countries, there are greater priorities, medical and non-medical, for capital investment in Australia'

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Brown
Mr Hayden	Mr Buchanan
	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraph 173 amended and agreed to.

Paragraph 174 amended and agreed to.

Paragraph 175 amended and agreed to.

Paragraph 176 agreed to.

Paragraph 177 Dr Gun moved the following amendment, by leave:

At the end of paragraph 177 insert the words:

'It is possible that some planned market-sharing is occurring. Even if this is so however, it would not be undesirable provided that a firm control is kept over pricing policies of companies to ensure that the public gets the benefits of resulting economies of scale'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
Mr Hayden	Mr Brown
	Mr Buchanan
	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraph 178 agreed to.

Paragraph 179 agreed to.

Paragraph 180 amended and agreed to.

Paragraphs 181-187 by leave, taken together and agreed to.

Paragraph 188 amended and agreed to.

Paragraph 189 amended and agreed to.

Paragraphs 192-200 by leave, taken together and agreed to.

New paragraph 200A agreed to.

Paragraphs 201-202 withdrawn, by leave.

Paragraph 203 amended and agreed to

Paragraph 204 agreed to.

Paragraph 205 agreed to.

Paragraph 206 agreed to.

Paragraph 207 amended and agreed to.

Paragraph 208 agreed to.

Paragraph 209 amended and agreed to.

Paragraph 210 agreed to.

Paragraph 211 agreed to.

Paragraph 212 agreed to.

Paragraph 213 amended and agreed to.

Paragraph 214 amended and agreed to.

Paragraph 215 withdrawn, by leave.

Paragraphs 216-228 by leave, taken together and agreed to.

Paragraph 229 amended and agreed to.

Paragraph 230 agreed to.

Paragraph 231 Mr Berinson moved the following amendment, by leave:

> Omit all words from and including 'there is' to and including the word 'excessive', insert the following words in place thereof, 'present profits for most firms as indicated by returns to the questionnaire, are high by comparison with the Australian average but are not excessive given the special nature of the industry'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Berinson	Dr Gun
Mr Brown	Mr Hayden
Mr Buchanan	
Mr Irwin	

and so it was resolved in the affirmative.

Paragraph 231

Question: That paragraph 231, as amended, stand part of the Report.

Question—put.

The Committee divided:

Ayes	*Noes*
Mr Berinson	Dr Gun
Mr Brown	Mr Hayden
Mr Buchanan	
Mr Irwin	
Mr Lloyd	

and so it was resolved in the affirmative.

Paragraphs 232-234 by leave, taken together and agreed to.
Paragraph 236 agreed to.
Paragraph 237 amended and agreed to.
Paragraph 238 amended and agreed to.
Paragraph 239 agreed to.
Paragraph 240 agreed to.
Paragraph 241 amended and agreed to.
Paragraph 242 withdrawn, by leave.
Paragraph 243 amended and agreed to.
Paragraph 244 withdrawn, by leave.
Paragraph 245 amended and agreed to.
Paragraph 246 amended and agreed to.
Paragraph 247 amended and agreed to.
Paragraphs 248-250 by leave, taken together and agreed to.
Paragraph 251 amended and agreed to.
Paragraph 252 amended and agreed to.
Paragraph 253 agreed to.
Paragraph 254 agreed to.
Paragraph 255 amended and agreed to.
The Committee adjourned until 3.00 p.m. on Wednesday, 17 May 1972.

Confirmed.

17 MAY 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

MINUTES

The Minutes of Proceedings of 9 May 1972, were read and confirmed.

MOTION FOR PUBLICATION

Resolved: That pursuant to the power conferred by Section 2 (2.) of the *Parliamentary Papers Act* 1908-1963, this Committee authorises publication of evidence received in reply to questions asked at public hearings of this Committee.

The Committee resumed its consideration of the Chairman's draft Report.

Paragraph 256 agreed to.
Paragraph 257 amended and agreed to.
Paragraph 258 amended and agreed to.
Paragraph 259 amended and agreed to.
Paragraph 260 agreed to.
Paragraph 261 amended and agreed to.
Paragraph 262 agreed to.
Paragraph 263 agreed to.
Paragraph 264 amended and agreed to.
Paragraph 265 amended and agreed to.
Paragraph 266 amended and agreed to.
Paragraph 267 agreed to.
Paragraph 268 agreed to.
Paragraph 269 amended and agreed to.
Paragraph 270 agreed to.
Paragraph 271 amended and agreed to.
Paragraphs 272-274 by leave, taken together and agreed to.
Paragraph 275 amended and agreed to.

Paragraph 276 agreed to.
Paragraph 277 amended and agreed to.
Paragraph 278 amended and agreed to.
Paragraph 279 amended and agreed to.
Paragraph 280 amended and agreed to.
Paragraph 281 amended and agreed to.
Paragraph 282 amended and agreed to.
Paragraph 283 agreed to.
Paragraphs 284-289 by leave, taken together and agreed to.
Paragraph 290 amended and agreed to.
Paragraph 291 amended and agreed to.
Paragraph 292 amended and agreed to.
Paragraph 293 agreed to.
Paragraph 294 amended and agreed to.

Paragraph 295 Mr Hayden moved the following amendment, by leave:

Omit paragraph 295 and insert the following paragraph in place thereof:

'295. The Committee recommends that post-1964 members of Friendly Societies Dispensaries receive the same benefits as pre-1964 members.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Hayden	Mr Berinson
Mr Lloyd	Mr Brown
	Mr Buchanan
	Dr Gun
	Mr Irwin

and so it was negatived.

Paragraph 295 Dr Gun moved the following amendment, by leave:

Omit paragraph 295 and insert the following paragraph in place thereof:

'295. The Committee recommends that post-1964 members of Friendly Societies receive the same benefits as pre-1964 members and in this event other organisations should be permitted to provide similar benefits at private pharmacies'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
Mr Hayden	Mr Brown
Mr Lloyd	Mr Buchanan
	Mr Irwin

and so it was negatived.

Paragraph 295 amended and agreed to
Paragraph 296 amended and agreed to.
Paragraph 297 amended and agreed to.
Paragraph 298 amended and agreed to
Paragraph 299 amended and agreed to
Paragraph 300 withdrawn, by leave
Paragraph 301 agreed to

Paragraph 302 Dr Gun moved the following amendment, by leave:

That sub-paragraph 302 (b) be omitted and the following sub-paragraph be inserted in place thereof.

'302. (b) the Department of Health confer with manufacturers and the Guild with a view to the issuing of an instruction sheet for the patient with each dispensed item'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Berinson
	Mr Brown
	Mr Buchanan
	Mr Hayden
	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraph 302 amended and agreed to.

Paragraph 303 amended and agreed to.

Paragraphs 304-307 by leave, taken together and agreed to.

Paragraph 308 amended and agreed to.

Paragraph 309 amended and agreed to.

Paragraphs 310-312 by leave, taken together and agreed to.

Paragraph 313 amended and agreed to.

Paragraph 314 agreed to

Paragraph 315 agreed to.

Paragraphs 316-319 by leave, taken together. Mr Hayden moved the following amendment, by leave:

Omit paragraphs 316-319 and insert the following paragraphs in place thereof:

'316. Wholesale distribution of pharmaceuticals involves unnecessary and costly duplication. A more efficient system of wholesale distribution offering important cost savings which can be passed on to the community would be through regionalised activities for each wholesaler. This may involve compensation payments to wholesalers found redundant to community requirements by this change.

317. It would further appear that regionalised wholesale distribution could be even more efficiently carried out by public enterprise.

318. On the evidence presented to the Committee it is clear that manufacturers cannot give the service which a full full-line wholesale outlet can and accordingly elimination of such wholesaling outlets will add to costs and reduce efficiency in the distribution chain'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Buchanan
Mr Hayden	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraph 316 amended and agreed to.

Paragraph 317 agreed to.

Paragraph 318 amended and agreed to.

Paragraph 319 amended and agreed to.

Paragraph 320 amended and agreed to.

Paragraph 321 withdrawn, by leave.

Paragraph 322 amended and agreed to.

Paragraph 323 agreed to.

Paragraph 324 amended and agreed to.

Paragraph 325 amended and agreed to.

Paragraph 326 amended and agreed to.

Paragraph 327 amended and agreed to.

Paragraph 328 amended and agreed to.

The Committee adjourned until 2.15 p.m. on Thursday, 18 May 1972.

Confirmed.

18 MAY 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr W. G. Hayden, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

The Committee resumed its consideration of the Chairman's draft Report.

Paragraph 329 amended and agreed to.

Paragraph 330 withdrawn, by leave.

Paragraph 331 agreed to.

Paragraph 332 amended and agreed to.

Paragraph 333 Mr Hayden moved the following amendment, by leave:

That between the words 'Scheme' and 'One' in paragraph 333, the following words be inserted:

'However these savings could be available where wholesaling outlets are regionalised and even more so were the wholesale outlets to be conducted as public enterprise'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Hayden	Mr Brown
	Mr Buchanan

and so it was negatived.

Paragraph 333 amended and agreed to.

Paragraph 334 amended and agreed to.

Paragraph 335 amended and agreed to.

Paragraph 336 agreed to.

Paragraph 337 agreed to.

Paragraph 338 agreed to.

Paragraph 339 agreed to.

Paragraph 340 agreed to.

Paragraph 341 Mr Hayden moved the following amendment, by leave:

That the following words be inserted at the end of paragraph 341:

'Nonetheless the nature of competition in this area involves unnecessary and costly duplication and the Committee recommends (i) activities of full-line wholesalers should be regionalised, (ii) full-line wholesalers becoming redundant by this development be compensated, (iii) consideration be given to having the full-line regionalised wholesaling conducted as public enterprise'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Hayden	Mr Buchanan
	Mr Lloyd

and so it was negatived.

Paragraph 341 amended and agreed to.

New paragraph 341A agreed to.

Paragraphs 342-359 by leave, taken together and agreed to.

Paragraph 360 Mr Hayden moved the following amendment, by leave:

Omit paragraph 360 and insert the following paragraph in place thereof:

'The Committee found that there is a case for the listing of oral contraceptives for there are genuine medical and social reasons for their provision on the Pharmaceutical Benefits Scheme'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Mr Berinson	Mr Brown
Dr Gun	Mr Buchanan
Mr Hayden	Mr Lloyd

The number for the 'Ayes' and the 'Noes' being equal, the Chairman gave his casting vote with the 'Noes', and so it was negatived.

Paragraph 360 amended and agreed to.

Paragraph 361 Dr Gun moved the following amendment, by leave:

Omit sub-paragraph 361 (a) and insert the following sub-paragraph in place thereof:

'361. (a) The Committee recommends the listing of suitable contraceptive drugs'.

Amendment—put.

The Committee divided:

Ayes	*Noes*
Dr Gun	Mr Brown
Mr Hayden	Mr Buchanan
	Mr Irwin
	Mr Lloyd

and so it was negatived.

Paragraph 361 amended and agreed to.

Paragraphs 362-365 by leave, taken together and agreed to.

New paragraph 365A agreed to.

Paragraph 366 agreed to.

Appendices I-VIII by leave, taken together and agreed to.

Confirmed.

24 MAY 1972

Parliament House, Canberra

PRESENT: Mr A. A. Buchanan, M.P. (Chairman), Mr J. M. Berinson, M.P., Mr N. A. Brown, M.P., Dr R. T. Gun, M.P., Mr L. H. Irwin, M.P., Mr B. Lloyd, M.P.

MINUTES

Question—That the Minutes of Proceedings for:

10 May 1972
11 May 1972
16 May 1972
17 May 1972
18 May 1972

as amended be confirmed by the Committee—put.

The Committee divided:

Ayes	*Noes*
Mr Brown	Dr Gun
Mr Buchanan	
Mr Irwin	
Mr Lloyd	

and so it was resolved in the affirmative.

Resolved—That the Chairman's draft Report as amended be the report of the Committee.

Minutes of Meeting 24 May 1972 read and agreed to.

Adjourned *sine die*.

Confirmed.

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