COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Reference: Health Legislation Amendment Bill 2005; National Health Amendment (Budget Measures—Pharmaceutical Benefits Safety Net) Bill 2005

THURSDAY, 13 OCTOBER 2005

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Thursday, 13 October 2005

Members: Senator Humphries *(Chair)*, Senator Moore *(Deputy Chair)*, Senators Adams, Barnett, Fielding and Polley

Participating members: Senators Abetz, Allison, Bartlett, Mark Bishop, Boswell, Bob Brown, Carol Brown, George Campbell, Carr, Chapman, Colbeck, Coonan, Crossin, Eggleston, Chris Evans, Faulkner, Ferguson, Ferris, Forshaw, Hogg, Hurley, Joyce, Lightfoot, Ludwig, Lundy, McEwen, McGauran, McLucas, Milne, Nettle, O'Brien, Parry, Payne, Robert Ray, Siewert, Watson, Webber and Wong

Senators in attendance: Senators Adams, Allison, Fielding, Humphries, McLucas, Moore and Polley

Terms of reference for the inquiry:

National Health Amendment (Budget Measures—Pharmaceutical Benefits Safety Net) Bill 2005

WITNESSES

Committee met at 5.53 pm

O'DEA, Mr John Francis, Director, Medical Practice, Australian Medical Association

CHAIR (Senator Humphries)—Welcome. I indicate that here we have two bills to deal with. Some witnesses will be giving evidence on both bills, some on only one of those bills but, of course, questions could be asked of witnesses on the bills on which they are giving evidence. We will range across both those pieces of legislation in the course of examining witnesses.

You are reminded that evidence given to the committee is protected by parliamentary privilege and that the giving of false or misleading evidence to the committee could constitute a contempt of the parliament. We have your submission. I invite you to make an opening statement, after which we will ask you questions.

Mr O'Dea—Firstly, apologies from our president, who is in Santiago in Chile, and from our vice-president, who is doing clinical work in Grafton today. They would have liked to have been here but are unable to be. Secondly, not wishing to be in contempt of the committee, I should point out that there is an error in the last sentence of the second paragraph of our submission, 'These two measures are expected to save $307.9 million over four years.' The figure should in fact be $210.4 million. The figure of $307.9 million—which I have corrected—concerns about six budget measures in relation to the PBS and the figure of $210 million concerns these two provisions relating to the safety net threshold and the 20 days. I will make a very brief statement about the two matters. Is it okay to run the two together?

CHAIR—Sure.

Mr O'Dea—Our main point on the first one is that it is a big imposition on people who are least able to afford it. The safety net threshold for the nonconcessionals at the end of this measure is going to go up over $1,000 and for the concessionals probably over $300. You have to ask the question whether there would not be a better way to do it which would impact more generally across the board on patients or taxpayers rather than to affect those who are using a hell of a lot of pharmaceuticals. To get to 60 scripts for a concessional you have got to be quite sick. I guess that is our main point to be made there.

The department says in its submission that individual contributions as a percentage of total expenditure on the PBS has declined from 20 per cent to about 16 per cent. That is a fair point. But what has happened, obviously, is that there is a pattern of letting it decline and then suddenly ramping it up and causing a lot of hardship for people. I think the government needs to think of ways to index it in a way that is more properly understood and more regular.

The second issue is the Health Legislation Amendment Bill 2005, which came as a surprise to us. There is a mechanism in place at the moment for the government to discuss with the profession and others the Medicare Benefits Schedule and how it is kept up to date both in the description of the services and the dollars. There is a Medicare Benefits Consultative Committee, a Medical Services Advisory Committee and there is effective consultation between the department, the profession and other craft groups. There is Medicare Australia, which has extensive powers. So there is a mechanism for sorting out problems. It is an open, transparent and effective one. It takes a bit of time, but it gets a result.

We think there is value in having it that way—open and transparent. This bill is not dealing with issues like fraud or inappropriate practice; there are other provisions for dealing with those. We do not defend those things at all. What this is talking about is a few items where new ways of providing a service come into being through new technology or new medical practice or whatever it is and those new ways fit within an existing item—they are comprehended within an existing item, although they were not intended to be so comprehended when the item was created, because they did not exist. We would be happy to discuss ways to improve consultation around these issues and mechanisms for dealing with inappropriate behaviour by members of the profession. That would be the way to go rather than to rush in with a legislative solution that we have concerns about anyway. That is all I would want to say at the start.

CHAIR—Thank you, Mr O'Dea. On the question of the repeat prescriptions within 20 days of previous supply, I understand that the figures do demonstrate that there is a problem with people who qualify for the safety net stockpiling in these circumstances. There is a little blip at the end of, I think, the calendar year on which the safety net operates. There is this blip of people who realise that they are coming to the end of the safety net period and they will go and get all the repeat prescriptions they can for medicines they have because it is cheaper to do it that way than to wait until after the end of the calendar year. I think you said that you acknowledge that there was a problem there. How would you suggest that this should be dealt with?

Mr O'Dea—From our point of view the stockpiling issue should be fairly much self-correcting. If you are spending above the safety net and you stockpile this year, it is going to take you longer to get to the safety net in the following year. So I would have thought that it was fairly much self-correcting. It is a very small measure—it is $70 million over four years. In PBS terms it is tiny. It is well under one per cent and it is probably under half a per cent. You have to make a judgment. It is adding a whole lot of complexity and issues. It is going to catch innocents as well. Not every instance of wanting to fill a script within 20 days is going to be inappropriate if you are travelling or whatever. It is one way. I cannot think of a better way to deal with that problem. I suppose I am saying that it does not need to be dealt with. A better way would be to do something that increased patient copayments across the board, which would not impact on a particular small section.

CHAIR—You point out that this could inconvenience some people but I understand that there is the capacity for a doctor to write another script for a person who has a genuine need—for example, if the medicine has been destroyed, lost or stolen or something of that sort. Isn't that a reasonable precaution to ensure that people are not actually disadvantaged by a rule like this?

Mr O'Dea—I accept that if people have the foresight to see that they will need that at the time. I think that they have to ask in advance and not everyone is going to have the foresight to know that they are going to be travelling or whatever at a certain time. I do not think it is going to be entirely satisfactory. I do not think there are provisions for that to be done at the time that it happens. I think you have to predict it in advance. Then the medical practitioner can change the dosage or the duration of the script or whatever.

Senator McLUCAS—Just to finish on that earlier prescription issue, I will ask you a question, Chair, because I did not follow what you were saying. Are you suggesting that if someone lost their medication, for example, they would have to go back to their doctor and get another script rather than get the repeat filled within the 20 days? Is that what you think it is?

CHAIR—I refer to the Department of Health and Ageing's submission on page 3 where they say:

> ... Regulation 25 allows the pharmacist to dispense a prescription as an early PBS subsidised resupply (within 20 days) where there is a genuine need (ie. if the medicine has been destroyed, lost, stolen or is required without delay for the treatment of the person).

If I said the doctor, I probably was in error.

Senator McLUCAS—That is where I got confused.

CHAIR—I said the doctor. The pharmacist obviously has that power under this regulation.

Senator McLUCAS—There would be another bureaucratic layer, then, I imagine. If someone loses their medication they go to see the pharmacist. You would have to ascertain that they are in the category of a person who is about to hit the safety net. They would have to know that as the patient. It would be unlikely that they would know, I would imagine. Then they have to tell the pharmacist that they are going to be exempted from inclusion in the safety net, potentially. Or would it all happen at the other end?

CHAIR—We can ask the department but I would assume that the 20-day limit on resupply applies to everybody, whether they have hit the safety net or not.

Mr O'Dea—It does. You should ask the department but my understanding of that is that, where the pharmacist is authorised to reissue a script, that is not counted towards a safety net, so they are still penalised.

Senator McLUCAS—Yes, it is just that it is being counted towards the safety net. So it is a bureaucratic process at the safety net end—at the counting end.

CHAIR—I assume so. We will ask the department about that.

Senator McLUCAS—Do you have any evidence to support the comment that you made that it 'will cause hardship for the people in our community least able to afford it'?.

Mr O'Dea—No. The only evidence I have is that someone who is taking 60 scripts a year is probably quite sick. If they are a concessional they are probably not working. They are probably not going to be loaded with cash. Obviously not 100 per cent of people fit within that. There are people who have big assets and low incomes who can manage to get into these things but, by and large, you can make a pretty good correlation, I think, between the concession card people and low income, particularly someone who is on 60 scripts a year. That is a lot of scripts.

Senator McLUCAS—They are not well. I think it is a common sense analysis but we have also tried over time to get some real data on the level of income of that group of people. It is not collected so it is hard to ascertain.

Mr O'Dea—It is very hard to collect, I think.

Senator McLUCAS—Can I go then to the Health Legislation Amendment Bill. You have alerted the committee to your concerns about the second amendment, which inserts a new power that:

... allows the minister to make a legislative instrument determining that Medicare benefits are not payable in respect of the professional services rendered in specific circumstances.

Your submission says:

There is no problem which justifies this new power.

Do you have a view on why this new power is being contemplated by the government?

Mr O'Dea—Only on the basis of what they have indicated in their own documentation and in the explanatory memorandum, which is that there is a problem about new technology and they want to be able to put an end more quickly to some inappropriate development around new technology. I am directly involved in this activity and it is just not a problem. For a start, there are 220 million services every year in this area and you have to expect that there would be a few that are not quite right or whatever. In this situation the doctors are trying to fit the service to an item so the patient gets a benefit. It is not bad. If the department comes to us and says, 'We don't like this and we want it to stop,' we immediately contact the craft group and it stops, and then we talk about it. It really does not happen very often.

The HIC has extensive powers. If there were some recalcitrant doctor who said, 'I'm not going to stop,' Medicare Australia could stop them. If you were worried about new technology and what it might do, I would have thought the appropriate thing to do in this situation would be to come and talk to us to see how we can modify the existing procedures to fix it up, rather than rushing legislation into the parliament that has not been talked through.

Senator McLUCAS—You said it does not happen very much. Can you give us an indication of how often it does happen?

Mr O'Dea—I think that is a good question for the department. I think there are probably six or seven items in the last three or four years that I have been aware of where the department was concerned that the items had suddenly started to be used for something or concerned about the profile for some doctor around a particular operation—say, a hernia operation. They can examine the profile of items. They can see if 99 per cent of the doctors are using the profile containing 10 items and if the other one per cent are using a profile containing 12 or 13. They look at those to see what they are and whether they are appropriate. Often the profession will ring Medicare Australia or the department and tell them that they are worried about someone else using an item and whether it is right. It is not a large amount. I would say there are about six items and each one may involve a maximum of 40 or 50 doctors around Australia. As soon as we found out about it and as soon as we were asked, we fixed it. We write to the craft group and say, 'You have to stop,' and that works. Then we sit down and talk about how we can change the items. It is a reasoned process that looks at the evidence and at the wording. You have to be really careful with the wording to make sure it covers every situation. That takes some months, but we do it properly and carefully and I cannot see that there is a problem with that.

Senator ALLISON—I want to press you on some examples of what the minister might be talking about. It is quite specific, as I understand it, that these are procedures or bits of

technology that have not yet been proven to be safe, effective or cost-effective. Can you give the committee examples of some procedures that might be in that category? What bits of technology come along that might fit the category?

Mr O'Dea—Probably not with the clinical authority that you might expect, but I certainly hope not to mislead the Senate. Of course, when most of these things arise, a submission is done and it is sent to the Medical Services Advisory Committee, which is set up to examine these things for safety and efficacy. That is the way they are dealt with. But occasionally one will come up that will fit within an existing item, and I did bring a couple of examples with me. I am not sure whether me reading it out to you will work, but I will try. One example the department has given us is vertebroplasty, which is a treatment for spinal fractures. That was previously done using immobilisation techniques, calipers and so on. Now there is a way of injecting some cement into the disc itself, so it is a quite different treatment. But it is still about 'spine, treatment of fractures'. The item says:

Spine, treatment of fracture, dislocation or fracture-dislocation, without spinal cord involvement, including immobilisation by calipers ...

So it is about spine, treatment of fractures, with the possibility of involving calipers. That is the way we interpreted it. This new procedure came along that was quite a different way of handling it. It did not involve calipers, and—

Senator ALLISON—So are doctors able to use new, unproven, possibly unsafe technology—leaving aside the question of whether or not there is a rebate for it? Is there no kind of protection for patients against doctors using newfangled, untested, possibly dangerous techniques?

Mr O'Dea—It would not be used if it was dangerous. It would have been tested in some way. It has probably been tested overseas; I do not know. But this one had not been to MSAC, and that is where it has gone now. But I would be very doubtful that it was dangerous or that it was untested.

Senator ALLISON—I think it is your submission or another that suggests that there are plenty of ways in which the minister could act in the current arrangements to prevent the rebate being used for procedures that are dodgy, whether the issue is cost-effectiveness or danger to patients. Do you agree with that?

Mr O'Dea—There are plenty of ways, yes. In that case, the amendment that was needed was to cross out the words 'including immobilisation by calipers' and change them to 'with immobilisation by calipers', so it makes it clear that, in the government's view, that item can only be used when calipers are used. So that is the change, and it is not difficult. It involves sitting down and working it through in a cooperative way.

Senator ALLISON—And what is the process? It is not altogether clear to me how you establish a particular rebate for a particular procedure. What would be the process in that case, and what is the process when a new procedure comes up? Do doctors say, 'This new thing is what we want to do now, and we go through this body to get an item number and a rebate value'?

Mr O'Dea—Basically, the profession makes a submission to the government. The government and the profession have agreed on what needs to be covered in a submission. It is

all set out in a pamphlet we have that we all hand out. A submission comes in covering all those areas, such as what the treatment is, what the evidence is, safety, what the likely usage is, the proposed fee and how you justify that, compared to what else there is. You look at the other items around the procedure on the schedule. It is harder than that one; it is easier than that—that is how you can decide. It is not that hard. It is not rocket science really. But, if it is new and if there are doubts about safety and efficacy, it goes off to the experts in the Medical Services Advisory Committee to be assessed. But for a lot of things there are no doubts; it is just a minor modification.

Senator ALLISON—So that committee makes a recommendation to the minister? That recommendation is not a public document, is it? You will not know what that body has recommended to the minister—is that correct?

Mr O'Dea—Some of the MSAC documentation is public, but the MBCC—we work with the government. We reach what we think is agreement, mostly. We reach agreement and they go off and approach the minister. We do not see what they say, but we trust them when they say they are going to put it forward in a certain way.

Senator ALLISON—Does the minister always agree with the recommendations?

Mr O'Dea—I do not know whether he always agrees. I think he mostly agrees though.

Senator ALLISON—Can he revisit that at any point in time?

Mr O'Dea—It can be revisited at any point in time.

Senator ALLISON—So the wording can be changed and the value of the rebate can be changed by the minister at any point in time. Is that right?

Mr O'Dea—Yes, but the schedule comes out in November and in May. Mostly they would make the changes within that timetable—May or November. So you might have to wait six months maximum, but in the scheme of things that is not a long time.

CHAIR—Are there any other questions?

Senator FIELDING—I have a comment, and I will be following it up further. It is just a comment about those savings and the issue about cost shifting, maybe onto families, in the first section. That is a bit of a concern, so I appreciate your raising that.

Mr O'Dea—They are savings to the federal budget but they are not savings overall. It really is a cost shift to households. That is appropriate in some situations.

CHAIR—You could describe many government savings measures in the same terms, couldn't you? Someone has to pay, in a sense, don't they?

Mr O'Dea—I agree.

Senator McLUCAS—I just want to get on the record your assessment that the process of assessment through MSAC is based on clinical evidence. Is that correct?

Mr O'Dea—Yes. For new procedures or treatments where there has never before been an assessment of the safety or efficacy, it goes off to MSAC and it is absolutely rigorously assessed for safety and cost effectiveness. That process can take two or three years; it is a matter of great frustration for us sometimes. But we accept that it has to be done.

Senator McLUCAS—For the protection of patients ultimately.

Mr O'Dea—Exactly.

Senator McLUCAS—I suppose what you are saying is that, if this bill is carried, we are entering a realm where that protection of patients that is on the basis of clinical evidence is removed and where the minister could make a decision to include or delete an item from the MBS.

Mr O'Dea—No, I think his only power is to make a determination that it not be used for a certain purpose.

Senator McLUCAS—But, unless that person happens to be a doctor, he is making a decision not based on clinical evidence.

Mr O'Dea—Yes, he is not required to. The decision certainly would not have to be based on clinical evidence.

Senator ALLISON—Or go to MSAC.

Mr O'Dea—Or go to MSAC.

CHAIR—Thank you very much for your evidence, Mr O'Dea.

[6.18 pm]

BEAUMONT, Ms Marilyn, Executive Director, Women's Health Victoria

RICE, Ms Kerrilie, Policy and Research Officer, Women's Health Victoria

Evidence was taken via teleconference—

CHAIR—We are hearing evidence on both bills that are before the committee, so you should feel free to range across both bills in the course of giving evidence. We have your submissions. Would you like to make an opening statement before we ask questions about those submissions?

Ms Rice—We would like to thank the committee for the opportunity to give evidence at the inquiry today. Firstly, I would like to speak about the National Health Amendment (Budget Measures—Pharmaceutical Benefits Safety Net) Bill 2005. As a statewide women's health promotion organisation, we are concerned about maintaining equity and access to health services for all Australians, particularly for women. Our primary concern with this bill is that it will transfer some of the costs of pharmaceuticals from the shared government purse to individual Australians and their families whose health status dictates that they already spend substantial amounts of money on medication.

This bill would mean that Australians whose spending on essential medications takes them over the current threshold will have to spend even more money before they receive financial support from the government. The health status of these people already consumes considerable money, both through utilising services and in the way their health problems impact on their financial security. Evidence shows that, increasingly, out-of-pocket expenses result in the decreased use of necessary medical services. We would like to draw the committee's attention to the impact of this as outlined in the submission from the Australian Women's Health Network.

This bill would affect women disproportionately. Evidence shows that, during their reproductive years, women utilise health services more than men and, in general, women also live longer than men. Combined with the fact that women are more likely than men to utilise and to pay for health services for people they have caring responsibilities for, it is reasonable to assume that the increased inequity brought about by this bill would hit women hardest. As we outlined in our submission, we do not believe that the cost-shifting inherent in the bill will create savings for the government in the long term, and it certainly will not be in the best interests of the Australian public. This bill will only further increase health inequities across the country, and Women's Health Victoria strongly opposes it.

Within the inquiry, Women's Health Victoria is mostly concerned, however, with the Health Legislation Amendment Bill 2005, and it is this we would like to focus on now. In particular, we are primarily concerned with the second amendment to schedule 3 of the Health Insurance Act. This amendment gives the government the power to exclude any medical services from Medicare funding. Over the last few years, we have witnessed the erosion of the universality of Medicare from a health system to a health system with a safety net to a safety net. If this amendment is supported, we will have a safety net with holes, with regard to not only medical

services but also ordinary Australians. Any service the government does not agree with can be excluded from Medicare funding. An example of this could be women over 40 who wish to access IVF services.

The amendment leaves decisions about what services to fund up to the health minister. While we recognise the need to control Medicare funding for new procedures whose efficacy and safety have not yet been confirmed, the amendment allows much broader scope for limiting access to safe, medically indicated and approved procedures. This is unnecessary. Health is already highly regulated, and there are sufficient means with which to deal with such concerns.

The health minister has made his personal views about a number of health issues well known. This includes access to confidential health services for young people, access to IVF for women over 40 and access to Medicare funding for termination of pregnancy. As representatives of the community, politicians' actions should reflect the attitudes of that community. Studies have consistently shown public support for termination of pregnancy, and the most recent independent studies show that only four per cent of the population do not support a woman's rights to access these services. The current amendment on the table allows the health minister to effectively remove access for many women by removing funding, and this would be in spite of the clear views of the Australian people.

Late termination of pregnancy is already excluded from Medicare funding, and Women's Health Victoria is very concerned that this amendment would allow the health minister to defund all termination services. Withdrawal of Medicare funding for termination of pregnancy will not prevent women from having terminations but, rather, like an increasing number of health care services that were previously universal, will ensure that terminations are available only to those who can afford private health care. We strongly oppose the introduction of this amendment, as it has the potential to severely restrict access to any medical services the health minister sees fit. The threat that this poses to women's access to termination services is real and will impact negatively on all Australians and their families. We are happy to answer questions about this.

CHAIR—Thank you. We are running short of time, so there will not be very many questions from my colleagues.

Senator McLUCAS—Thank you for your submission. I think it covers the issues very well. I will go to the Health Legislation Amendment Bill. I notice that you are quite supportive of the amendment which extends the operation of ACPA to continue the negotiations on the pharmacy agreement. Essentially, that is what the first part of that bill does. You support schedule 2. You also support schedule 3, except for one part. I am getting to a technical point now. If it is possible—and I am asking for advice about parliamentary process—would you suggest to the committee that we recommend that the bill be split into those parts that you support, so that they could proceed, and the second part, which goes to the extra power that the minister is being provided?

Ms Rice—If that were possible, we would support that. It was particularly the second amendment in schedule 3 that we were concerned about. If those elements of the Health

Legislation Amendment Bill were split then we would support the forwarding of the earlier parts of it, yes.

Senator McLUCAS—If it were not possible to split those elements—and this is highly speculative and it is okay if you do not want to answer—what would you recommend the committee recommend?

Ms Beaumont—We would recommend that the committee consider withdrawing this bill completely and give it further consideration. It seems to us to be inappropriate to give such a short period of time for public consultation and only three paragraphs in the second reading speech to a significant amendment with significant impact and a very short period of time for the public even to know about it or to make submissions on it. We would suggest you withdraw the whole.

Senator McLUCAS—Thank you for such very clear advice.

CHAIR—Thank you very much for your evidence and for waiting on the line for so long.

[6.29 pm]

ROSS, Mr David, Director, Healthcare Access, Medical Industry Association of Australia

Evidence was taken via teleconference—

CHAIR—Welcome. I am sorry about the delay in getting to you. We thank you for your submission. Would you like to make an opening statement before we proceed to ask you questions?

Mr Ross—I appreciate the opportunity on behalf of the medical device suppliers and the Medical Industry Association of Australia to address the committee this evening. Our specific interest is schedule 3 of the Health Legislation Amendment Bill and the provisions addressing the perceived misuse of MBS item numbers by medical practitioners. I would like to make it clear that my association does not condone the inappropriate use of MBS item numbers and readily acknowledges the needs of patients with respect to safe and effective care.

The explanatory memorandum covering schedule 3 states, on page 11:

... some medical practitioners utilise existing MBS items for services the items were never intended to cover. This issue most commonly arises in relation to new medical technologies.

Although not stated in the memorandum, new technology frequently involves new medical devices and in particular surgically implanted prostheses. Therefore the bill has relevance to suppliers of medical devices involving new technology, which have first been approved by the Therapeutic Goods Administration, I should add. I am not aware of the extent of the problem, whether it is a significant problem and, if so, the frequency with which it has caused adverse medical events. Before supporting this amendment, I hope that the committee will review supporting evidence from the Department of Health and Ageing in this respect.

MIAA is concerned that this amendment may be seen as an alternative to delivering a process which can review new medical technology in a timely, effective and transparent manner. The Medical Services Advisory Committee, in performing its role of advising the minister on new procedures involving new medical devices, is known for its slowness and lack of transparency. In its recent report on the impacts of medical technology in Australia, the Productivity Commission noted that it is possible that the frustrations reported by participants about the MSAC process may have discouraged some parties from making applications.

I note that the AMA in their submission to this inquiry believe that appropriate mechanisms already exist for government to deal effectively with the misuse of MBS codes. We also note that the memorandum does not explain where the minister's advice is to be sourced from in exercising these new powers. For all its faults, members of MSAC and its advisory committees are sourced from expert clinical and health economics organisations. MIAA would be concerned if expert clinical advice is to be replaced by bureaucratic imperatives.

The Productivity Commission made a qualified conclusion that benefits of technological advances to the Australian community have outweighed the costs. Our preference would have been for this committee to consider improved access to appropriate advances in medical technology rather than closing off perceived loopholes in access. MIAA actively contributed

to the internal review of MSAC which commenced in August last year and we had hoped for a more positive outcome by now than what is being proposed here. Nevertheless, we remain hopeful that the government will respond positively to address outstanding issues.

Our industry has worked constructively with government in the development of the new prosthesis benefits arrangements which will take full effect at the end of this month. We would welcome consultation to develop an environment which more effectively facilitates Australians' access to new and better medical technology. I appreciate the opportunity to address the committee this evening.

CHAIR—Mr Ross, thank you very much for that. I will lead off and ask a question. You say that if there is a concern about, as you put it, code drift in the way in which doctors and others access items in the health services tables then you are prepared to talk about that through bodies such as the Medical Services Advisory Committee. Who sits on the Medical Services Advisory Committee? Are there doctors as well as organisations like your own?

Mr Ross—Unlike the Prosthesis and Devices Committee, our industry does not have representation on the MSAC. There is a consumer representative and I believe the other representatives are specialist medical and health economics people who are involved in the assessment process.

CHAIR—Did you say medical economists?

Mr Ross—Health economists. The role of MSAC is to review the cost effectiveness as well as the clinical effectiveness of procedures involving devices.

Senator MOORE—Just to get this on record—and I know you have given a verbal submission as well as a written one—until this legislation appeared last week or a couple of weeks ago—I forget the actual date—had you had any discussion with the department at any of the different meetings you attend—I know you attend a lot of meetings—that led you to believe that the particular changes could be coming on board?

Mr Ross—I was not aware of this until last Monday, so I rushed to try to get something in yesterday.

Senator ALLISON—Is it unknown for the minister to alter a rebate or withdraw a rebate from the schedule for a particular item? The reason I ask is that submissions have made the point that the minister can, in any case, do what is being proposed under this bill. Do you agree with that?

Mr Ross—I accept the AMA's position on that and I have no reason to think otherwise. I have not heard of MBS procedure numbers being withdrawn which affect our members. I would not think it is something that happens often, so it is not a concern. Like the AMA, I was not aware that there was a particular problem here.

CHAIR—Thank you very much. We are short on time this evening but you have covered the issues quite comprehensively in your submission and in your remarks tonight. Thank you very much indeed for waiting on the line for us for so long.

[6.37 pm]

ANAF, Dr Gil, Past President, National Association of Practising Psychiatrists

Evidence was taken via teleconference—

CHAIR—Welcome. Thank you for your patience in waiting to give evidence to the committee tonight. We have the submission you have provided to our inquiry, which we have numbered No. 1. Thank you very much. Would you like to make a short opening statement based on the evidence you want to put before the committee tonight?

Dr Anaf—Thank you for the invitation to talk to you. I will initially point out that my submission, as it appears on your program, does not indicate that I referred to both the issues of the PBS and the Health Legislation Amendment Bill. I am quite happy to comment, and indeed interested in commenting, on both of those issues rather than just the PBS, as indicated on the program. I will take it that the submission has been read by the committee but, in my brief opening comments, I would like to set out NAPP's comments to put the whole issue in a broader context.

As we see it, the broader context is really an escalating burden, imposed by government policy over the last decade or so, which can result only in increased rates of stress, illness and therefore costs on the community. Since the mid-nineties, government policy has actually been aimed, in my view, at altering the way psychiatry itself is practised, despite a WHO warning of increased rates of mental illness affecting the community. The aim of this policy, either intentionally or unintentionally—it is not clear which—is really to downsize the psychiatric work force and to lessen the costs by shifting care for these patients onto allied health groups. In effect, that is going to mean that psychiatry will become a profession of consultants where we the experts consult lesser paid professional to do work at a much cheaper rate. So it becomes a cost-shifting and cost-saving exercise to the detriment of patients.

The way this is actually being achieved, in practice, is by attacking the basis on which psychiatry rests—what we refer to as 'the biopsychosocial model'. So, in essence, seeing the patient in various ways, in a holistic way, is comprehensively being attacked. That, in turn, is being achieved by, on the one hand, attacking, for example, the psychotherapies which are being targeted as too costly and too labour intensive, and, on the other hand, by promoting quick-fix approaches—and there have been at least four semi-governmental reports aimed at achieving this. An example of the restrictions to psychotherapies and the attack on them is the existence of MBS item 319, which I can go into later, and various articles to support that. On the other hand, the promotion of quick-fix approaches can be found in such things as the marketing of cognitive approaches in a one-size-fits-all way, and the upskilling of GPs, which also slots into that approach.

In regard to all of that, negative outcomes as a result of these policies are quite clearly being ignored, despite having been put to governments several times. Negative outcomes include: GPs refusing to refer patients on; failed treatments being just left stalled and, more importantly for the community in the long term, declining levels of expertise as these areas become less and less attractive for people to take up in training. In conclusion, it is the overall

context—the policy direction—that we feel needs to be borne in mind when considering these particular changes.

CHAIR—Can I be clear about what you are saying to the committee? You seem to suggest that there is a combination of government policy and medical professional practice which is having the effect of squeezing practising psychiatrists out of the picture with many procedures, and that you feel this is going to be exacerbated by the passing of this bill. Have I understood your point correctly?

Dr Anaf—That is pretty much it. I think there is less and less ability to practise psychiatry as it used to be practised—for example, when I was training—in a biopsychosocial way; there is more and more regulation as to what can and cannot be done, and there are all sorts of justifications brought to bear to justify these policies, and so, in effect, patients are not getting treated. So, in essence, there is going to be more and more reliance on medication and quick-fix approaches and that, in turn, is going to drive up costs. You are going to get these kinds of amendments put up to try and curb that cost explosion, but, in fact, policy direction is promoting this problem.

CHAIR—What evidence is there that the changes in the health legislation bill are likely to be targeted at item numbers covering psychiatry?

Dr Anaf—As I said in my submission, I was quite alarmed to read at the very end the amendment to the health insurance act No. 2 because, although the justification is to rein in new technology and to be able to contain the costs of that, in fact item 319 restrictions were brought in on a government whim in 1996; that is the evidence. There is already a restriction; it was brought in on a government whim—it was justified in a way that did not stand up to later scrutiny. It was justified in terms, for example, that it would increase access to psychiatric services. In fact, we proved later—and it was acknowledged in *Hansard*—that the number of psychiatric services actually fell following this policy introduction, so the reason for its introduction never worked. So what we are concerned about is that, if it was done in 1996, and the government wants to be able to do it any time, without consultation, without any safeguards and without looking at the effective negative outcomes, in our experience trying to put the negative outcomes of item 319 restrictions to the government has singularly failed, because the government refuses to acknowledge it, discuss it or do anything to remedy it. So we would be greatly alarmed at the government having power to do that even more.

CHAIR—How have you made representations to the government?

Dr Anaf—Firstly, I was the founding president of NAPP, formed in 1996. It is a collection of concerned psychiatrists that wanted to lobby government directly. In our view, the various colleges involved were too intimidated by various governmental agencies, if I could put it like that, to represent the clinical issue bluntly. So we decided to do that off our own bat. In order to do that we put out media releases and spoke to many advisers. We still speak to governmental advisers. Most importantly, we have put in a lengthy submission based on evidence, clinical anecdotes and research to indicate that item 319 restrictions are clinically unjustifiable. They breach privacy regulations, are discriminatory and clinically do not work. They actually provide for negative outcomes for patients. As far as I know, that submission,

which I wrote, is still sitting in an in-tray somewhere in the health department. So we have made numerous representations; they have been and continue to be ignored.

CHAIR—Are you saying that the college of psychiatry would support the contention in your submission about the pressure on psychiatry through these processes?

Dr Anaf—I cannot and do not speak for the college, because our organisations are quite separate.

CHAIR—Fair enough. You have covered the issues fairly comprehensively in your submission and in your remarks tonight. On behalf of the committee I thank you for your appearance before us via teleconference today.

[6.47 pm]

CORBETT, Ms Joan Lorna, Assistant Secretary, Pharmaceutical Benefits Branch, Department of Health and Ageing

HUXTABLE, Ms Rosemary, First Assistant Secretary, Medical and Pharmaceutical Services Division, Department of Health and Ageing

ROBERTSON, Ms Samantha, Acting Assistant Secretary, Medicare Benefits Branch, Department of Health and Ageing

CHAIR—As you would know, you are not required to answer questions on the advice you may have given in the formulation of policy or to express a personal opinion on matters of policy. Thank you for your submission. Do you wish to make an opening statement about the issues raised in it?

Ms Huxtable—We have put in a lengthy submission so I do not think it is necessary for us to make an opening statement. We are certainly happy to answer any questions you might have about it or any other matter.

CHAIR—Thank you. While they are fresh in our minds I will touch on some of the issues that have been raised by the National Association of Practising Psychiatrists. Do you have a response to the issue they raised about a bias against psychiatry in the way that item numbers are formulated and administered?

Ms Huxtable—I have not reviewed their submission. I have only just flown in today and come straight to the hearing. I am certainly aware of the issue from listening in part to their evidence today. It is quite a longstanding issue and has certainly been raised with us in the past. I was not sure of the direct relevance of the matters they raised to the issues that were before us.

CHAIR—Actually, I am not sure either.

Ms Huxtable—To cut a long story short, we did not come prepared to respond to those specific issues. But if there are specific matters that you wish us to take on notice, please let us know.

CHAIR—We might put some questions on notice about that. On the pharmaceutical benefits safety net bill, the committee was looking at the question of the circumstances in which a person would be able to seek an exemption from the 20-day limit on seeking a resupply of a medicine supplied under prescription. I understand that the pharmacist has the capacity to resupply in circumstances where medicine has been destroyed, lost or stolen. Apart from the safety net application, does that occasion any extra cost to the consumer, the patient? Do they have to pay any extra for that access?

Ms Huxtable—Under the proposed arrangements?

CHAIR—Yes, under the proposed arrangements.

Ms Huxtable—Under the proposed arrangements, the proposal is that, where a supply is within the 20-day rule—and that can be done under regulation 25—if the person has not reached the safety net then that copayment would not count for the safety net threshold and if

the person has reached the safety net then they would pay the higher amount, not the reduced safety net amount.

CHAIR—So does this 20-day restriction apply to anybody who is seeking resupply of a medicine at any point irrespective of whether they qualify for the safety net or not?

Ms Huxtable—Yes, that is correct.

Ms Corbett—Except for the fact that it will only apply to a certain proportion of the listed drugs on the PBS; it will not apply to everything on the PBS. There will be a specific list and that will be subject to the advice from the Pharmaceutical Benefits Advisory Committee of drugs for which it is appropriate for us to apply this rule.

CHAIR—The AMA made the point in its evidence that people do not get any benefit from the stockpiling effect at the moment because if they rush in and get all their drugs resupplied it simply delays the point in a subsequent calendar year when they have to go back and get their next lot of medicine under that prescription. They say there is actually not any real saving under the measure. Would you have a comment on that submission?

Ms Huxtable—There are a few issues there. There is a quality use of medicines issue, where people are seeking to more quickly access medicines that have been prescribed for them and where, through home medicines review and the like—often in homes there are medicines that have been squirreled away—there is a quality use of medicines issue. We also have some data which we can table. It shows the sawtooth effect of stockpiling. We are happy to provide that.

Ms Corbett—Yes, we are happy to table these graphs so you can see them.

CHAIR—That would be helpful.

Ms Huxtable—These are probably pretty hard for you to see. The spikes on the graphs are around November and December every year. That is when you get the spiking effect.

Ms Corbett—Every year over the last 10 years we have a spike in November-December. It is not balanced out by an equal and opposite effect in January, February or March. On the contrary, what this graph shows is that there is a driver of PBS costs that relates to the point at which people achieve the safety net. If we then go a little further into the story—and I have the two-year pattern here—we see the immediate supply story looks like this. This is for the 2002-03 year. If immediate supply were just being used for those genuine cases where people have lost or had stolen or misplaced their medicine or have damaged their script, you would expect a pattern in which immediate supply would be evenly occurring over the course of the 12 months in a year. But that is not what we see in this pattern.

If you look for that year at the two graphs together, here are your PBS total script volumes—at the top—and here are your immediate-supply script volumes, and you can see there is a similar pattern. So we are convinced that there is an issue of stockpiling and that it is not evening out in the subsequent months. We do know there is a dip in the script volumes in January and February—and that is fine. We do know that some people need to get more supplies of their drugs in anticipation of January leave or travel, but there are arrangements in place for that. This stockpiling pattern is a significant issue.

Senator McLUCAS—So you do not think it is just Christmas holidays, Ms Corbett?

Ms Corbett—It is certainly bigger than that. It is a lot bigger than that.

Senator ALLISON—Does the drop-off equal the spike?

Ms Corbett—No, it does not. The spike in each year is definitely larger than that. It is not balanced by the drop-off. So we are sure there is excess supply happening at that point where people have the opportunity to get their scripts at that reduced safety net rate.

Senator POLLEY—Can you identify drugs that are being stockpiled? Can you identify the age groups, whether they are older or younger Australians, and the types of drugs? That could have other social implications. Surely, you must have some information? If you do not have it today, perhaps you can present it to us later.

Ms Corbett—We could look at the matter in relation to the drug categories. Certainly it would be possible to look at it in age groups. It is also possible to look at it in relation to concession card holders as opposed to general patients. But we do not have that analysis with us at the moment.

Senator POLLEY—Chair, if we could have that information tabled I think it would be valuable.

Ms Huxtable—We will have a look at doing some breakdowns for you.

CHAIR—What did you say was the saving you expect by virtue of that 20-day lag before resupply occurs?

Ms Corbett—It would be $70 million over four years.

CHAIR—Is there an administrative cost to the pharmacist in those circumstances? Do they have to fill in some sort of paperwork to explain why they have had to resupply?

Ms Corbett—It is a very similar process to that which is in place now. When a patient presents at a pharmacy wanting to have something issued within 20 days, the pharmacist is already obliged by the law to make an assessment of whether it is an appropriate issue of a pharmaceutical benefit. They do record now that it has been issued under an immediate supply. That is why we can gather the data that shows us those script volumes, so it is separately identified now. The difference in future will be that, in the case of these identified drugs, the pharmacist will need to advise the consumer that there will be an impact on their safety net, and we will provide them with communication material suited to that. It will be fairly seamless because the pharmacy software will indicate as they process the script what the impact will be on the consumer's safety net.

CHAIR—In your submission you make the point that the portion of the total cost of the PBS which is borne by patients through their contribution has fallen, from 20 per cent or so 15 years ago to about 16.4 per cent now. Where would that figure move to, approximately, as a result of these changes?

Ms Corbett—I do not have that calculation with me. It would be a small adjustment—$70 million out of a $6.3 billion program is fairly small. And that is $70 million over four years compared with the over $6 billion annual figure that we now have of PBS expense.

Senator McLUCAS—Chair, I think your question was going to the changed thresholds of the safety net, wasn't it, rather than to the stockpiling question?

CHAIR—Yes, but I was asking about the stockpiling. For the two measures, including the threshold, would you have the figure for the proportion of the total cost that will be borne by patients?

Ms Corbett—My recollection of the total figure is that it will be around $200 million over the four years for the two.

CHAIR—What about in terms of the proportion of the cost of the Pharmaceutical Benefits Scheme now being borne by patients as opposed to the taxpayer? Do you have a figure on that?

Ms Huxtable—We would probably have to take that on notice so as to be sure that we are giving you the correct figure, rather than trying to do the math in our heads.

Ms Corbett—I would think it would be a pretty marginal figure, but we can certainly do the calculation. I am pretty sure we do not have that figure here.

Senator McLUCAS—Ms Huxtable, you said that the PBAC will identify the list of drugs that will go onto the stockpile list, for want of a better word. On what basis will they make an assessment of what should go on the list?

Ms Corbett—They will be looking for drugs that are suitable for this measure, such as those for chronic conditions and ongoing medicines, the kinds of medicines that are normally prescribed with a month and five repeats—that is, a six-month supply—and there are some exceptions to that. There has been some initial discussion on this matter. Once the legislation is in place they can formalise and recommend a list, which would become the list of drugs to which this measure applies. We think it will be fairly straightforward. Certainly in the initial discussions the PBAC did not regard this as a controversial list. It will not apply to medicines such as morphine, or to palliative care medicines, chemotherapy medicines or section 100 medicines, but it will apply to a number of the prescription medicines for, say, lipid-lowering, blood pressure and ongoing conditions of that kind. Some of the antidepressants will certainly be there, but these are the sorts of issues that the PBAC can look through.

Senator McLUCAS—What about drugs that cannot be stopped being taken? I am thinking of prednisone.

Ms Corbett—In those cases the drug may well be suitable for this measure to apply, and it will be very important for prescribers to make sure that patients are in a position to maintain their use of the medication. But, you see, the immediate supply is not being changed in any sense from what it is now. It is only the financial incentive. If somebody is in a situation where suddenly they lose their medicines and their repeat scripts, then they will need to get a script replacement through a locum or in some way. That is a normal procedure that operates now. There will not be an additional barrier to access to medicines; there will be a different financial incentive for getting them early.

CHAIR—Can I ask about the graphs you have just referred to?

Ms Corbett—I can table them in a form more conducive to circulation, such as on A4 paper, but you are welcome to the bigger ones if that helps.

CHAIR—Thank you. Senator McLucas?

Senator McLUCAS—The worst outcome of introducing a measure such as this would be if somebody was prescribed a drug that you cannot quickly stop taking. Prednisone is an obvious one. For instance, the patient turns up within their 20 days, the safety net measure is triggered, they have to pay the full price rather than the cheaper price and, on the basis of that, the patient decides not to purchase and stops taking prednisone with significant results. That scenario could occur.

Ms Corbett—I cannot deny that that scenario could occur, but I think it is quite possible now that, if a pharmacist is not convinced that the medicine is required, there could be that disincentive. I would not have thought that this financial incentive will itself be the detriment.

Senator McLUCAS—But it is not a question of the pharmacist making a decision that early supply is not required. A pharmacist would not fail to prescribe prednisone in that circumstance, because the pharmacist knows what can happen if you do not continue to take it. But if the trigger for the patient not to purchase it was in fact the increased cost, I would be concerned that, on the basis that the cost of the medication has increased because they are not under the safety net, a patient would cease taking a medication that cannot be stopped without medical advice.

Ms Huxtable—The patient would have the choice of returning to the doctor to get a new script issued. I am sure the pharmacist would be advising the patient in that regard.

Senator McLUCAS—It is not a question of a new script being issued; in this scenario the patient still has repeats on the script. It is a question about an early supply and the increased cost to the patient at the time. Prednisone is a good example because you cannot stop it. It is a bad example because it is a generic drug now, but I am sure there are others in the same category of drugs that cannot be stopped without medical advice.

Ms Huxtable—I am not sure how much discussion there has been on this, but I am sure our submission goes to the issue of regulation 24, where a doctor can authorise that more than one repeat can be filled at the time should there be any specific need—for example, if the patient is going overseas and wants to take some of the drug with them. Those arrangements have not been changed by these measures.

Senator McLUCAS—That is not the point I am getting to. It is about the patient making a decision not to purchase because it is too expensive since they are outside the safety net due to the early supply. It would trouble me if we ended up with an outcome like that. Saving $70 million is very important, but you do not want to end up with people making poor decisions about their medications as an unintended consequence. It is hard to know how many times that would happen. It would be troublesome if it happened at all.

Ms Corbett—And whether indeed drugs in that category will be on this list in the end. Some of them may. Some of them may be excluded by the PBAC's advice from being on the list, if there are those kinds of sensitivities. The maximum financial disincentive we are talking about there is the difference between $4.60 and $28.60 at the moment, with those rates indexing each year. I am sure it is a significant amount of money—

Senator McLUCAS—For some people.

Ms Corbett—for some people in need. No doubt. But it is not as if we are asking them to pay the full cost of those medicines. They are still getting a subsidised supply under the PBS with, we hope, good support from pharmacists and their prescribers. In some of the sorts of instances you describe, casualty departments will organise a script in a hurry if that is necessary, but I hope that you are talking about a very small number of cases.

Senator ALLISON—Can I go to the Health Legislation Amendment Bill. A number of the submissions have raised questions about whether this provision would allow the minister to, for instance, deny the rebate for terminations—possibly second-trimester terminations. Is there anything in the legislation that would suggest that is not possible?

Ms Huxtable—The intention of this amendment is to allow the minister to have some flexibility and responsiveness around the introduction of new technologies. That is its genesis.

Senator ALLISON—What in the bill limits the minister's decision to new technologies?

Ms Huxtable—The wording in the bill, I think, goes to services and describing a capacity to identify what services may not be provided for Medicare purposes.

Senator ALLISON—So the answer is that there is nothing in the bill to stop that?

Ms Huxtable—The point you are making about the minister's powers in regard to specific items—these are powers that he already has. In May and November the General Medical Services Table is amended and published. At that time, there is a capacity for items to be revised, added to or removed. The purpose of this bill is really to give some flexibility in the interim periods. It was very much generated from information that we had from the Health Insurance Commission about specific cases where there was a spike in the utilisation of items that had not had much activity at all. Suddenly there was an unexplained spike in utilisation that equated to a new technology that was in the process of going through MSAC but was sneaking onto the schedule and then sneaking into practice without having that cost-effectiveness analysis concluded. So that is what has generated that.

Senator ALLISON—What mechanisms or procedures will be in place to make sure that decisions made by the minister are informed by expert advice?

Ms Huxtable—We have had some discussions with the AMA about this issue. A letter went to them prior to the legislation being introduced, identifying an intention to consult with them. We are having ongoing discussions about the sorts of processes that might be put in place to ensure that there is an opportunity for advice to be part of the decision-making process without unnecessarily slowing the process, because one of the key things we are trying to achieve here is to have that responsiveness. So there is an ongoing discussion with the AMA about that.

You would be aware that already there are processes in place that relate to that regular publication of the General Medical Services Table. We have engagement through Medicare benefits consultative committees, which include representation from the AMA and from relevant specialist colleges in regard to streams of activity that may be being looked at, at a point in time, in that broader context. The discussions we have had are around what sort of mechanism we could put in place that would give the same sort of scrutiny but have flexibility.

Senator ALLISON—And this mechanism is that the minister might talk with the AMA?

Ms Huxtable—No, I was going more to an MBCC type process, where there actually is a degree of dialogue between us, the Health Insurance Commission and the AMA around particular evidence that we may be aware of so that we can better understand what it is that we are seeing. Often it is quite hard to really work out what is going on when we see spikes in the activity of items, and that would be part of informing the minister when advice goes to the minister. Those discussions are ongoing, so we have not really concluded those as yet.

Senator ALLISON—How long would the process you describe take?

Ms Huxtable—One of the key factors here is that it needs to be a responsive and rapid process, and that has been part of our discussions.

Senator ALLISON—How long or short is rapid?

Ms Huxtable—What we are looking for is something that allows the minister to act within existing cycles, so it would need to be rapid enough to be able to fill that need.

Senator ALLISON—So would it take three months or two months?

Ms Huxtable—It would be hard to say because it would really depend on the complexity issue before us. It would really vary. There may be an instance where it is very hard to understand exactly what is going on, so we would need to do a lot more ferreting around, either through data or through consultation with the college and the AMA. There would be other instances where it would be a fairly straightforward engagement.

Senator ALLISON—How many instances of unexplained spikes in technologically driven or unsafe procedures regarding new technology have there been in, say, the last 12 months?

Ms Huxtable—I am not sure that I could answer about the specific time frame of the last 12 months, but certainly there have been recent examples. The one that is probably most widely discussed is vertebroplasty.

Senator ALLISON—That is, putting the cement into the vertebrae?

Ms Huxtable—Yes, that is right. That is one subject that has generated a lot of discussion between us and the Health Insurance Commission around the lack of flexibility in current arrangements.

Senator ALLISON—Where is that 'Spakfilla approach'—

Ms Huxtable—You have been waiting for that one, I can tell!

Senator ALLISON—Where is that in the process of the normal procedure for approving such processes?

Ms Huxtable—That has been going through the MSAC process.

Senator ALLISON—How far away is it from being resolved? When did the spike or the incidence of it first come to your attention?

Ms Huxtable—I am not sure that I can give you that level of detail.

Senator ALLISON—I think it is important because we are talking here about fairly substantial powers of the minister and we are trying to identify what the problem is. If you

cannot give us an example where the length of time is problematic between one six-month period and the next then we are not likely to be persuaded.

Ms Huxtable—I do not know when we first became aware of the vertebroplasty issue—it was in 2001, I have been told—but I know that it has been an ongoing issue and that the MSAC consideration of it has also been ongoing in that time.

Senator ALLISON—So MSAC has been considering this since 2001?

Ms Huxtable—I do not believe so. A referral is made to MSAC and there is often a process that precedes that. The referral often comes from the devices industry.

Senator ALLISON—As we understand it, the minister at the present time is able to make a change to solve the problem you describe.

Ms Huxtable—In the cycle, which I have already referred to—the opportunity every six months to review what is in the table—there is an opportunity to tighten, amend or vary items. That in itself can be a little restrictive, because we have been made aware of cases where things appear to pop up at various points in the schedule. So if there is an attempt to stop something from happening in one area then it may appear somewhere else. It is quite hard to actually get a handle on it because it is an item-driven approach, whereas here we are describing a particular service rather than a Medicare item.

Senator ALLISON—So there would have been difficulty between 2001 and the present time in stopping the rebate going to this service, if that were determined by the minister to be necessary?

Ms Huxtable—The process has been taking its course through that time. In regard to that specific example, it has taken some time for us to have discussions with the HIC and to work through what is going on in this area.

Senator ALLISON—How would the new powers make that any different? Would you not still talk with the HIC? It is hard to understand what would be different.

Ms Huxtable—It would provide a capacity to move quickly, have a discussion about it and for the minister to say, 'While MSAC is considering this, effectively, it is not to be funded under Medicare.'

Senator ALLISON—And yet no action was taken, in the one example you have given us, between 2001 and the present time to do that in the normal processes.

Ms Robertson—Essentially there is an item in the schedule which describes the service that is being performed. In this particular case, with vertebroplasty, we consulted with the Health Insurance Commission, the AMA and the profession involved. We also tracked back through policy papers, which I believe were over 10 years old, to clarify the intent of the item. In the various discussions we had with them around the item, it took quite some time to achieve resolution and to make sure we got an application going before MSAC.

CHAIR—Senator Allison, we have come to the end of the time we have allocated for this, but questions on notice are perfectly okay. Senator Moore, do you have a question?

Senator MOORE—We have to follow up on the case that Senator Allison has raised. We would really like to see a case study. You could use that one, because we all have been using

that, to show us the way the process operates. My own view at the moment is that we would be saving five months. That is way too simplistic, I know, but from the evidence that has been given that seems to be the case. If you can put that on notice, for all of us, to get, that would be very useful.

Ms Huxtable—Certainly.

Senator McLUCAS—I do not know if he was more specific than this, but the gentleman from the AMA said that he thought there were six or seven occasions in the last few years where there was a potentially inappropriate—that is not the right word, but I will use it—use of items that have been resolved. Can you go back over your documents and find out how many there have been over the last few years and what the different procedures are that may have been used for a purpose for which they were not intended? Also, could you provide an assessment of the area of concern—for example, has the use of plastic filler as opposed to cement hurt anybody in Australia? Is it something we should be concerned about in terms of safety? Is it a concern in terms of efficacy? Are we talking about doctors cheating? What is the basis of the concern—that is what I think I need to understand. Ms Huxtable, could you explain what you meant when you said to Senator Allison that we are talking about a service, not an item? I do not understand what you meant by that. Could you explain that in writing?

Ms Huxtable—Can I—

Senator ALLISON—I do not think we are allowed to continue. We are confined by the Senate.

CHAIR—You can take the question on notice. We really have to race. There is also a document that has come from the Pharmacy Guild in which they have raised a couple of issues about the potential disadvantage from the 20-day resupply arrangements. I will pass that to you and ask you to respond to those issues to give us an idea of how to assess those issues.

Committee adjourned at 7.20 pm