COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

ESTIMATES

(Budget Estimates)

MONDAY, 2 JUNE 2003

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Monday, 2 June 2003

Members: Senator Knowles *(Chair)*, Senator Allison *(Deputy Chair)*, Senators Barnett, Denman, Hutchins and Tchen

Senators in attendance: Senator Knowles *(Chair)*, Senator Allison *(Deputy Chair)*, Senators Barnett, Bishop, Carr, Collins, Crossin, Denman, Evans, Faulkner, Forshaw, Greig, Harradine, Heffernan, Humphries, Lees, Mackay, McLucas, Moore, Nettle, Tchenand Webber

Committee met at 9.06 a.m.

HEALTH AND AGEING PORTFOLIO

In Attendance

Senator Patterson, Minister for Health and Ageing

Department of Health and Ageing

Executive

Ms Jane Halton, Secretary
Mr Philip Davies, Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Professor John Mathews, Deputy Chief Medical Officer

Business Group

Mr Alan Law, Chief Operating Officer
Mr Stephen Sheehan, Chief Financial Officer
Ms Wynne Hannon, Head Legal Services
Mr Mark Gladman, Principal Legal Officer, Legal Services

Portfolio Strategies Division

Mr David Webster, First Assistant Secretary
Ms Karen Bentley, Assistant Secretary, Budget Branch
Mr Nhan Vo-Van, Assistant Secretary, Parliamentary and Portfolio Agencies Branch
Ms Shirley Browne, Director, Parliamentary and Corporate Sector Support Section
Ms Carolyn Smith, Acting Assistant Secretary, Aust-US Free Trade Agreement Health Liaison

Audit and Fraud Control

Mr Stephen Dellar, Assistant Secretary, Audit and Fraud Control

Information and Communications Division

Dr Rob Wooding, Chief Information Officer
Ms Gail Finlay, Assistant Secretary, Communication Branch
Ms Laurie Van Veen, Director, Social Marketing Unit, Communications Branch
Ms Virginia Dove, Director, Public Affairs Unit, Communication Branch

Outcome 1—Population Health and Safety

Population Health Division

Mr Ross O'Donoughue, First Assistant Secretary
Mr Greg Sam, Assistant Secretary, Communicable Diseases Branch
Ms Sarah Major, Acting Assistant Secretary, Food and Environmental Health Branch
Ms Jenny Hefford, Assistant Secretary, Drug Strategy and Health Promotion Branch
Mr Brendan Gibson, Acting Assistant Secretary, Strategic Planning Branch
Therapeutic Goods Administration
Mr Terry Slater, National Manager
Dr Leonie Hunt, Acting Principal Medical Adviser
Dr Neil Mitchell, Acting Director, Drug Safety and Evaluation Branch
Dr Brian Priestly, Director, TGA Laboratories
Mr Pio Cesarin, Director, Non-Prescription Medicines Branch
Ms Rita Maclachlan, Director, Conformity Assessment Branch
Ms Ngaire Bryan, Acting Director, Trans Tasman and Business Management Group
Ms Catherine Patterson, Director, Trans Tasman Group
Dr Fiona Cumming, Director, Office of Complementary Medicines
Dr Margaret Hartley, Director, Office of Chemical Safety; Director, National Industrial Chemicals Notification Assessment Scheme
Dr Sue Meek, Gene Technology Regulator
Ms Elizabeth Flynn, Assistant Secretary, Policy and Compliance Branch, Office of the Gene Technology Regulator
Mr Jonathan Benyei, Assistant Secretary, Evaluation Branch, Office of the Gene Technology Regulator
Ms Robyn Foster, Assistant Secretary, Trans Tasman and Business Management Group
Dr Larry Kelly, Departmental Officer, Therapeutic Goods Administration Laboratories
Mr Tony Gould, Good Manufacturing Practice Auditor, Office of Devices Blood and Tissues
Mr Noel Fraser, Good Manufacturing Practice Auditor, Office of Devices Blood and Tissues
Dr David Briggs, Departmental Officer, Non Prescription Medicines Branch
Dr Albert Farrugia, Manager, Blood and Tissues Unit, Office of Devices Blood and Tissues
Mr Stephen Howells, Section Head, Surveillance Section, Trans Tasman and Business Management Group

Portfolio Strategies Division

See Whole of Portfolio

Primary Care Division

Mr Andrew Stuart, First Assistant Secretary
Ms Rosemary Huxtable, Assistant Secretary, Policy and Evaluation Branch
Mr Rob Pegram, Principal Medical Advisor
Ms Leonie Smith, Assistant Secretary, General Practice Access Branch
Ms Sandra King, Acting Assistant Secretary, Primary Care Quality and Prevention Branch
Ms Cath Halbert, Assistant Secretary, Red Tape Taskforce

Australian Radiation Protection and Nuclear Safety Agency
Dr John Loy, Chief Executive Officer
Food Standards Australia New Zealand
Mr Graham Peachey, Chief Executive Officer
Dr Marion Healy, Chief Scientist
Ms Claire Pontin, General Manager, Strategy and Operations
Mr Gerg Roche, General Manager, Food Safety, Legal and Evaluation
Mr Peter Liehne, General Manager, Standards
Mr Kent Brown, Program Manager—Corporate
Ms Geraldine Lynch, Program Manager—Finance
Dr Chris Branson, Program Manager, Product Standards
Ms Sue Campion, Program Manager, Nutrition and Labelling
Outcome 2—Access to Medicare
Medical and Pharmaceutical Services Division
Dr David Barton, Medical Officer, Diagnostics and Technology Branch
Ms Pauline Clynes, Director, Pharmaceutical Benefits Branch
Dr Jane Cook, Medical Officer, Medicare Benefits Branch
Ms Joan Corbett, Assistant Secretary, Pharmaceutical Benefits Branch
Ms Jan Feneley, Assistant Secretary, Office of Hearing Services Branch
Dr Ruth Lopert, Director, Pharmaceutical Benefits Branch, Executive Section
Mr Ian McRae, Assistant Secretary, Medicare Benefits Branch
Mr Andrew Mitchell, Director, Pharmaceutical Benefits Branch, Pharmaceutical Evaluation Section
Mr Raino Perring, Acting Assistant Secretary, Medicare Benefits Branch
Dr John Primrose, Medical Officer, Pharmaceutical Access and Quality Branch
Mr Allan Rennie, Assistant Secretary, Pharmaceutical Access and Quality Branch
Mr Chris Sheedy, Assistant Secretary, Diagnostics and Technology Branch
Dr Bernie Towler, Director, Diagnostics and Technology Branch, Executive Section
Acute Care Division
Dr Louise Morauta, First Assistant Secretary
Mr Charles Maskell-Knight, Principal Advisor
Mr Richard Eccles, Assistant Secretary, Australian Health Care Agreements Taskforce
Mr Peter De Graaff, Assistant Secretary, Blood and Organ Donation Taskforce
Mrs Christianna Cobbold, Assistant Secretary, Blood Products Unit
Mr Alan Keith, Assistant Secretary, Hospitals Branch
Primary Care Division
See Outcome 1
Information and Communications Division
See Whole of Portfolio
Health Insurance Commission
Mr James Kelaher, Acting Managing Director
Mr Geoff Leeper, Deputy Managing Director
Ms Ellen Dunne, Acting National Manager Operations

Mr David Hancock, Manager, Pharmaceutical Benefits Scheme Branch, Program Management Division
Mr John Trabinger, Manager, Medicare Branch, Program Management Division
Mr Lou Andreatta, Manager, Medicare Reform Taskforce, Program Management Division
Dr Janet Mould, General Manager, Program Review Division
Ms Donna Daniell, Pharmaceutical Advisor, Pharmaceutical Benefits Scheme Initiatives Group, Program Review Division
Dr Brian Richards, Chief Information Officer
Ms Sharon Rose, Manager, Privacy Branch

Outcome 3—Enhanced Quality of Life for Older Australians

Ageing and Aged Care Division

Mr Nick Mersiades, First Assistant Secretary
Ms Jane Bailey, Assistant Secretary, Quality Outcomes Branch
Mr Warwick Bruen, Assistant Secretary, Community Care Branch
Ms Virginia Hart, Assistant Secretary, Policy and Evaluation Branch
Ms Lesley Podesta, Assistant Secretary, Residential Program Management Branch
Mr Mark Thomann, Assistant Secretary, Office for an Ageing Australia
Dr David Cullen, Executive Director, Aged Care Price Review Taskforce

Aged Care Standards and Accreditation Agency

Mr Mark Brandon, Chief Executive Officer
Ms Kristina Vesk, General Manager, Corporate Affairs

Outcome 4—Quality Health Care

Primary Care Division

See Outcome 1

Acute Care Division

See Outcome 2

Medical and Pharmaceutical Services Division

See Outcome 2

Health Services Improvement Division

Mr Bob Wells, First Assistant Secretary, Health Services Improvement Division
Dr Vin McLoughlin, Assistant Secretary, Health Priorities Branch
Mr Dermot Casey, Assistant Secretary, Mental Health and Suicide Prevention Branch
Mr Brett Lennon, Assistant Secretary, Workforce and Quality Branch
Ms Phillipa Lowrey, Director, Rural Health and Palliative Care Branch
Ms Jan Bennett, Assistant Secretary, Rural Health and Palliative Care Branch

CRS Australia

Dr David Graham, General Manager

Outcome 5—Rural Health Care

Health Services Improvement Division
See Outcome 4

Outcome 6—Hearing Services

Medical and Pharmaceutical Services Division
See Outcome 2

Health Insurance Commission
See Outcome 2
Outcome 7—Aboriginal and Torres Strait Islander Health
Office of Aboriginal and Torres Strait Island Health
Ms Helen Evans, First Assistant Secretary
Dr Patricia Fagan, Medical Adviser
Ms Mary McDonald, Assistant Secretary, Program Planning and Development Branch
Ms Yael Cass, Assistant Secretary, Workforce, Information and Policy Branch
Ms Helen McFarlane, Acting Assistant Secretary, Health and Community Strategies
Outcome 8—Choice through Private Health Insurance
Acute Care Division
See Outcome 2
Medibank Private
Mr George Savvides, Managing Director
Private Health Insurance Administration Council
Ms Gayle Ginnane, Chief Executive Officer
Private Health Insurance Ombudsman
Mr John Powlay, Private Health Insurance Ombudsman
Outcome 9—Health Investment
Health Services Improvement Division
See Outcome 4
Information and Communication Division
See Whole of Portfolio
Office of the National Health and Medical Research Council
Professor Alan Pettigrew, Chief Executive Officer
Dr Clive Morris, Executive Director, Council of Australian Governments Implementation Taskforce
Ms Cathy Clutton, Executive Director, Centre for Health Advice, Policy and Ethics
Ms Suzanne Northcott, Executive Director, Centre for Research Management
Mr Tony Krizan, Acting Assistant Secretary, Centre for Corporate Operations

Department of Health and Ageing

CHAIR—Good morning. I declare open this hearing of the Senate Community Affairs Legislation Committee. On 13 May 2003, the Senate referred to this committee the particulars of proposed expenditure of the year ending 30 June 2004 for the portfolios of Health and Ageing and Family and Community Services. The committee will now commence the examination of the Health and Ageing portfolio. Before commencing the outcomes, senators are advised that they do not require the Australian Institute of Health and Welfare and the Professional Services Review. There are no other areas of the portfolio for which senators do not have questions. I welcome the Minister for Health and Ageing, Senator the Hon. Kay Patterson, the departmental secretary, Ms Jane Halton, and officers of the Department of Health and Ageing. I draw to witnesses' attention the resolutions agreed to by the Senate on 25 February 1988, *Procedures to be observed by Senate Committees for the protection of witnesses*, and in particular to resolution 1(10), which states in part:

Where a witness objects to answering any question put to the witness on any ground, including the ground that the question is not relevant or that the answer may incriminate the witness, the witness shall be invited to state the ground upon which objection to answering the question is taken.

I also remind officers that a department of the Commonwealth shall not be asked to give opinions on matters of policy and should be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. Witnesses are further reminded that the evidence given to the committee is protected by parliamentary privilege. However, the giving of false or misleading evidence may constitute a contempt of the Senate. Minister, do you wish to make an opening statement?

Senator Patterson—No.

CHAIR—The committee will be working from the portfolio budget statements. I propose to call on the estimates in the following outcome order: outcomes 2, 1 and then 5 to 9, followed by outcomes 3 and 4. After the dinner break this evening, the committee wishes to commence with outcomes 6 and 7 and return to the other outcomes which may not have been completed. Before the committee commences with outcome 2 on page 95, I suggest that the committee begin with any questions on the portfolio overview on pages 7 to 20.

Ms Halton—Before we start, can I just indicate that we have a corrigendum to the PBS. I understand that committee members have actually been provided this through the secretariat. I would just like to table that officially and explain that this is, unfortunately, typographical. There is one duplicate reference and there is a reference to one review that was omitted from the PBS.

CHAIR—Thank you, Ms Halton. Yes, the committee has been provided with that corrigendum.

Ms Halton—Can I also just indicate for the record that the one officer in particular who is available to answer questions on blood is only available today. So, if there are questions on blood, it would be useful if we could get to those today.

CHAIR—One of our colleagues who is not present at the moment has some questions on that, so we will let them know.

Ms Halton—That is why I raised it.

CHAIR—Thank you. We will bring it on after lunch. Before the committee commences, are there any questions on overview pages 7 to 20?

Senator McLUCAS—With indulgence, I would prefer to do the whole of the portfolio questions towards the end of estimates.

CHAIR—If that is what the committee wants, we can do that. We can do corporate issues at the end. Let us go to questions.

Senator McLUCAS—I also welcome the minister, Ms Halton and members of the Department of Health and Ageing and thank you, on the record, for providing us with answers to questions that we submitted after last estimates. First of all, I would like to go to the so-called A Fairer Medicare package and to questions about implementation. I understand that the measure is intended to commence in November this year. Could you provide the committee with the timetable for the implementation of the measure, including activity that

the department has undertaken to this point in time and activities that will be undertaken in terms of consultation with doctor groups and various other interested parties. Can I have an understanding of that whole implementation program, please.

Mr Stuart—There are, obviously, a number of moving parts to that, including the work force measures, the safety nets and the General Practice Access Scheme. If I speak for the General Practice Access Scheme, I may need to ask colleagues to fill in on the other parts. In respect of—

Senator McLUCAS—Can I interrupt there, and I understand the point you are making: yes, it is a very comprehensive package—

Senator Patterson—I am glad that you acknowledge that.

Senator McLUCAS—Sorry, it is a very large package. Can we just go to the area around concession card holders. When will the implementation of, as it is entitled in fact sheet No. 1, 'Addressing affordability for Commonwealth concession card holders' take place?

Mr Stuart—That would be the General Practice Access Scheme. The implementation plan says November—that is, of course, dependent on the passage of legislation. Presuming the passage of legislation, there would then be letters to general practitioners seeking their interest in participating in about October, leading into the November implementation time line. Prior to that, we are undertaking a process of consultation with leading doctors groups, and also we are going to be going state by state to meet with groups of doctors more at the grassroots level to discuss implementation issues, and that is expected to start in mid-June.

Senator McLUCAS—So there are essentially two parts to the consultation?

Mr Stuart—There are higher level discussions with senior doctors groups. For example, we recently met with the General Practice Reference Group, which includes four of the very major GP representative organisations. But we are also going to be speaking to practising doctors state by state, in workshops essentially designed to obtain their input on matters of implementation.

Senator McLUCAS—Let us go to the first item you describe. You said that letters will be sent to GPs in October. What is the purpose of that letter?

Mr Stuart—The scheme is planned to be extremely simple, but the HIC needs to know whether a practice is opting in and which doctors practise at that practice.

Senator McLUCAS—So that is seeking confirmation of participation?

Mr Stuart—It is essentially seeking confirmation that the practice is going to opt in, and the identities of the doctors that practise at that location.

Senator McLUCAS—By what date do doctors have to advise you of their opting in?

Mr Stuart—It is open-ended in that, for the foreseeable future, doctors can opt in at any time after the invitations are issued. There is no closing date envisaged. General practices can continue to reflect for a while on their wish to opt in or otherwise and advise us later if they wish, but we anticipate that the invitations will begin in October, presuming the passage of legislation.

Senator McLUCAS—So it is essentially an open-ended invitation?

Mr Stuart—Yes, essentially.

Senator McLUCAS—I understand that they are meant to start on 1 November. To commence participation at that date, by what date must they have opted in?

Mr Stuart—The scheme may commence from 1 November but there is no deadline envisaged by which doctors need to opt in. The first doctors may opt in during October and begin their participation in the scheme in November, but other practices may take longer to reach their decision and may opt in at a later date.

Senator McLUCAS—That must make it hard for planning.

Mr Stuart—I do not really see why. I do not understand why that would make it difficult to plan. You might have to be clearer about the issue of difficulty.

Senator McLUCAS—I am sure we will get to that later, about the planning process.

Senator Patterson—They might decide that it is in their interests to opt in when they find out that the practice down the road has, or a new doctor may come who wants the practice to do that.

Senator McLUCAS—I am just trying to get an understanding of time lines. That is all on the letters to the GPs. You are undertaking a process of consultation with doctors organisations starting in mid-June. Do you have a timetable for that?

Mr Stuart—We have a draft timetable which is still being worked through. It takes a while to secure a place to have the meetings and to make sure that the people we would like to be available are available, so we are working through that currently. I will see where we are with that time line and will provide it later if I can. I understand that it is still in draft form and we are still working through the logistics of it.

Senator McLUCAS—You have already undertaken your meeting with the General Practice Reference Group. Is that the only meeting?

Mr Stuart—Yes, there has been a meeting.

Senator McLUCAS—And there will be subsequent meetings?

Mr Stuart—We expect that we will be meeting with that group again, yes.

Senator McLUCAS—You talked about having to speak directly to practising doctors—how will that occur?

Mr Stuart—As I have suggested, we will be undertaking workshops on implementation level issues for the general practice access program in each state capital with participants—we hope—from each of the divisions in that state, as well as others in the state from other organisations. We will be seeking their views on areas of implementation of the program.

Senator McLUCAS—Is there a time frame for those meetings?

Mr Stuart—As I have said, beginning in mid-June and going on from there until about mid-July, I believe.

Senator McLUCAS—You are not travelling to rural destinations?

Mr Stuart—We are going to be trying to get as many GPs from as many divisions as possible, including rural ones. We will be waiting to see whether such doctors can attend in places like Adelaide and Perth and Darwin, or whether we will need to go to some rural centres as well—that is still under consideration.

Senator McLUCAS—Mr Stuart, is there a document that describes the implementation plan for the GP access implementation?

Mr Stuart—The implementation plan would be something that would come after this program of dialogue. We have some issues that we would like to discuss with GPs before we have an implementation plan.

Senator McLUCAS—Maybe we are talking about a consultation plan then—the process that you are undertaking. It is a different name, but—

Mr Stuart—A consultation plan? We are calling it dialogue about implementation, but there is—as I suggested—a draft plan. But we are still working through the logistics of it.

Senator McLUCAS—It is not possible for the committee to have a copy of that draft dialogue plan?

Mr Stuart—We are still in the process both of finalising the logistics and of finalising the advice on it, so I do not believe I can make that available at this stage.

Senator McLUCAS—And there is dialogue about the implementation plan for each of the measures in the package?

Mr Stuart—In respect of some there is, but the need for dialogue differs for different parts of the package. I do not think I ought to speak for my colleagues on the dialogue issues.

Senator McLUCAS—Certainly. Going back to the letters that you will send to GPs in October, have you sent letters to GPs directly already?

Mr Stuart—The minister sent a letter to all general practitioners. I believe it was the middle of last week.

Senator McLUCAS—Could we get a copy of that letter?

Mr Stuart—Certainly. I have a copy here. I am prepared to find it now and to table it if you would like.

Senator McLUCAS—Thank you. That was sent last week, you say, Mr Stuart?

Mr Stuart—That is correct. I appear to be being defeated by my filing system, Senator, but I will find it.

Ms Halton—We will find it this morning and we will table it for you.

Senator McLUCAS—Thank you. So, Mr Stuart, there is the process of dialogue with GPs and GP doctor organisations that will be undertaken, essentially between here and October-November. What is the process that occurs after that?

Mr Stuart—Could you repeat the question?

Senator McLUCAS—We were talking about implementation and you said that there were two parts to it—I think that is what you were indicating to me—a process at the moment, that

you are entitling dialogue about implementation, and then there will be a further process that is undertaken after that. How do you describe that process?

Mr Stuart—The government has announced its policy. Within that policy, we want to keep the implementation—especially of the General Practice Access Scheme—as simple as possible for GPs. The dialogue with GPs is about issues at the implementation level that will assist in keeping it very simple for them. Once we understand those issues, we will be producing advice to the minister which will delineate the outcomes of all that discussion and then propose an implementation process and a final set of administrative arrangements.

Senator McLUCAS—When do you imagine that will happen?

Mr Stuart—In the period between July and October.

Senator McLUCAS—So there will be periodic advice to the minister—is that what you are suggesting?

Mr Stuart—There may be advice once, but it would be in the period between July, when the dialogue is completed, and October, when we expect invitations to be issued to GPs.

Senator McLUCAS—I am trying to work out when you will have completed that dialogue and have a notion of what procedural and practical recommendations you will be making to the minister.

Mr Stuart—We expect the dialogue to be finished towards the middle or end of July, depending on the logistics, and we will then be framing our advice to the minister about the implementation detail. I cannot be more precise than that.

Senator McLUCAS—Thank you. I understand—that is fine. Going now to the substance of the issue, the fact sheet that was provided on budget night talked about seven million Australians being covered by the range of cards that entitle those individuals eligible to receive free medical care from participating practices. Can you tell me the total number of people who are covered by the three types of card—the pensioner concession card, the health care card and the Commonwealth seniors card?

Mr Stuart—That would be out of the seven million figure?

Senator McLUCAS—Yes, please.

Mr Stuart—You would like it disaggregated by card?

Senator McLUCAS—Yes.

Mr Stuart—I do not have that information with me—

Ms Halton—We will get it to you.

Mr Stuart—but we will provide it later in the hearing.

Senator McLUCAS—You can provide that to us during the hearing?

Mr Stuart—Yes.

Senator McLUCAS—There is also the other question of eligibility for a card and people who actually have the card. Have you ever done any work on eligibility for and actual possession of the three types of cards?

Mr Stuart—I am sorry—have we done any work on what?

Senator McLUCAS—I understand there are a range of people who are eligible for those three cards and I am wondering whether the department has any indication of the difference between eligibility for and actual possession of the cards.

Mr Stuart—So that is the issue of take-up of cards?

Senator McLUCAS—That is correct.

Ms Halton—The issue of who is entitled to particular sorts of cards is fundamentally a Centrelink issue.

Senator McLUCAS—I understand that.

Ms Halton—We do not administer that. The thing that we as a portfolio have a better relationship with is the question of who, for example, reaches the safety net, which is an issue that we would look at with our colleagues in the Health Insurance Commission. But entitlement to particular cards is fundamentally an issue for Centrelink.

Senator McLUCAS—I understand that; however, people's take-up may change, and I thought that might be information that you would want to have.

Mr Stuart—My understanding is that pensioner concession cards and the various health care cards would be provided to those who are eligible by Centrelink, so there is no need for an application in respect of those cards. Then there are cards for which applications are required, such as the low-income card and the Commonwealth seniors card—and yes, I imagine that take-up of those cards could vary, but the department of health does not currently have information about that.

Ms Halton—The point that the colleague was just making to us was that of course in relation to concessions, people will get a concession contingent on that card. So the assumption is that there is a fair degree of take-up. In relation to the other cards, as Mr Stuart says, those are automatic entitlements. We know we have some at the margin issues with some Indigenous peoples, for example, in relation to the take-up of a Medicare card. That is something which we believe is at the margin and in this portfolio we have been trying to pursue to ensure that people are actually enrolled. But we do not think that there are significant proportions of people who are not enrolled, if that is the substance of your question.

Senator McLUCAS—Enrolled for the Medicare card—

Ms Halton—From which would flow your entitlement to a pharmaceutical concession, for example.

Senator McLUCAS—So you are saying that the number of people who are eligible for the three different types of card—and it is mainly I think the seniors card that is at issue—is not considerably different from the number of people who have actually taken up the card.

Ms Halton—That is our understanding but we can go and take some advice from the other portfolio, if you would like us to.

Senator McLUCAS—Because the net effect, if you do not know that figure, of the cost of the package could be somewhat different.

Mr Stuart—The same group of cards currently confer eligibility for the Pharmaceutical Benefits Scheme. You would have to consider whether an additional benefit under this scheme would lead to any variation. It would be very questionable whether it would, given the current link to the Pharmaceutical Benefits Scheme.

Senator McLUCAS—I would appreciate if you were able to find out what the differential is between the eligibility to a card and the actual take-up rate. If that work has been done, the committee would appreciate it.

Ms Halton—I am not sure whether anyone will actually have the answer to that. We can inquire, or I think Centrelink will be here with Family and Community Services later in the week. Fundamentally, that is not an issue for us as a portfolio. In terms of the costings of the package—which may be where the question is going and clearly that is something that was discussed with the Department of Finance in some detail—that was not a significant issue. As I say, our experience of what happens with cards is there is an issue at the margin with Indigenous people and enrolment but that is our understanding of where the issues are.

Senator McLUCAS—We might follow that up with FACTS as well. If we could get the figures of the number of people who are covered, which I think you have said you will provide—

Ms Halton—We will come back with that as soon as someone has the figure for us.

Senator McLUCAS—I would also like that information by state and territory, if you could.

Ms Halton—We might have to take that on notice. I do not know whether we will have that to hand but let us see what we can do.

Senator McLUCAS—I am also interested in the total number of people who are covered by the three different types of card by each of the RRMAs. Is that some information that you have?

Ms Halton—We would not necessarily have that. Again, that is a data arm for another portfolio. Obviously, we have Medicare information by RRMA. I will have to take advice on whether we as a portfolio have that. I suspect the answer is no, but let me take advice and we will come back and tell you in a moment. We have concessional claims as a portfolio. We do not have place of residence of person with card. That is not something our portfolio holds.

Mr Stuart—I have that information that you asked for previously—that is, the numbers of cardholders by card type. As regards pensioner concession cards, there are 3,099,843 cardholders. This is as at March 2003. In addition, there are over a million dependants listed on those cards: 1,081,700. As regards the health care cards, there are a bit over 1.6 million—1,684,507 cardholders—and there are 1,069,979 dependants on those cards. As regards the Commonwealth seniors health cards, there are 281,189 cardholders.

Senator Patterson—I am presuming, Senator McLucas, that all this information is going to be used in the Senate committee—that we will not have to go through all these figures again in the Senate hearing—

Senator McLUCAS—They are two separate processes.

Senator Patterson—because we need to economise.

Ms Halton—And just to confirm, this disaggregation of that information by state—which I think was the follow-up you asked—we do not hold as a portfolio. I would feel uncomfortable providing information from another portfolio on that issue.

Senator McLUCAS—Certainly, I just thought you may have had it in the planning process.

Ms Halton—No, we do not, I am sorry.

Senator McLUCAS—Ms Halton, you were talking about concessional claims a moment ago. That is under the PBS. Can you describe what you meant?

Ms Halton—Mr Stuart can follow this up. Basically your questions were going to the integrity of enrolment, and essentially the point that I was making was that there are already significant benefits attached to these cards—for example, the pharmaceutical concession which is attached—so as a consequence our belief is that there would not be a significant change in enrolment. The only point I was making to you is that, where we do have a concern about enrolment, it goes to Medicare card enrolment for a small group of Indigenous people. It is absolutely at the margin.

Senator McLUCAS—Do you collect information by RRMA of people making concessional claims?

Mr Stuart—I am sorry, Senator, what do you mean by concessional claims?

Senator McLUCAS—That is where I am trying to be very clear.

Ms Halton—But what do you mean by concessional claims?

Senator McLUCAS—It was the term you used, Ms Halton, that is why I am trying to understand what—

Senator Patterson—You used it for pharmaceutical benefits.

Ms Halton—No, the only point I made was in relation to pharmaceutical benefit and access to concessions under pharmaceutical benefits. We know concessional pharmaceutical scripts that are issued geographically—

Senator McLUCAS—Yes.

Ms Halton—but in terms of where those people live, for example, we cannot give you the disaggregation of that because as a portfolio we do not hold residential status by possession of concessional card.

Senator McLUCAS—That is clear, thank you. So you do not have it by state and territory, and you do not have it by RRMA. Do you have data on the total number of people—using the department's figures—that you assume to reside in each of the territories and in each of the RRMAs? Do you have information that tries to understand—I suppose the RRMA issue is more significant, but by state and territory as well?

Mr Stuart—This is population level data?

Senator McLUCAS—Yes, that is correct.

Mr Stuart—On concessional—

Senator McLUCAS—No, just population.

Ms Halton—Population estimates.

Mr Stuart—I believe that the department would obtain that from ABS data, if we were to need it. Our work in relation to this package is based on data on services provided by GPs, called 'unreferred attendances', which we are able to analyse significantly according to spatial information. The Senate committee has seen a significant amount of the data. That is essentially what our work has relied upon, because it is directly relevant to the costing of the package.

Senator McLUCAS—I understand that, but I am just trying to understand the premises, the assumptions, that underlie the planning you have done in the development of the package. In terms of getting an understanding of population by RRMA—or of concession card holders by RRMA—are you telling me that you do not have the data and that that is not the data that informed the development of the package?

Mr Stuart—That is correct.

Ms Halton—Of course, we do use population data for other purposes. For example, in the work force context we use ABS data and we can tell you exactly which series, if that is of interest you. The issue is: which parts of the package use which particular data—if you see what I am saying. I think that Mr Stuart is saying that, in relation to this part of the package, it is actual utilisation, attendances, which is relevant to the calculation; whereas on a work force basis—it clearly comes to determining where there is an area of work force shortage—we use population and doctor numbers.

Senator McLUCAS—In that context, do you break that down into RRMA numbers?

Mr Wells—Yes, we break that down to statistical local area, SLA, which is a lower break-up than RRMA.

Senator McLUCAS—So you do it by SLA and by RRMA?

Ms Halton—You can aggregate—the point being that it is a building block.

Mr Wells—You can aggregate up to RRMA.

Senator McLUCAS—Can I get that on notice?

Ms Halton—We will tell you this morning. We will find out which ABS series we use and we will come back and read that onto the record.

Senator McLUCAS—Do concession card holders use GPs services at a different rate than the rest of the population?

Mr Wells—Yes, they do, reflecting their older average age than the rest of the Australian population. Concessional patients form about one-third of the patient population but about one-half of the visits to general practitioners.

Senator McLUCAS—Do you use that as a general rule of thumb or is there some more specific formula than that?

Mr Wells—There is no specific formula. That is just a high-level description to answer your question.

Senator McLUCAS—Are you saying that concession card holders, being one-third of the population, use half of the GPs services?

Mr Wells—Yes, that is right.

Senator McLUCAS—Do those rates vary between holders of the three different types of concession card?

Mr Wells—I do not know. The information is not currently available to the department of health.

Senator McLUCAS—So you do not know how differently people use their cards in terms of attendance at a GP?

Mr Wells—Not by the different kinds of card. Obviously some individuals visit GPs very infrequently and some very often.

Senator McLUCAS—Yes, but you have already made the point that someone on a seniors card or a pensioner card would use GP services at a higher rate because of their age, essentially.

Mr Stuart—On average, it is more often.

Senator McLUCAS—But we do not know whether general health care card holders have a different rate of attendance?

Mr Stuart—We do not have that information disaggregated by the kind of card.

Senator McLUCAS—Who would collect that information?

Mr Stuart—Sorry?

Senator McLUCAS—How could you collect that information?

Mr Stuart—I believe that would be quite difficult because currently there is no requirement for concession cards to be shown to the GP, and what you are looking for is data about the utilisation of differing cards at the point of service of the GP. So I think that would be quite difficult, using currently available information.

Senator McLUCAS—Just to confirm, are you telling me that 50 per cent of GP services are currently provided to people who have one of the three concession cards?

Mr Stuart—Yes.

Senator McLUCAS—The budget fact sheet says that the value of the incentives that are going to be provided to GPs each year will be around— that is the word used—$3,500 in capital cities and at various other rates in other parts of the country. Why is it 'around' that figure? I am trying to understand how those payments will be made.

Mr Stuart—The actual payment to a general practice will depend on the volume of concessional patient visits to that practice on a monthly basis.

Senator McLUCAS—So how did the department come to the notion that in the city that will be $3,500 and in the metro area it will be at another level? I know it is because of the differential in payment, but—

Mr Stuart—That was done by looking RRMA by RRMA at the current volume of concessional patient visits to general practices in each RRMA.

Senator McLUCAS—So you have data by RRMA on the number of concessional patient attendances?

Mr Stuart—Yes, we have that.

Senator McLUCAS—Is that available to the committee?

Mr Stuart—Let me describe what it is and where it has come from, in brief. For the purposes of this package, we received a data set from the Health Insurance Commission of unreferred attendances for concessional patients, matched as well as possible to Centrelink data for concessional patients only. That did not disaggregate, as I said, by the different kinds of cards. The data set we received was aggregated to the level of the individual provider—that is, the GP—by RRMA. The estimates based on that were produced by looking at the number of services for concessional patients by each GP in the RRMA and their current billing policies in relation to those patients. That data set is the basis of the modelling but is not available for external distribution. In fact, I have a letter from the HIC to the department that mentions section 135A(4) of the National Health Act, describing the penalties that would apply to any public servant who released that data.

Senator McLUCAS—Was it a very stern warning?

Mr Stuart—Yes.

Senator McLUCAS—I can understand that, because it is identifying the doctor.

Mr Stuart—It is identifying individual GPs, some of whom have very low service volumes—in particular, RRMAs—and potentially also identifying the concessional patient.

Senator McLUCAS—So did the department aggregate that information from GP by GP into the number of concessional attendances by RRMA across the nation?

Mr Stuart—Yes.

Senator McLUCAS—Is that information available to the committee?

Mr Stuart—It is available at a level of aggregation, and I do have a table here of that information, which I am prepared to table.

Senator McLUCAS—So that is a table of concessional attendances by RRMA nationally—is that correct?

Mr Stuart—That is correct.

Senator McLUCAS—That would be very useful.

Mr Stuart—It is a table dividing those figures into metropolitan and rural areas, so it shows RRMA 1 and RRMA 2 together and RRMAs 3 to 7 together for 2001 and 2002 for concessional services. This table shows the bulk-billing rate for those clients.

Senator McLUCAS—The bulk-billing rate for concession card holders?

Mr Stuart—That is correct.

Senator McLUCAS—You have got RRMA 1 and RRMA 2 together, but you cannot break it into RRMAs 3 to 5 and RRMAs 6 and 7. Is that because of the differential use of those three areas in the package?

Mr Stuart—That would be possible; I do not have it with me today.

Senator McLUCAS—Could we have the one where you have RRMA 1 separated from RRMA 2 and the rest broken into RRMAs 3 to 5 and RRMAs 6 and 7? I dare say you have done that work anyway.

Mr Stuart—It is potentially available. I need to take that on notice. We may be able to come back with it later today or tomorrow; I will need to investigate that.

Senator McLUCAS—Thank you.

Ms Halton—We will table this table in the interim.

Senator McLUCAS—Mr Stuart, the HIC collects data by individual GPs. Do you then aggregate that into data by practices?

Mr Stuart—Can I backtrack for a moment.

Senator McLUCAS—Certainly.

Mr Stuart—I believe I said the HIC matched the data to concessional status. I am advised that the department did that matching process within the department based on data obtained from the HIC and Centrelink.

Senator McLUCAS—So the department did that work. Can you aggregate by practice information rather than by GP?

Mr Stuart—No, that is very difficult technically.

Senator McLUCAS—Yes, I can imagine it would be.

Mr Stuart—And quite a lot assumptions need to be made—

Senator McLUCAS—People working in ranges of practices and so on.

Mr Stuart—HIC data is at the level of the provider, which is the individual GP.

Senator McLUCAS—Thank you for that table. I will peruse it at a later point. Let us go from that information to the question about how the incentive payments will be made to the doctors. You have got those figures, which are the number of concessional attendances, but how did you then use the information that you have just handed up to a point where you could come to around $3,500 for a metro GP and $22,050 for a RRMA 6 or 7 GP? Can you walk us through that process?

Mr Stuart—GPs have existing billing patterns, so the department was looking GP by GP at their billing patterns for concessional patients. It was looking, for example, at whether they bulk-bill some or all of their concessional patients and at the level of the gap that they charge currently, where they do charge a gap. The department then estimated the amount of incentive which would be required so that the great majority of GPs would be better off from accepting

the incentive compared with the amount that they are currently earning from charging gaps for concessional patients.

Senator McLUCAS—So you estimated the incentive that would be required; you worked backwards from the point where the doctor would change practice to find out the amount per visitation that would be required to provide that incentive?

Mr Stuart—I am not sure; I do not think I have completely understood you.

Senator McLUCAS—I am trying to repeat to you what I think you have said to me. Are you telling me that the department estimated the quantum, the total, incentive that the GP would require in order to change their behaviour in treating concessional patients?

Mr Stuart—Yes. We are looking at what they are earning now from concessional patients and estimating what would be required to provide a positive financial incentive for the great majority of them to change their billing practices.

Senator McLUCAS—How did you make that estimation? What are the principles by which you decided that $3½ thousand was the appropriate figure for a city based GP and $2,200 for a rural based GP?

Mr Stuart—The $3½ thousand was an average based across all GPs in that RRMA—$3½ thousand is just where the average came out in what is required to provide funding, presuming GPs are going to behave on the basis of financial benefit—for them to change their billing to bulk-billing all concessional patients.

Ms Halton—It is important to understand that it is not the aggregate figure that was offered; it is basically a per service visit figure.

Senator McLUCAS—That is the point I am trying to get to.

Ms Halton—Exactly. The per service amount aggregates, on average, in metropolitan regions to about $3½ thousand. There is no point in saying to doctors that they will get exactly $3½ thousand or they will get upset if it is, for example, $3,499, and hence the use of the word 'about'. Essentially, what Mr Stuart is trying to say is that you work out what will be sufficient incentive for the vast majority, as he said, and that is the level at which the incentive was pitched. When you then work back and say, 'If you put in an incentive of this amount, what does that work out to be on average?' it ends up being, on average, about $3½ thousand, recognising that there is a distribution around the $3½ thousand based on what it is you are currently doing.

Senator McLUCAS—It is the order that I am trying to ascertain: whether or not you made a decision that it was going to be a per patient payment that would lead you to $3½ thousand or whether you decided that $3½ thousand was the appropriate incentive and then you divided that by the average number of concessional attendees at a metro practice. Can you explain that to me. Which way did it work?

Mr Stuart—In the model we began with the individual practitioner and aggregated up to $3½ thousand and then worked back to the per service to a dollar.

Senator McLUCAS—You identified the incentive and then you worked back from there?

Mr Stuart—Yes.

Ms Halton—It is a bit circular, in a sense.

Senator McLUCAS—When offering an incentive, why is $3½ thousand an appropriate amount for a metropolitan practice to change its behaviour?

Ms Halton—We need to go back to the fact that $3,500 is the average. Essentially, as Mr Stuart says, it is a question of working out what would be a sufficient financial incentive for the vast majority of doctors to change their behaviour to opt in. Essentially, the figure varies across individual practices, because of course their behaviour varies, the number of concession card holders they see et cetera. Behaviours—and you will see from that table I think—in metropolitan areas are different to those in regional areas, and therefore the incentive that is required is different. The per service amount, which on average gives you the $3½ thousand, is what is financially necessary in metropolitan regions because behaviour is different. In rural and remote regions, the figure by definition is different. It is a sort of rather large financial mathematical algorithm, if I can describe it to you in that way.

Senator McLUCAS—That is what I am trying to understand. What is the rationale behind coming to that figure of $3½ thousand for a metropolitan doctor and what is the rationale behind $22,050 for someone who works in RRMAs 6 and 7?

Mr Stuart—Essentially, it is a model with substantial departmental financial analysis underlying it to look at what financial incentive is necessary for the great majority of doctors to be financially better off. So we are looking doctor by doctor at what is required for them to be better off from joining the package and setting the rate accordingly by RRMA.

Ms Halton—If you go to that table that we just tabled, if it is not too elliptical, you will see that metropolitan areas estimated bulk-billing rates for unreferred services provided to concessional patients—I bet that would have a hell of an acronym, if we tried—is 85.8 but if you look at rural areas it is 65.33. In other words, the attendances with a gap in metropolitan areas are lower, because we know the bulk-billing rates are still higher for concessional patients and for others in metropolitan areas; therefore, the financial incentive for that group by definition needs to be lower than it is in rural areas where we currently have a rate of 67.3.

Senator McLUCAS—The next part of the question, though, is: how did you get to a figure—let us use 6 and 7—of $22,050 as being the appropriate incentive that would change that doctor's billing behaviour to concessional card holders?

Ms Halton—As I think Mr Stuart indicated, we looked at gap charging—in other words, what actually is being charged to concessional patients. Can I do this in my head? So, of the 32.7 per cent of attendances in rural areas that are not bulk-billed to concessional patients, what amount of money is actually being charged to those concessional patients when they have an attendance? You say to yourself, 'If that's the amount that the doctor is earning from those attendances, what financial incentive do I need to provide to actually make it worth their while to change that practice?'

Senator McLUCAS—Yes.

Senator CHRIS EVANS—So you are looking to substitute what is left from the gap with what you are going to pay in additional subsidy.

Ms Halton—We have indicated that the vast majority of doctors would be better off. Some people already have practices where you could not hope to have a sufficient incentive—they charge a very large price, for whatever reason—but, essentially, this is calculated to make the vast majority of doctors better off under the incentives.

Senator McLUCAS—Mr Stuart talked about the formula and modelling that occurred. Did you test that prior to coming to the decision about the level of incentive?

Ms Halton—It is a matter of public record that the minister and the Prime Minister had a couple of conversations with members of the medical profession in relation to some of the details of the proposal.

Senator CHRIS EVANS—So you worked out the gap, say, that a rural GP was charging on top, cutting out I presume the highs and the lows of those who were charging a lot extra but looking at the average, and then said that they would need, on average, $20,000 worth of income to replace that gap on what—100 per cent of their patients or 90 per cent of their patients?

Mr Stuart—Not on average.

Senator CHRIS EVANS—Or did you take a target bulk-bill rate?

Mr Stuart—I think it would be wrong to affirm that question in terms of the average, but your basic description of the dynamics of it is correct—looking at the gaps currently being charged by GPs RRMA by RRMA and working out what incentive is necessary to pay to the GP such that they will change their billing practice. In terms of the incentives that have been set, some doctors will be neutral in terms of being better off, some will have a modest gain and those who are currently bulk-billing all of their patients and receive the incentive in respect of all of those patients will be substantially better off.

Senator CHRIS EVANS—Did you have a target, though, when setting that rate as to what you thought the bulk-billing could be brought back to with those incentives? Clearly, as you said, you had decided that for those who had a huge gap you were not trying to meet their gap. You accept that they are running a practice and managing to charge a rate that you say you cannot afford to buy them out of. Did you, therefore, set a target number of GPs or a target rate of bulk-billing that this was supposed to achieve?

Ms Halton—No, we did not. Essentially, as Mr Stuart indicated, the incentives are calculated to ensure that the vast majority of doctors are better off. As you know, there are other elements to this package: for example, in outer metropolitan areas there are practice nurses—I could go on. We did not set a target as part of this process, but what we did do was set the incentives sufficient that the vast majority of doctors would be better off. You would understand well that there are a number of things at play here, one of which significantly is the financial side, another of which is what your colleagues are doing in terms of competition between doctors and the other things are the other incentives on offer as part of this package. As Mr Stuart says, the key determinant for us in setting incentives where they were—and clearly this was a decision of government, so we did not set them—was to ensure that the vast majority of doctors were better off. But we did not set a target.

Senator CHRIS EVANS—You certainly did not set a target for the number of consultations that then might be bulk-billed as a result, but you did not set a target as to the number of doctors in your target group who you thought would be better off?

Ms Halton—We know that the vast majority of doctors will be better off.

Senator CHRIS EVANS—'Vast majority' is a fairly loose term.

Ms Halton—I think we have said on the record that it is about three-quarters.

Mr Stuart—That would be RRMA by RRMA.

Senator CHRIS EVANS—So you used the figure that 75 per cent of doctors would better off as a guide when setting those rates?

Ms Halton—Yes. It is about three-quarters—there are a number of things at play here.

Senator CHRIS EVANS—Yes, I think I understand that.

Senator McLUCAS—I would like to go to the question of how many doctors are going to be better off. I understand that the figure that 85 per cent of practices will be better off has been used.

Mr Stuart—Based on the latest information that we have, the 2002 data, our estimate is that it is in the financial interests of around three-quarters of GPs in each RRMA to take up the package.

Senator CHRIS EVANS—Whether they act according to those financial incentives you leave to them.

Ms Halton—It is a free country.

Mr Stuart—Doctors make their own decisions.

Senator McLUCAS—So you are working on a figure that 75 per cent—

Ms Halton—Around.

Senator McLUCAS—of practices will opt in?

Mr Stuart—The incentives have been set sufficiently so that around three-quarters will find it in their financial interests to do so. But, as the secretary has pointed out, there is not a target for that take-up.

Senator McLUCAS—So 75 per cent taking up the option is the figure that you have used in calculating the $386 million over four years? Is that how, essentially, you have come to that figure, in the broad?

Ms Halton—Yes, I am advised.

Senator McLUCAS—I have not got the reference for this the moment, but there has been a figure used that 85 per cent of practices will be better off under the package.

Ms Halton—I am not aware of that figure. The reality is, as I indicated, there are a number of things here which would go to advantages to practices—for example, the practice nurse initiative. You may find that there has been some aggregation in people's minds of all of those benefits. Certainly when we have been talking about this we have been talking about the financial side of this being that about three-quarters of doctors would be better off. As I have

indicated to you, there are other benefits that flow. So I cannot comment on where that has come from.

Senator McLUCAS—I might have to come back to that. How many practices is it assumed will become participating practices in 2003-04?

Mr Stuart—There are assumptions underlying the year by year financial allocation. Essentially, the financial allocation has been made sufficient so that if doctors who are financially better off are attracted to the package and all take it up at a significant rate there will be sufficient funds to do so. There are assumptions underlying that take-up rate, year by year, to produce the financial annual costing. But I do not have that with me currently. We will look for it during the day.

Senator McLUCAS—We might come back to the take-up rate questions. Is that okay?

Ms Halton—Yes. We will see if we can get that for you.

Senator McLUCAS—I am looking for the take-up rate for 2003-04 and then in the out years. Is it possible to look at the number of practices and also the number of doctors? Going to your earlier point about doctors and practices, I do not know how, from the number of doctors, you work out how many practices there are.

Ms Halton—Can we take that one on notice? The incentives are actually structured around practices, and I would not want to give you an answer to this on the fly. We might come back on notice for one, if that is all right.

Senator McLUCAS—If you could get that data today, that would be terrific.

Ms Halton—We will see what we can get.

Senator McLUCAS—Good. You would also have done some work to estimate the take-up—

Ms Halton—Hang on a second. As it transpires, someone did have that.

Mr Stuart—The financial assumption of $3,500 was per individual GP, so going from individual provider to practice would depend on how many GPs there were in the practice.

Senator McLUCAS—So it is simple multiplication? Is that what you are saying?

Mr Stuart—To go from estimating per GP to estimating per practice, that is correct.

Ms Halton—Except, of course, that doctors work different amounts—some are part-time, some are full-time.

Senator McLUCAS—I understand that.

Mr Stuart—This is in terms of $3,500 being for a full-time equivalent, average GP.

Senator McLUCAS—You would also have that information by RRMA, I dare say?

Mr Stuart—Which information?

Senator McLUCAS—The information about the number of practices. Probably it is better to go to GPs by RRMA that you are expecting to take up the option.

Mr Stuart—We can do providers—that is, GPs—by RRMA.

Senator McLUCAS—Yes, that would be terrific.

Mr Stuart—Are you seeking the number of GPs by RRMA or full-time equivalent GPs by RRMA?

Senator McLUCAS—The full-time equivalent number would be better, but, if there is a possibility, I would like to have both—I remember Mr Wells offering that once.

Mr Stuart—We can do a head count of providers that provide some unreferred attendances. But the numbers are very large, because there are a large number of low-volume providers, so full-time workload equivalent is the measure that we prefer.

Senator McLUCAS—It is probably more instructive or informative to go with full-time equivalents—is that what you are saying?

Mr Stuart—The full-time workload equivalent is more helpful. We will be able to provide that by RRMA later in the day.

Senator LEES—What do you consider to be a full-time equivalent—how many hours a week is that doctor working?

Mr Stuart—I can help you there. I think it would be simplest if I just read this into the record—

Ms Halton—It is a technical explanation.

Mr Stuart—Then I can try and give a plain English version of it: 'Full-time workload equivalent is calculated by dividing each doctor's Medicare billing by the average billing of all full-time doctors for the reference period. Where the doctor's Medicare billing is greater than or equal to the mean billing a full-time doctors'—

Senator LEES—But what is a full-time doctor? What you dividing by—40 hours a week?

Mr Stuart—The basic methodology is to find out what the average billing for a GP is. We call the average the full-time equivalent.

Senator LEES—Even though some doctors are working one day week and some might be working seven days a week?

Mr Stuart—We are not using the amount of time worked—we are using the amount of billing.

Senator LEES—The number of patients that are seen? How many patients do you expect a doctor to see in a day if they are working full-time?

Mr Stuart—We do not have a figure for how many patients. We use the billing value of Medicare for this construct. Essentially, it is a helpful statistical approach to trying to work out what an average doctor does and, from there, working towards a full-time workload equivalent—doctors billing very small amounts would form a part of that amount. I am doing my best to explain it in plain English.

Senator LEES—So what is the billing rate that a full-time equivalent doctor is allocated per day or per week?

Mr Stuart—This is post-hoc analysis of existing data.

Ms Halton—Our view would be that someone who bills about 6,500 services a year is probably about full-time, if that helps. One of the reasons why we have these incredibly convoluted technical statistical descriptions of full-time workload equivalent is basically because there are as many different approaches to being a general practitioner as there probably are general practitioners. But we would think that someone who bills about 6,500 services a year would be about full-time. That is our rule of thumb. But, as soon as you get into any kind of calculation, then you have to have a statistical description of these things, which is what I think Mr Stuart is going to here with these definitions. If we publish figures, we have to have all of these underlying assumptions.

Senator LEES—I will not disturb Senator McLucas's questioning for now, but my interest is in the acknowledgement that we are short of GPs and that it is not just a problem with where they are, hence the plan that you have for additional medical training places and the effort to put them into places of real need. I would just like to know what has changed over the last year or so, although it seems more like five or six years since we had a major issue. Has this system that you are explaining now changed recently?

Mr Stuart—There are two answers to that. One is that we provided you—I believe at the February hearing—with updated data on numbers of rural doctors and full-time workload equivalents for rural doctors—

Senator LEES—I am not interested in rural; I am looking at the bigger picture generally.

Ms Halton—We could have a lengthy discussion about work force but Mr Wells is probably the appropriate officer to answer those questions.

Senator LEES—Okay, I will raise them later on.

Ms Halton—Essentially, work force is something that we have been investing a lot of time and energy in. It is one of those areas where everyone has got an opinion—and, more than an opinion, they have all got an anecdote. There is a real challenge in getting a bit of science into this area. So that is where we have these more detailed technical descriptions of what constitutes workload as against our rule of thumb—if I can describe it in that way—that, with about 6,500 attendances, this is about a full-time GP.

Senator LEES—I have one last question before Senator McLucas continues. When you talk about 6,500, does that include people who appear at the doctor's surgery and basically refer themselves—

Ms Halton—It is attendance.

Senator LEES—So it does not matter whether they are in a screening program or—

Ms Halton—Again, this is one of our problems—and you will understand it well—in that doctors' practices change. Sometimes they will go off and do a clinic somewhere, sometimes they will be in a surgery and sometimes they will be doing an education session. To define what actually constitutes a full-time GP is really hard based on the data that we have.

Senator McLUCAS—I have another definition question. In the fact sheet there is a reference to the average number of patients with a concession card. Going to this issue about what is the average GP, do you have an indication of what that number is?

Mr Stuart—Per GP?

Senator McLUCAS—The document, fact sheet No. 1, states that 'for a full-time equivalent GP seeing an average number of patients with a concession card, the value of the incentive will be'—and it goes on. What is the average number of patients with a concession card?

Mr Stuart—I believe I can help you there. At a dollar a visit for an urban GP, we have estimated that they would see on average in a year 3,500 concessional patients.

Senator McLUCAS—So that is more than half of their practice.

Ms Halton—It is attendances.

Mr Stuart—It is around half of their attendances.

Ms Halton—And you may remember that Mr Stuart told you before that about half of attendances were from concessional patients.

Senator McLUCAS—So 6,500 is the average number of attendances—3,500 in a metro area. Do they vary across the full grouping?

Mr Stuart—Does what vary?

Senator McLUCAS—The average number of concession card patients.

Mr Stuart—That would vary regionally, depending on where concession card holders live. But I am not sure how it varies RRMA by RRMA. It certainly varies suburb by suburb.

Senator McLUCAS—You seem to be reading from a document that says that 3,500—

Mr Stuart—It is the fact sheet.

Senator McLUCAS—So 3,500 in RRMA 1 and 3,500 in RRMA 7 as well. Is that what we can imagine is the basis?

Mr Stuart—I can suggest how we could easily calculate it from fact sheet 1. For RRMAs 3 and 4, for example, it is $18,500 in rural centres divided by the average sum for that RRMA—which is $5.30, from memory. That would give you the average concessional visits that we have estimated for that RRMA.

Senator McLUCAS—That is the proportion of patients at a practice in each of the different RRMAs?

Mr Stuart—Not the proportion but the average number.

Ms Halton—Remembering that there is statistical variation across individual practitioners.

Senator McLUCAS—Thank you. Do you have the maps of the different RRMA areas? We are interested in getting an understanding of where the outer limits of the boundaries are described. I know there are maps on the web site but I find them hard to read, to be frank.

Mr Stuart—RRMAs vary quite a lot. A town in a rural area might be a RRMA 2 or a RRMA 3, but the surrounding area might be something else.

Senator McLUCAS—That is correct.

Mr Stuart—So we would need a lot of quite detailed maps.

Senator McLUCAS—You do not work from a GIS based system?

Ms Halton—We do not own detailed maps. We have all the descriptions of where the boundaries lie but, because we are not an agency that maps, we tend to rely on other agencies for whom it is their core business. We do not generate our own maps but we do, for example, put on our web site broad indications of where they lie. Then we have the specific descriptions and we rely on other agencies for whom that is core business, but we do not duplicate what other agencies do.

Senator McLUCAS—Is the data on the web site—the descriptions provided there—the totality of the data you use?

Mr Stuart—We have a reference table that maps postcode to runner. That has been the basis of our work for this budget estimation.

Senator McLUCAS—Is that available to the committee?

Mr Stuart—A table of postcode by RRMA?

Senator McLUCAS—Yes.

Mr Stuart—It is a very large table, Senator, but it is factual information and is available.

Ms Halton—It is not a table, Senator; it is half a tree.

Senator McLUCAS—Is it on the web site?

Ms Halton—We can provide it. It is not on the Web.

Senator McLUCAS—If it could be provided electronically, that would be very useful.

Senator FORSHAW—How often are the boundaries of RRMA areas reviewed to determine, for instance, whether or not they are still accurate?

Ms Halton—RRMA is a system which was originally developed by the industry science portfolio and which the Department of Health and Ageing has taken advantage of over a period of time. A number of our programs are linked to the RRMA system. Sorry, Senator, what was the question?

Senator FORSHAW—This may not be the appropriate time and I do not want to interrupt Senator McLucas's flow of questions, but if a particular town believes that it is inappropriately classified under RRMA, what are they able to do about it, particularly if there have been some changes in the data on which the original decision was made to place a town in a particular RRMA grading or area status?

Mr Stuart—The RRMA system is a construct based on data. Like all constructs, it is about regions, subject to people arguing that it is wrong in their particular case. It is difficult to change once it is embedded in a set of arrangements and costings, but circumstances do change, and the RRMA system might be something that we need to have a look at from time to time.

Senator FORSHAW—Let me take you to a specific example, which the minister should be aware of. The town of Nimbin in New South Wales is currently classified as RRMA 3 because it is part of what is called Lismore SLA or statistical local area. Are you aware of this particular case?

Mr Stuart—I am prepared to accept your advice on that, Senator.

Senator FORSHAW—Is there anyone here who can answer some questions about this at the moment? I can come back to it later.

Ms Halton—The question is: exactly what would you like to know?

Senator FORSHAW—I am going to get to some further questions, but—

Ms Halton—I am sure, Senator, but we would normally expect particular details about this issue under outcome 4. If you would like to—

Senator FORSHAW—Right, we will do it under outcome 4. I am happy to do it then.

Ms Halton—We will see what we can dig up in the interim.

Senator FORSHAW—Thank you.

Senator McLUCAS—Just to complete my questions about RRMA, why did we use RRMA and not the ARIA model—the new system of classification?

Mr Stuart—There are programs in Health that use RRMA and there are programs in Health that use ARIA. They have different underlying logic. The logic of this particular program is similar in some respects—because it is a practice based program—to the Practice Incentives Program, which is reliant on RRMA and therefore well understood by doctors at the practice level. For that reason, the RRMA system was chosen as the model. It is also because we know more about doctor locations in respect of RRMA because of that work in relation to the Practice Incentives Program.

Senator McLUCAS—Thank you. I am trying to understand the issue of reduction in payment lag times. Do all doctors get a benefit from the reduction in payment lag times or is it only those who are participating GPs?

Mr Stuart—I will ask our colleague from the HIC.

Mr Leeper—Payment lags at the present time vary according to the form in which Medicare claims are submitted by general practices. For claims submitted on paper, there is a 17-day payment lag. For claims that are currently submitted over what is called the X400 Medclaims arrangement, there is an eight-day payment lag. As part of the Fairer Medicare changes the government has announced that practices using HIC Online to transmit their claims will enjoy a two-day payment lag time, which is not necessarily tied to participation in the General Practice Access Scheme.

Senator McLUCAS—So anyone who uses HIC Online will be paid in two days?

Mr Leeper—I am sorry—I have been corrected. In order to get access to the two-day payment lag a practitioner would have to take part in the access scheme.

Senator McLUCAS—But to join up—I think it is strategy 5 or 6—to HIC Online you do not have to be a participating practice; is that correct?

Mr Leeper—Absolutely not, no.

Senator McLUCAS—Right. So how will you differentiate between a participating practice and a non-participating practice in order to make a decision about whether you pay a person in two days or at another time?

Mr Leeper—The HIC will be required to implement administrative systems to distinguish between practitioners in practices offering the GP Access Scheme and those that would otherwise use HIC Online to do their claiming. We can manage to do that quite easily.

Senator McLUCAS—So, whilst it is physically possible to pay those non-participating doctors within two days, you will pay them in a different time frame.

Mr Leeper—They will be paid under an eight-day payment lag, as is the current policy.

Senator Patterson—I was one step behind. I thought it had been tied, but apparently it is too difficult to tie those participating doctors and those not with a two-day lag. So they will all get a two-day lag if they are on HIC Online. I had hoped it would be able to be tied with it, but apparently it would make it an administrative nightmare.

Senator McLUCAS—So Mr Leeper's first contention is in fact correct—that everyone will be paid—

Senator Patterson—I had not caught up with that change.

Senator McLUCAS—irrespective of whether they are a participating practice, in two days.

Ms Halton—If they are on HIC Online.

Senator McLUCAS—Are there any doctors who, because of their remoteness, will not be able to be connected to HIC Online but who do want to be participating practices?

Mr Leeper—I would be very surprised if that were the case. Any practice which has access to a telephone line or a telephone communications device and a modem, for example, with as low a capacity as 28.8 kbps will be able to use HIC Online to transmit in what we call store and forward mode. That in effect means the practice would accumulate the claims through the course of the day. At the end of day, they are able to hit the transmit button and the transmission occurs and is received by the HIC. The only thing they would not be able to use, if they wished to do so, would be a real-time mode if the communications capacity of the line they were using was of a relatively low standard. That will not be required in order to claim the incentive payments under the GP Access Scheme or to use what we call a store and forward or batch mode in HIC Online.

Senator McLUCAS—You simply need a phone line.

Mr Leeper—That is all.

Ms Halton—The other point to remind you of is that the package did include a significant amount of money—

Senator McLUCAS—It is one of the measures.

Ms Halton—precisely to connect. So there would be ultimately, we hope, real-time access for all those remote GPs as well.

Mr Stuart—I have 12 copies now of the minister's letter to table.

Senator McLUCAS—Thank you. I have some general questions about the package. I understand that the legislation was tabled last Thursday in the House. Can you tell me why there was no regulatory impact statement tabled with the legislation.

Mr McRae—The production of regulation impact statements is based on advice from the Office of Regulation Review and we were advised that it was not necessary to provide one in this case, fundamentally because any of things that are included in the package are of a voluntary nature. There is no obligation on any of the things that are going forward. As such, it was not deemed necessary to have an RIS.

Senator McLUCAS—So the Office of Regulation Review wrote to the department and said, 'Because everything is voluntary, we do not need an RIS.' Is that what happened? They wrote of their own volition.

Mr McRae—No. With any of these matters, we have to go to the office and say, 'Do we need such a document?' and 'What would you like us to cover?' We were advised that it was not necessary in this case.

Senator McLUCAS—So the department contacted ORR and asked them what the scope of the RIS should be—am I right?

Mr McRae—Yes.

Senator McLUCAS—Is that usual? That is your normal process.

Mr McRae—Indeed.

Senator McLUCAS—Every time.

Mr McRae—Yes.

Senator McLUCAS—So you write a letter that says, 'This is the scope of the legislation.'

Mr McRae—In this case, the process was actually, in a sense, managed at the earlier stage. We went to the Office of Regulation Review at the stage when the government was considering all of the processes and considering the package as a whole and said, 'Do we need to look for a regulation impact statement in any of this?' and they said no. That then follows through to the legislation where obviously we are only looking at part of the package.

Senator McLUCAS—It is the biggest change in Medicare for 20 years and ORR says that we do not have to have an impact statement.

Mr McRae—My understanding of its position was that we did not have to have an impact statement because there was nothing in the package obliging small businesses—in this case the general practitioners—to do anything. They are fully able to participate or not participate in the package of their own volition.

Senator McLUCAS—But the intent of the package, as we have heard this morning, is to change the practice of 75 per cent of general practitioners in Australia. Irrespective of the voluntary nature of it, it is going to change, according to the government, the practicing and billing behaviour of 75 per cent of doctors in Australia; yet ORR says that because it is voluntary we do not have to work out what the impact is going to be. Is that, essentially, what you are saying?

Mr McRae—What you are asking me to do is to speak for another organisation. I have told you what they told us. I do not know that it is appropriate for me to speak for them beyond that.

Senator McLUCAS—Could you provide me with a copy of the letter from ORR that advises the department that it is voluntary in nature?

Mr McRae—Can I take that on notice. I have the letter. The letter I have was done in the context of the cabinet process, not in the context of the legislative process, and I will have to take advice on whether it is appropriate that I hand that over. I am happy to take that on notice.

Senator McLUCAS—The cabinet process occurs further down the track. You identified that there was correspondence between the department and the ORR about the need for a RIS.

Mr McRae—Yes.

Senator McLUCAS—That is the letter that I would like a copy of.

Ms Halton—Can we be clear. What the officer is saying to you is that, as part of the cabinet process, we were required to identify any legislative change that would be necessary consequent upon particular and potential decisions of cabinet. The ORR provided advice in writing in the context of the cabinet process. What the officer is saying to you is that we do not know what of that letter we are able to release because it is actually covered by the cabinet process.

Senator McLUCAS—So all correspondence between the Department of Health and Ageing and the Office of Regulation Review is part of the cabinet process?

Ms Halton—No, not necessarily. I will give you an example. When we are looking as part of the regulation of food—through the Food Regulation Standing Committee, which I chair—we are required to do RISs on a number of the policy debates there before they go to ministers. There is a different process there. Essentially, what has happened here is that the department has consulted the ORR as part of the formulation of a cabinet submission, which included, obviously, multiple options. The ORR has responded in relation to whether anything is required in particular circumstances in the cabinet context. That formed part of the advice to cabinet. So what we are saying is that, no, the ORR did not say that we were required—in fact, on the contrary, they said that we were not required—to produce a RIS. What we are simply saying is that we may not be able to provide that document because that document is relevant to the cabinet process. But we will take advice on that.

Senator McLUCAS—When did the department contact the Office of Regulation Review in the initial stages?

Mr McRae—It would have been some time relatively early this year. I imagine it was in January or February, but I do not have that exact information with me.

Senator McLUCAS—Could I get that on notice, please?

Mr McRae—Yes, sure.

Senator McLUCAS—When will you be able to provide me with advice as to whether or not I can receive a copy of the correspondence between the department and ORR and ORR and the department?

Ms Halton—As I say, we will firstly have to find the correspondence; then we will have to take some process or procedural advice about what constitutes material which is effectively

cabinet-in-confidence and what does not. When we have that advice we will come back to you. We will come back to you on notice.

Senator McLUCAS—We will come back to this issue later today possibly or when you can provide me with that advice.

Senator Patterson—We will not be able to do it by today.

Senator McLUCAS—Why not?

Senator Patterson—In due course, when we have the answer, we will give it to you.

Senator McLUCAS—You seemed definitive. Why not?

Senator Patterson—Because it will take a considerable time and all the officers that would need to do that are here at estimates. It really is an issue on which, as the secretary said, we need to seek advice.

Senator McLUCAS—From whom?

Senator Patterson—Cabinet.

Senator McLUCAS—Not Health and Ageing.

Senator Patterson—By a cabinet process.

Ms Halton—In a case like this I would normally ask my officers to take the advice of Ms Belcher from Prime Minister and Cabinet as to what properly constitutes material which is cabinet material and what constitutes material that is not. That is not a judgment I would ask my officers to make. I would ask them to seek advice from PM&C about such a matter. And they will have to get the correspondence, provide it to Prime Minister and Cabinet and then get their advice back.

Senator McLUCAS—Given the nature of the legislation and the fact that there is no RIS and the explanation it is because it is voluntary, I think this is an issue that we will return to at some point, hopefully within this estimates period.

Senator Patterson—I am just saying to you, Senator McLucas, that it will not be in this estimates period.

Senator McLUCAS—That is very unusual, Minister. You know that.

Senator Patterson—No, because it is not something that we just go and get from the department. Be reasonable. It is unreasonable to expect an answer to be back by tomorrow night.

Senator McLUCAS—There is Friday.

Senator Patterson—You might be here on Friday—

Senator McLUCAS—I possibly will be. I want to move away from the GP Access Scheme, so if others want to cover GP access I am happy to let them.

Senator NETTLE—I have questions about bulk-billing rates. I presume they are to be done in this component or do you have another spot you are moving on to do that?

Senator McLUCAS—There is a time when we will talk more generally. I am just working through the package fairly systematically. If anyone wants to ask any questions on GP access, I am happy to share the time.

CHAIR—How about you proceed?

Senator McLUCAS—Thank you. I will go to the $500 safety net for concession card holders. You say in fact sheet No. 2 that the safety net is $500 per family. What do you mean by that?

Mr Stuart—It would be a family as registered with the HIC as a family and it would be $500 for out-of-hospital services covered under the Medicare benefits schedule.

Senator McLUCAS—So it is all of those people who are listed on that relevant card that the person might have?

Mr McRae—The families for this purpose will be families that register with the Health Insurance Commission as families according to the rules. It does not link to your Medicare card. As you would be aware, Medicare cards—because they serve a different purpose—do not have to be kept up to date in the same way. Many families will have multiple cards and so on.

Senator McLUCAS—So it is those people registered under HIC rules as a family?

Mr McRae—Yes.

Senator McLUCAS—If there are four people in a family, will they get the same safety net as a one-person family?

Mr McRae—If there are four people in a family, they will reach the safety net when the out-of-pocket expenses of the four of them add up to $500. If you are a single person living alone, you will reach the safety net when your out-of-pocket individual expenses make $500.

Senator McLUCAS—The implementation of the safety net process is to commence in January 2004. What is the timetable for implementation of the safety net proposals?

Mr McRae—Fundamentally, there are two tasks to be done. One is to build the necessary computer infrastructure, if you like, in the Health Insurance Commission. That process is now at the stage where we are working through all the detail of what will go into that system when they start to build it. We are working through that part of the process now, and that will all be in place by January as required. The other part of the process will be to inform the community that families need to register and so forth. Of course, we cannot do much about that until the legislation is in place.

Senator McLUCAS—Which could be later this year.

Mr McRae—Assuming that the legislation goes through, then clearly we will have to have that communication going later this year, yes.

Senator McLUCAS—Would you expect to be able to that piece of work between later this year and January?

Mr McRae—Yes.

Senator McLUCAS—So that is possible. Just remind me: the first thing is that you need IT systems—

Mr McRae—Yes, the systems to be built by the Health Insurance Commission to add up the $500 and so on.

Senator McLUCAS—And the second component?

Mr McRae—The second point is to inform families who are in the concessional category and who think they will have high levels of health expenditure that they need to register to be able to benefit from this.

Senator McLUCAS—When do you imagine the process of informing families will start?

Mr McRae—I imagine it would be late this year. We do not have a formal time set at this point.

Senator McLUCAS—Will that be by mail, by correspondence?

Mr McRae—Again, we are still working through the best ways to do that—whether to do it that way or through broad advertising, if you like, within Health Insurance Commission offices or whatever. There is an array of ways we could go forward and we are still working our way through them.

Mr Stuart—It would obviously be very important for the public to be aware of this safety net and to be well informed about it so that they can register with the HIC and obtain the benefits.

Senator McLUCAS—When do you think you will know how you will communicate with potential users of the program?

Mr McRae—I think we will be working that through over the next few months. We are now in June and over the next few months we will sort that out. In the few months after that, assuming that we have the authority, we will get out and do it.

Senator McLUCAS—Going back to the development of the IT system that will add up to $500, so to speak, what is the progress on implementing that?

Mr McRae—We are still in the process of working through with the Health Insurance Commission the mechanics of all the detailed itty-bitty rules that one inevitably gets into in these sorts of things so that they have their specifications absolutely precise before they get to write the code.

Senator McLUCAS—So it is the preplanning and legislative questions?

Mr McRae—Yes, that is the way to describe it.

Senator McLUCAS—Will the safety net be administered by the HIC? Is that how that works?

Mr McRae—Yes.

Senator McLUCAS—You have a whole series of sets of information that are currently being collected. Are there any gaps in that set of data that have to be changed in order to deliver the program?

Mr McRae—No. At the moment there is another safety net in existence, as you would be aware, that also operates on a family basis. The information that is needed is the definition of families for those people and how much money out of pocket the person expends. Clearly we know how much they have spent, because they bring in their receipts to make their claims, and we know how much the Health Insurance Commission is giving them back. So we know what the gaps are.

Senator McLUCAS—Fact sheet No. 2 says that an extensive range of Medicare funded services will be covered by the package. What is the complete range of services that will be covered?

Mr Stuart—In short, it is all out-of-hospital services provided under the Medicare benefits schedule. We have provided lists of examples in fact sheet 2, for example. It includes out-of-hospital specialists, radiology, radiation, oncology, diagnostic services, general practice services—I am starting to run out of examples.

Senator McLUCAS—I get the picture. In the fact sheet it says 'extensive' but not 'totality'. You are telling me that all MBS services will be included?

Mr Stuart—All out-of-hospital MBS services.

Senator McLUCAS—Does it include out-of-hospital specialist services?

Mr Stuart—Yes.

Senator McLUCAS—The costing of the program is projected to be $67.1 million over four years. Can you tell me how that figure was arrived at?

Mr McRae—We clearly do not have family data as such in the system, as I said before—families will have to register. So it was necessary for us to estimate the expenditure of families and the distribution of that expenditure, because it is a distribution issue here and how many of them are likely to spend over $500, not an average. So, having told you that the Medicare card is by no means the same as a definition of family, we used the Medicare card structures as an approximation to the families to get a distribution of how much families would spend out of pocket. We were then able to look at that distribution, see how many of them were under and over $500 and, from the numbers over $500 and from how much out of pocket they were when they were over $500, we could multiply up and come out with our estimates.

Senator McLUCAS—So you used the Medicare card information?

Mr McRae—That was the only thing we had any access to which would give us approximation to a family structure.

Senator McLUCAS—As I understand it, and I might be wrong, concession card information is not linkable to the information held by HIC on the Medicare card. How did you connect those two sets of data?

Mr McRae—You are correct: the Health Insurance Commission is not able to connect the pharmaceutical and medical data. The work we did on that distribution was across the whole of the population. It was then necessary to make approximations to bring it back to what we

believed, as best we could work out, the distributions for concessionals would be, based on the sort of information that Mr Stuart was talking about before.

Senator McLUCAS—I am sorry, I really cannot understand how you can make an assumption about it. You could make assumptions about the types of services that people use, but I really cannot work out how you collected data to get to that $500 threshold.

Mr Stuart—I think Mr McRae was answering a somewhat different question. Is it the $500 threshold that you are asking about?

Senator McLUCAS—Surely that is the trigger for some expense. I am trying to work out how we got to $67.1 million.

Mr Stuart—The $67.1 million includes a number of components, one of which is refunds to families under the safety net. That is calculated, as Mr McRae has been explaining, on the basis of what we know about the patterns for all families and individuals in Australia and then pro rata-ed to what we expect the proportion of that to be for concessional patients.

Senator McLUCAS—That is the point I am getting to. You used general demographic trends and then just extrapolated that on to concession card holders?

Mr Stuart—We used population level information about what we know about families and individuals under Medicare and then extrapolated that, as you said, to concession card holders.

Senator McLUCAS—Even given that we know that concession card holders have different patterns of usage of general practice?

Mr Stuart—Indeed.

Ms Halton—And that was taken account of.

Senator McLUCAS—Was that taken into account in the 50 per cent type figure that we referred to earlier?

Mr McRae—Certainly, yes. It was not actually using the 50 per cent, because that is more with what happens to doctors. Here we are talking about what happens to patients. The issue really is, on average, how much concessional patients are charged compared to what other patients are charged. That is the factor we have to use to adjust down. Mr Stuart has shown you some data on bulk-billing rates for concessionals and others. From that same set of information we are able to work out the average amount which concessional and other patients are being charged. So you can actually see that is differential and you can use that differential then to work back from this larger population figure.

Senator McLUCAS—Can we have that data, which describes essentially what the out-of-pocket payment is for concession card holders?

Mr Stuart—In principle, there is a level of data available at a fairly high level of aggregation. Would you like to be more specific about the request?

Senator McLUCAS—I am asking for national figures—

Ms Halton—Do you want to know the average out-of-pocket charge for a concessional?

Senator McLUCAS—For a concessional payment.

Ms Halton—Yes.

Senator McLUCAS—The other question is: how many concessional card holders actually will, on your predictions, reach the safety net?

Mr Stuart—That is a matter of—

Ms Halton—That is a matter of public record.

Mr Stuart—public record. I believe that 50,000 individuals or families is the estimate.

Senator McLUCAS—Individuals or families?

Ms Halton—Recognising that some individuals constitute—

Senator McLUCAS—a family.

Ms Halton—Yes.

Senator McLUCAS—Do you also have a prediction over the out year of those two pieces of data of the number of people who will meet the safety net, or are you assuming the same—

Mr McRae—We are fundamentally assuming that number will stay relatively stable. There is no real significant growth built into that.

Senator McLUCAS—Mr Stuart, you said that the $67.1 million was made up of a range of costs, one being refunds to families. What are the other costs that are associated with that?

Mr Stuart—There is some funding to the Health Insurance Commission for implementation, and there is some funding to the department of health for implementation.

Ms Halton—Basically, departmental money.

Mr Stuart—Departmental funds. The amount in the budget for refunds under the safety net over the four forward years is $46.9 million.

Senator McLUCAS—About $20 million essentially in administrative costs?

Mr Stuart—Yes.

Senator McLUCAS—Could we have that data broken down? You may like to take it on notice or to provide it later. If you have got the document there, it can be handed up. That would be good.

Mr Stuart—Yes, I will be able to do that a bit later.

Senator McLUCAS—Thank you. Has the department taken into account that some doctors and some pathology providers may increase their fees due to the existence of the safety net?

Mr McRae—Do you mean in terms of the costing?

Senator McLUCAS—Yes.

Mr McRae—The answer is no. The costings did not make any assumptions like that.

Senator McLUCAS—Why not?

Mr Stuart—The construction of the policy is that the refund rate is at 80c in the dollar after the threshold of $500 is reached, and therefore consumers will be very interested in the charges of them.

Senator McLUCAS—In the charges of them?

Mr Stuart—Patients will be very interested in what they are being charged because they are continuing to pay 20 cents in the dollar above the rebate.

Senator McLUCAS—I understand that.

Senator ALLISON—Are there guarantees from the government that there will be no increases in fees as a result of the safety net?

Ms Halton—Senator, as you know, the government does not set the charges that doctors levy—it never has done—and this package does not change that arrangement.

Senator ALLISON—But Mr Stuart has just indicated that consumers will be in some position to see that those charges are not increased. Am I reading correctly what you are saying?

Senator Patterson—You have to assume that doctors are not rapacious and are not going to increase their charges, but will deal with those people who face considerable expense—not very many; 50,000. It is not beyond our wit, as a parliament, to monitor that to ensure that people do not do that. Not to have a safety net because of that would be, I think, counterproductive. I think it could be monitored and should be the next appropriate discussion we have in the Senate inquiry.

Senator ALLISON—I think what Senator McLucas is asking is how much work has been done to try to establish how likely it is that the safety net will see increases in doctors' costs. I think the answer is no. Mr Stuart is suggesting that consumers are empowered in some way to see that this does not happen—this is worth exploring.

Ms Halton—It is also important to understand that when you trigger the safety net you do not automatically walk through the doctor's door with a stamp on the middle of your forehead saying, 'Now on the safety net.' There is nothing that identifies you to the doctor.

Senator ALLISON—Do you think the doctor would not know that you are already on the safety net?

Ms Halton—Not necessarily. In fact I would be surprised if they did.

Senator Patterson—You would be accumulating your costs over a range of doctors. You might have been to three or four different specialists—

Senator McLUCAS—Your GP would know that.

Senator Patterson—because that is the sort of person who ends up hitting the safety net, a person with very serious illness who is seeing a number of specialists, not going back to the same doctor all the time. It is not about GPs.

Senator ALLISON—You do not think the doctor—whether it was a specialist or the GP—would have some understanding of the general health of the person they were dealing with and their likelihood to be racking up enough costs to be picked up by the safety net?

Senator Patterson—I am sure the doctors would be interested in your comments, Senator Allison.

Senator ALLISON—I think the committee is interested in the government's work on this issue. There has been none, is that what you are saying, Ms Halton?

Ms Halton—No, Senator. In terms of our expectation about price increases consequent on somebody hitting the safety net, it is not our belief that there will be price increases. The Health Insurance Commission can and will monitor what happens in terms of charging. Indeed, the minister has indicated publicly that in the event that any behaviours are observed, the Health Insurance Commission would be discussing that matter with relevant doctors. But as I say, it is not possible for the doctor to identify somebody and it is not our expectation that there would be an increase in charging.

Senator ALLISON—How soon would those figures be available? When will this review begin—within six months or will it be a longer period?

Ms Halton—Which review?

Senator ALLISON—You said that the HRC would be asked to examine the figures and tell us whether there were increases in fees as a result.

Ms Halton—The HRC will monitor charging practices. The HRC is available—obviously, by definition—to identify someone or a family who are on the safety net and they will examine whether there is any charging irregularity, which I think is what you are going to, in respect of individuals who have triggered the safety net.

Senator ALLISON—So this will not be an overview of general increases; did you say that this will be irregularities?

Ms Halton—That is what you were going to. Your contention was, I think, that when a doctor knew that a person had triggered the safety net, they would charge an increased amount to the person.

Senator ALLISON—No, that was not my contention. My contention was that it is likely that the safety net may see—generally speaking; not for an individual—a general increase in fees. Are you saying that the HRC will not be looking for that? It will be looking for what, individual doctors who might—

Ms Halton—If there is, using your words, 'a general increase in fees' that must be reflected on a per patient basis. What the HIC will do—and you will acknowledge that the HIC already produces data in relation to charging, so we will be able to look at charging in respect of this particular group of people; it will be data that will be available to us—is examine charging practices in relation to individual doctors if there is an observable change in their charging practice once patients have hit the safety net.

Senator ALLISON—When will data be available that will demonstrate whether this has happened in significant enough numbers for us to be concerned about it?

Ms Halton—That will go to how long it takes people to hit the safety net and then a period of behaviour thereafter. So we would not expect to see any data, I would think, inside the first 12 months. To the extent that you have had 12 months experience of the safety net, you would

hope that the Health Insurance Commission would act very quickly, if it saw anything, by way of having a conversation with doctors. As I say, it will need 12 months worth of data because it takes a while for anyone to reach a safety net.

Senator ALLISON—After 12 months—I am sorry to pursue this—the HIC will be asked to look at this data and report any increases which might be irregularities?

Ms Halton—No. The Health Insurance Commission will give us regular reporting, as it does now. We will ask it to report to us from the commencement of the safety net arrangements what is happening in terms of the number of people who have reached the safety net and what has happened in respect of charging for all those people. So we will get a regular report of data from the HIC throughout this process; we will not wait.

Senator ALLISON—And will this be made publicly available?

Ms Halton—In terms of what is going to be published, I do not know that any decision has been taken on that. In terms of information that will be available to senators at estimates, it is my expectation that information will be (1) asked about and (2) discussed.

Senator McLUCAS—I want to come back to the point where you said, 'It is not our belief that there will be any inflationary pressure on doctors fees.' How can you say that? What evidence do you have to support that?

Ms Halton—I will ask the officers concerned to talk about it in more detail, but it is not our belief that, firstly, because people will not be identified in a way that when they walk through the surgery door it is clear they are on the safety net and, secondly, in relation to charging practices, that doctors would change their behaviour. This is something that the minister has discussed, I know, in some detail with the medical profession.

Senator McLUCAS—I want to go back to the point you make about the doctor not knowing whether or not you have hit the safety net. For people with chronic illnesses they usually have one GP who is providing them with service and a range of other people who are servicing them. Surely that doctor will have a bit of an idea. I think it is a quantum leap to say that you have not got it tattooed on your head.

Senator Patterson—You are implying that doctors, when they are faced with someone who is seriously ill—and when that is one of the reasons why they hit the safety net—are going to take advantage of that person. That is the implication, Senator McLucas. I am sure that people who read *Australian Doctor* magazine would be fascinated with this discussion.

Senator McLUCAS—Maybe it would help if I quote an Adelaide doctor who was on *The World Today* on 30 April. He said:

> ... What's the point of keeping my fees down? Why would I want to sign up to bulk bill when I can charge a standard fee of $100 for a consultation and know that eventually the patient is only going to be paying $20 out of their pocket?

Senator Patterson—That is one doctor. Every other doctors' group—the ADGP, the AMA and the RACGP—has indicated that doctors are very careful when they make changes to their billing practices and do not just make a rash decision to increase fees. I think Dr Trevor Mudge said that they never have and they never will. You are making assumptions based on one person who is making a claim. I do not think that is how doctors practice, particularly

when you have someone who is seriously ill. These people are concession card holders as well.

Senator McLUCAS—The point I am making, Minister, is that it appears from the evidence given this morning that no work has been done by the department on the potential for there to be an inflationary effect of introducing the safety net when a range of commentators and a range of individuals have said that there is potential for that to occur.

Mr Stuart—The work that has been done by the department is in terms of its policy advice—the policy design—which, as we have been pointing out, is that the patient continues to have a 20 per cent expenditure. This increases their interest in what the doctor is charging. If the patient believes the doctor is charging unreasonably, they can go up the road.

Senator McLUCAS—If you live in a metropolitan area.

Mr Stuart—The patient, before claiming back under the safety net, is also out of pocket for the entire charge for a period; thus sharpening their interest in what they are being charged by the doctor. And the patient knows far more about what they are being charged than the doctor does, because the doctor has to make, if they were so minded, guesses about who else the patient is seeing and what kinds of services they are using and therefore whether they might be approaching the safety net. So the patient is in a far better position in terms of information, we think, than the doctor. The department has, with the policy design, therefore provided its advice to government on the matter.

Senator McLUCAS—So was it a point of question in the policy design?

Ms Halton—It was a matter of discussion, and the whole basis for that 80-20 split is precisely for the reasons that Mr Stuart outlined. The other point that I made—and I take your point about tattooing—is that it will not, we believe, be that obvious to doctors when someone comes through the door. The reality of course is that if you are only seeing a general practitioner it will take a little while, if you are being charged an out-of-pocket fee—remembering that, if you are a concessional patient and a doctor does charge you an out-of-pocket fee, they tend to charge you slightly less. It would take, by definition, some time to get to the safety net. It is our belief, with the 80-20 split, that there would not be a significant issue.

Senator McLUCAS—You said that HIC would have to act quickly if they did see something. What power does the HIC have to act quickly?

Ms Halton—The HIC have the power to discuss a range of issues with doctors. In the event that they see a change in billing practice they would be able to go and have a conversation with the doctor about that arrangement.

Senator McLUCAS—But they have no ability to direct change, do they?

Ms Halton—They have an ability to bring that to the attention of the doctor as being a matter of concern.

Senator McLUCAS—This sort of work would have been covered in a RIS, under usual practice, wouldn't it—some predicting about what inflationary effects may have occurred in normal procedure?

Mr McRae—A regulation impact statement is based around the impact of legislation on a business. Fundamentally what we are talking about here is impact on individuals. Therefore it is not something which would have ever been part of a RIS, I believe.

Senator McLUCAS—I wanted to raise the implementation of the swipe facilities. Does anyone else have any questions before we move on?

Senator ALLISON—I have some questions about the safety net. According to the figures that we have been provided, you say that 50,000 patients per year will be protected by the safety net.

Ms Halton—That is families.

Senator ALLISON—That works out to be about $200 a year return if you look at the around $10 million a year that is in the budget for this measure. That would suggest that if that is 80 per cent of the cost then the patient is paying $550 a year or thereabouts. How does that compare with the average out-of-pocket expenses for concessional patients now?

Mr McRae—I do not have the numbers here with me, but obviously the overall average out-of-pocket cost for concessional patients and families is really quite a low number. What we are looking at here are the people at the top end of the expenditure pattern. I should not even guess what the number would be for the overall average, but it would be quite low. Most people do not go to the doctor all that much, but a small number go very often.

Mr Stuart—I am without my table, Senator, but your back pocket estimation of $10 million does not take into account that the first year is a half-year

Senator ALLISON—So it is more like $12 million or $13 million a year?

Mr Stuart—For the first financial year it is a half-year cost. There is also a take-up trajectory, such that $40 million might be the average over the four years, but the final year and full-year costs would be higher than the $10 million. That table is being prepared for tabling to the committee, following an earlier request, so I do not have it in front of me. But you would need to look at the final-year costs as a guide to that.

Senator ALLISON—Could we also have a comparison with the current concessional arrangements as well?

Mr McRae—Sure.

Senator ALLISON—There are fairly significant differences between the two types of concessional systems under PBS and under MBS and, as a general question, isn't that going to be very confusing? What steps will the department take to provide information to people on how they sit within what safety net?

Mr McRae—May I ask what differences you are alluding to?

Senator ALLISON—The PBS is on a different basis from the MBS, as I understand it.

Mr McRae—Fundamentally, the concessional definitions are the same. The family definitions are the same—obviously the cut-offs are different because they are different programs—and in both cases families have to identify themselves. In the pharmacy case they have to identify themselves with the pharmacy rather than with the Health Insurance

Commission and in the Medicare case they have identify with the Health Insurance Commission. I am sorry, but I find it difficult to understand exactly what the problem is.

Senator ALLISON—I will come back to that later, then.

Mr McRae—Thank you.

Mr Stuart—Senator, I now have the table on the safety net breakdown of costs available for tabling.

Senator ALLISON—Thank you.

Senator McLUCAS—I would like to move on to the swipe facilities. The measure is expected to commence on 1 February next year. What are the activities that will lead up to the implementation of the swipe card facilities?

Mr Stuart—Apparently the officer from the HIC is on his way back quickly from another small room. This issue is between the department and the HIC, and Mr McRae might like to start with an answer and then we will get detail from the HIC.

Senator McLUCAS—Thank you, Mr Stuart.

Mr McRae—The implementation of this one, again, has a series of components. The first is that the Health Insurance Commission has had to change its software so that it is able to make direct payments to the doctor at the same time as a copayment is paid. There is work to be done on that, and it is in train. The second thing is that software providers around the country who provide the software used by the general practitioners have to include in their software the HIC Online facility, and that process is also in train.

Fundamentally, they are the two components. Doctors, obviously, will need to be informed of what they can do because they only have access to this facility when they sign up to the General Practice Access Scheme. The information flow to doctors would come as part of the General Practice Access Scheme that Mr Stuart talked about earlier.

Senator McLUCAS—Have we started discussions with GPs on this point?

Mr McRae—Sorry; let me ask you first: when you say 'started discussions with GPs', started discussions on what?

Senator McLUCAS—You are saying that GPs have to change their software. Have we written to them to tell them that that has to happened?

Mr McRae—I actually said that the software providers have to make the changes first.

Senator McLUCAS—Pardon me. Well, have you written to them?

Mr McRae—Perhaps at this point I can hand over to Mr Leeper.

Mr Leeper—We are just finalising arrangements to hold discussions with software vendors. The principal issues, from their point of view, are around the cost of incorporating the software into their own commercial packages and the timetables and lead times required to allow them to support rollout to interested and participating practices. So, between now and November and, in particular, February next year, there is a fair amount of work to do.

Senator McLUCAS—Have you had feedback from software manufacturer designers?

Mr Leeper—Yes.

Senator McLUCAS—Are they saying that it is possible to do that?

Mr Leeper—We already have, as you may be aware, 10 software vendors who have successfully incorporated HIC Online into their practice management software. More than 50 practices are currently transmitting around 40,000 claims per month to the HIC using the HIC Online. We already have 10 vendors who have been through the incorporation and testing stages and who have now positioned themselves to respond quickly when general practitioners seek to get access to the software. A very substantial number of other software vendors have taken the material from us—the HIC Online claiming package—but have yet to come through the testing processes. It will take probably a month to six weeks for them to incorporate that and for us to test it. That still leaves substantial time, we believe, for there to be able a concentrated but orderly progress in migration of general practices over to online claiming for those who wish to make the changes.

Senator McLUCAS—Has HIC's software changes process begun?

Mr Leeper—Which software changes do you mean?

Senator McLUCAS—Mr McRae talked about there being two parts to the implementation of this program.

Mr Andreatta—The changes you are referring to are the program changes to incorporate the copayment arrangement. Work has commenced on that. We are still in discussion with the department about the business rules to implement that system. We envisage that the system will be ready for the 1 February start next year.

Senator McLUCAS—Is it similar to the discussions that Mr McRae was talking about earlier of the data collection of the $500 safety net measure?

Mr McRae—Detailed business rules need to be established before anybody codes it wrong.

Senator McLUCAS—Back to the software providers, you said that 10 are essentially up to speed. How many are there altogether?

Mr Leeper—That is a very good question. Every time I ask it, it seems to get a little larger. Seventy-five software vendors have taken our packet of code—what is called an applications program interface, or API—for the current version of HIC Online. There are another probably 30 or 40 vendors. It is a very dispersed space. Six to eight vendors, though, probably explain for about two-thirds to three-quarters of all Medicare claiming that is done through the software. So there is a small number of very significant players and a very large number of quite small players.

Senator McLUCAS—Have you had any feedback from either group about their ability to comply with the time frame that the government has proposed?

Mr Leeper—I am confident that there is sufficient time for a software vendor who is going to incorporate the material to incorporate that, have it run through our testing facility and then be in a position to offer it in the marketplace to any doctor who wishes to take it up. We believe that the time between now and particularly 1 February next year, which is the

important date in terms of patient rebate claiming, is adequate if we get going relatively quickly.

Senator McLUCAS—That is very nice, but that is not the question I asked. Have you had any feedback from software manufacturers about the time that they have got?

Mr Leeper—I am not aware of any comments by software vendors that go to the issue of whether there is enough time to do this. As far as I am aware, they are all saying they are ready to go once arrangements have been finalised between the HIC and the vendors around incorporating the programming software.

Senator McLUCAS—The cost of the measure is given at $11 million over four years. How is that money going to be applied?

Mr Andreatta—Of the $11 million, the set-up cost to change the software for incorporating the copayment arrangement is the bulk of the cost. Ongoing cost is around supporting the new technology and the new changes that have been implemented in terms of IT support in particular.

Senator McLUCAS—Have you got a separation of those amounts?

Mr Andreatta—In what sort of detail are you looking at?

Senator McLUCAS—Over the next four years between the set-up and the maintenance that you have described.

Mr Andreatta—The set-up is around $4.7 million.

Senator McLUCAS—That is 2003-04?

Mr Andreatta—Yes. And around $1.9 million ongoing.

Senator McLUCAS—And then in the out years?

Mr Andreatta—It is $1.9 million ongoing support.

Senator McLUCAS—I cannot get to $11 million. It is $1.9 million a year over the next three years in the out years.

Mr McRae—Yes, $1.9 million by three, plus $4.7 million, plus a small amount of money this year because the process had to begin quite early.

Senator ALLISON—I understand from the letter which was sent to GPs that there is a one-off payment of $750 to GPs in metro practices and $1,000 to those in rural practices. First of all, why the difference?

Ms Halton—It was a decision of the government about what they believed was an appropriate amount to give practices in different geographic locations.

Senator ALLISON—On what basis is there a difference?

Senator Patterson—A lot of rural practices are more often single practices and therefore cannot share their costs as easily. If they are moving to broadband, they maybe have slower transmission. We believe that that is a way in which we can encourage them to—

Senator ALLISON—So why wouldn't you just offer the $1,000 to single practices so that you pick up those that are in outer metropolitan areas where there might also be problems with broadband?

Senator Patterson—That was the decision we made.

Senator ALLISON—So there is no basis apart from what you have just said. Will the one-off payments of $750 and $1,000 that you have just spoken about come out of the $4 million in set-up?

Mr McRae—No, it is in a different appropriation. The money that Mr Andreatta just talked about was the funds needed by the Health Insurance Commission to do their work. The incentives are included under a different head.

Senator ALLISON—I thought that was what we were talking about—we are not.

Mr McRae—No. The $11 million that we were talking about is the cost of the Health Insurance Commission making this work.

Senator ALLISON—So what is the budget for the one-off payment for doctors?

Mr McRae—It adds up to about $4.1 million over four years.

Senator ALLISON—What are the assumptions behind that?

Mr McRae—They are obviously based on the $750 and the $1,000 multiplied by the assumed take-up.

Senator ALLISON—But what is the assumption about the number of GPs that will be taking it up?

Mr McRae—I believe the assumption was that something like 85 per cent of practices would, over time, be operating this way.

Senator ALLISON—And how was that assumption derived?

Mr McRae—It is based on the recent experience of the Health Insurance Commission in dealing with these people. It is the experience within the Practice Incentives Program, where there are direct incentives for practices that use computer based systems.

Senator ALLISON—But this is not just computer based systems; this is opting into—

Mr McRae—A particular way of working.

Senator ALLISON—a particular system which doctors have said they are not interested in.

Mr McRae—I do not know that I wish to enter that discussion!

Senator ALLISON—It is anticipated that that $750 will cover the extra cost of software. Is that right? I know we do not have a rationale necessarily for $750 versus $1,000, but is that a one-off payment that you can spend on whatever you like? If you already happen to have a really good computer system and the software is cheaper, that is okay?

Mr McRae—That is correct. It is an incentive payment for doctors to participate. What they choose to spend it on is up to them.

Senator ALLISON—What do you expect the software to cost to doctors?

Mr Leeper—Again the answer is: it depends. The vast majority—I think that term has been used earlier this morning; I am certainly talking more than 90 per cent—of general practices are computerised, so in large part you would expect that a practice moving from another form of claiming to HIC Online claiming would generally only need to acquire the software package itself. That is the minimum end of the spectrum. As you move back into less advanced forms of claiming at the practice level at the present time, you might find that a practice needs to acquire a modem for an Internet connection, for example. At the very bottom of the spectrum, of course, is the situation where the practice is not computerised at all. I would stress, though, that for HIC Online to work in the practice it needs only to reside on a single computer that works at the practice desktop level. It does not need to sit in the consulting rooms. There has been a fair amount of figures pushed around about the costs of getting across to HIC Online, most of which I could most charitably describe as fanciful. You need a single computer with a telephone line and an Internet connection and a packet of software to claim with HIC Online. That is why we said in the material that we estimate the costs to be in the range of $1,000 to $2,000. It depends on the state of computerisation and the current claiming arrangements.

Senator ALLISON—Leaving aside the computerisation for the moment, if we can, the software itself obviously is a clear and direct cost to doctors. They have to buy the software.

Mr Leeper—Yes.

Senator ALLISON—You have been talking with software providers. What is likely to be the cost of that software?

Mr Leeper—HIC takes great care not to be seen to be promoting or otherwise endorsing any of these products because, as you as would be aware, with as many players in the medical software space as there are, it would be very dangerous for us to be seen to be giving—

Senator ALLISON—That is not what I am asking you to do.

Mr Leeper—The only way that I can answer your question is to say that I am aware of a range of potential costs for people to acquire the software. I know of a couple of them where it has been indicated to us completely informally and confidentially what the likely costs might be. I am aware of a couple of cases already where a vendor plans to announce in the very near future that they will give HIC Online away to a practice that picks up the rest of their software suite. In that case, the marginal cost of HIC Online is zero. That is why it is so hard to answer your question definitively. I am aware of costs as low as $300 to $400 to acquire the software, plus an installation charge and then an ongoing licence fee. For larger, multicomputer and multidoctor practices, the fees do tend to get higher in the dollar sense. But on a per doctor basis they would be lower than for a smaller practice. I cannot give you more information than that because it is a commercial issue between the software vendor and the GP. The HIC is right out of the picture.

Senator ALLISON—I understand that. Will there be any assistance provided to doctors to tell them about the range of software that might be available?

Mr Leeper—At the moment, on our web site we provide, with the consent of the vendor, an indication of which vendors have received what we call a notice of integration, which is the HIC's little stamp of approval that says that the software works in the way that we intend

it to. A general practitioner could consult our web site. Where participating vendors give us permission to do that, we will put that information up there as an information service to doctors. They can ring us on our HIC Online help line—I cannot think of the number off the top of my head, I am sorry—and we can provide factual advice, or information rather, about whether or not a particular vendor has yet incorporated the software and whether therefore HIC Online would be available to do claiming through that particular software package. We are happy to provide that kind of information as the package unfolds.

Senator ALLISON—Are you doing any testing of the compatibility with your system?

Mr Leeper—Yes.

Senator ALLISON—Presumably it will have some sort of tick of accreditation by you before doctors would buy it.

Mr Leeper—Yes. Having discussed this with the vendors, there are a range of ways in which government agencies can incorporate their requirements into the desktop. With HIC Online, the advice from the software sector was that they would like us to build a black box for them that they could then incorporate into their material. When they have incorporated that, it then comes back through our test facility, and we check that it works in its own right and that it will maintain a proper dialogue with our mainframe systems to process the claims. When that is done and we are satisfied, we issue a notice of integration to the vendor which says, 'This is now a product that complies with our production standards.'

Senator ALLISON—The one-off payment goes to a practice regardless of the number of practitioners in that practice—is that correct?

Mr Leeper—Yes, it goes to the practice.

Senator ALLISON—Just to clarify, I think you said the costs were likely to be higher for those practices where there were multiple computers and presumably multiple doctors.

Mr Leeper—That is only because I am aware that software vendors may charge a higher amount based on the number of doctors practising. Again, that is a commercial issue between the vendor and the government.

Senator ALLISON—It just seems to be at odds with the split of $750 for metro areas, where you would expect to see most of the multidoctor practices, and $1,000 for rural areas—but, as you say, that is a government decision. The minister said in a statement recently that $400 million had been provided over time for computer services to GPs. I think you mentioned earlier that there was a percentage of doctors who were still not computerised—was that 15 per cent?

Mr Leeper—No, I think it is well under 10 per cent.

Senator ALLISON—Under 10 per cent?

Mr Leeper—Well under 10 per cent.

Senator ALLISON—Presumably some of them computerised early on. Will the need to accommodate this new software and to be online mean a range of doctors will need to upgrade their hardware?

Mr Leeper—I hate to keep saying, 'It depends,' but it depends. The software that uses HIC Online will work on a 486 computer. If you have a Pentium computer, which these days is reasonably low end, it works fine on that. It will transmit over a relatively low-volume Internet connection—it will work on 28.8 kbps; 56.6 kbps is recommended. If you have broadband or ADSL, it is going to work much faster than that. So we designed it to operate—

Senator ALLISON—So you would be surprised if doctors said they needed $30,000 in order to accommodate this software?

Mr Leeper—I would be very surprised.

Senator ALLISON—Thanks.

Senator McLUCAS—I will just finish off with some questions about HIC Online, if this is an appropriate time. I think Senator Allison asked how many practices there were in metropolitan areas and how many there were in rural and remote areas. What is the split between the $750 and the $1,000? Was that question asked, and if not can we have the answer?

Mr McRae—Are you asking where we expect the money to be expended?

Senator McLUCAS—Yes.

Mr McRae—The way we did the arithmetic was to basically assume that it would be pro rata—that there would be the same take-up in both—for the purposes of budget costing.

Senator McLUCAS—Just to clarify, does metropolitan area mean RRMAs 1 and 2 and rural and remote means RRMAs 3 to 7?

Mr McRae—My understanding was that metropolitan actually meant the capital cities, which is RRMA 1, but can I seek clarification of that before it is locked in?

Senator McLUCAS—You think it might be RRMA 1?

Mr McRae—I think it is RRMA 1.

Ms Halton—Senator, if that is incorrect, we will inform you.

Mr McRae—Okay, I am wrong. Sorry, Senator, I have the advice already. It is just as well I asked a friend instead of locking it in! In fact, RRMAs 1 and 2 will get the higher rate.

Senator McLUCAS—RRMAs 1 and 2 will get the lower rate?

Mr McRae—The lower rate, yes—I am sorry.

Senator McLUCAS—Also in A Fairer Medicare—Fact Sheet 8, you describe three parts to the program: HIC Online, real time HIC, and then you say:

- assistance will be available to help improve current business practices.

Could you explain what that means?

Mr Stuart—That is a part of the program which is about working with GPs. The chief area there is on working with GPs on access issues to general practice. There has been in recent years quite a lot of overseas evidence from both the US and the UK that, by working together in a collaborative way, GPs can learn how to set up their practices so that better access is obtained by consumers, by patients, without doctors necessarily working any harder or

practicing their medicine any differently—by thinking hard, for example, about how many vacant spots they leave on a Monday where there tends to be greater demand, what they do with their recall for patients that need to come back and when they choose to see them. Essentially, it is by managing the patient queue and the scheduling process better. Overseas evidence is that patient times to see a general practitioner with the doctor not necessarily working any harder or doing their clinical work any differently can be cut quite dramatically as a result of that.

Senator McLUCAS—Was that a recommendation from ADGP or one of the doctor groups that was an area of need that would be valued?

Mr Stuart—The department has had broad discussions about that issue with a range of groups, including the ADGP, over a period of time and its potential benefit in Australia. This package provided an obvious opportunity, being about access and affordability, for that to be taken forward.

Senator McLUCAS—What is the separation of cost with that assistance to improve current business practices as part of the $24.3 million—and could I have it over the four years, please?

Mr Stuart—It adds up to $4.1 million over the four forward years being $1 million in 2003-04, then $1.535 million, then $1.046 million, and then $0.534 million.

Senator McLUCAS—How do you imagine the program will be delivered?

Mr Stuart—We are in discussion now with a range of groups about that. It will be delivered by the profession through the profession for the profession. We are working with possible partners on that now.

Senator McLUCAS—You are negotiating with some of the players at the moment. When do you expect the program to start being delivered?

Mr Stuart—There will be a process of program development. Currently we have open discussion with what we think are three key players in this area. We will want to have slightly broader discussions. We anticipate there will be an industry led steering committee for this. We anticipate that Divisions of General Practice will have a role in providing infrastructure for the roll-out of this initiative, but those issues remain to be settled. We are just opening the dialogue on those.

Senator McLUCAS—Can we just come back to the point we were making about who is going to take up the cash payment. You said to me earlier that we would have the same take-up rate irrespective of RRMA—is that right? Have I made my notes correctly?

Mr Stuart—Yes, that is right. Around three-quarters, irrespective of RRMA—that is the basis of the financial estimates.

Senator MOORE—I have questions on the business plan. As the three people from HIC are here, I wonder whether it is appropriate to ask that question now.

CHAIR—Certainly.

Senator MOORE—You have referred to the business plan with the implementation of the changes, in particular the swipe arrangement and being able to access Medicare from the

doctor's surgery as opposed to visiting an office. What has the department done in terms of business planning for the impact that will have on the internal staffing of Medicare?

Mr Leeper—That is an issue for the Health Insurance Commission, not the department, so I will answer. Two and a half years ago the HIC developed a proposal and put it to government to substantially modernise its business operations—it is called our business improvement program—and that was funded by the government in the 2001-02 budget to commence from July 2002. So we have been getting cracking on that. As part of the program, we anticipate that over four to five years from 2002 onwards we will probably reduce our data entry and data processing staff by between 800 and 1,000 full-time equivalent staff—meaning 36¾ hours per week—Australia-wide. That announcement was made to our staff at the end of 2000. The A Fairer Medicare changes and the incorporation of HIC Online as the primary claiming channel will allow us to achieve the results we had already forecast and were working towards in relation to the business improvement program. In short, there are no additional staff savings in Medicare offices as a result of this package. We were already working towards substantial reductions in data entry and data processing costs, including staffing costs, as part of putting HIC claiming online.

Senator MOORE—So the impact would be a continuation of the impact that is already public in terms of the process with no additional savings?

Mr Leeper—Yes. There are no additional staff savings. As you heard from Mr Andreatta and Mr McRae during the morning, with the implementation loads, help desk support and all kinds of things, we are putting a few jobs back out there, which is nice, but in large part, particularly the changes announced by the government to allow a doctor to claim, with the patient's consent, the patient rebate from 1 February next year, I expect that will substantially reduce our cash claiming through Medicare offices.

Senator MOORE—That is part of the premise that there will be a reduction of counter service?

Mr Leeper—A reduction in cash claiming, yes. We are keeping our branch office network open, however. We have already done planning in forecasting workloads and the kind of work that is done, which will allow us to keep the branch office network open in the foreseeable future at the present 226 level.

Senator MOORE—You alluded there to job mapping. Jobs may change?

Mr Leeper—Absolutely.

Senator MOORE—There is no further saving but the jobs themselves may change, so people may be doing different work but still under the banner of Medicare?

Mr Leeper—Yes, that is right. Jobs will certainly change. There will be fewer jobs overall. In an average Medicare office there will be fewer jobs, but the office will be kept open. In our state headquarter processing area, there will be fewer jobs as well. At the moment, we believe it is in the range of 800 to 1,000 when online claiming for both Medicare and pharmacy is fully implemented. There is a lot of work still to be done, but that is our plan and that is the announcement we have made to our staff.

Senator MOORE—Have any of those jobs already gone, because that is a two-year program—800 to 1,000? I would have thought some would already have gone.

Mr Leeper—At this stage, we have done some very minor rationalisation of some of our backend work and we have rationalised a small number of jobs at present. In large part, that is driven by claiming volumes, particularly cash claiming, which is really driven by HIC Online itself.

Senator MOORE—Can we get figures of how the implementation of the business plan that you announced for 2001-02 is going?

Mr Leeper—I do not have the figures with me, but we would be happy to provide them.

Senator MOORE—On notice would be fine, thank you.

Senator McLUCAS—Could we get a state by state breakdown of the job losses that we have lost out of Medicare?

Mr Leeper—That is very hard to give. Let my explain why that is so—I am not being obstructionist. We have intentions to restructure our operations for Medicare and pharmacy support. At present, each state has both Medicare and pharmacy support conducted at the head office level. Because the data entry staff and data processing staff numbers go down as electronic claiming picks up, we believe that it does not make sense to try and have six smaller versions of what is currently out there. So part of what we are doing is rationalising those operations into three states for Medicare and three states for pharmacy processing. So there will be some impact, which we are planning for on a state by state level—that is known. The element of uncertainty is that I cannot tell you what impact there will be on a Medicare office by Medicare office level, because cash claiming and electronic claiming will vary according to the decisions of local practices about what they want to do and whether they offer HIC Online to their patients or not. So at an Australia-wide aggregate level it is certainly possible to say from where we believe the numbers will come, but it would be artificially precise of me to say to you, 'These are the numbers state by state.' For our organisation it will be very much dependent on the take-up of claiming at a branch by branch level.

Senator MOORE—Your original time frame was until the end of 2004, wasn't it?

Mr Leeper—The business improvement plan is out to 2005-06. But the Fairer Medicare announcements certainly quickened the pace of that program, which has been a little bit slow to date. When you asked before about how we are going, the answer is that we are certainly a little bit behind, but the Fairer Medicare changes, particularly the support for online claiming, will substantially increase the take-up of that channel.

Senator McLUCAS—Going back to the implementation of the swipe card, has the department prepared any analysis on the likely effect on gap fees of the introduction of the swipe card?

Mr Leeper—I would like to clarify the swipe card idea. It is a wonderful figment of the imagination. Whether or not a person actually swipes their card at a participating practice is really immaterial. All that is important is that the practice has recorded the fact that they visited and that they have tied that to the Medicare number. Our job at the back end is to match that with the concessional information and get the payment to the doctor. In some

practices you may well be able to swipe your Medicare card—it is really not that essential. All that is important is that the person's Medicare card is captured and recorded, and that allows us to take on the rest of the processing that goes on.

Senator McLUCAS—Thank you; that is an important clarification.

Mr McRae—Senator McLucas, were you asking whether our figuring had made any allowance for increased charges somewhere?

Senator McLUCAS—Yes. Have you done any analysis of the likely effect on the gap on the introduction of electronic refunds at the point of service?

Mr McRae—I presume you are talking about the ability to direct bill with copayment.

Senator McLUCAS—Yes, the impact on the copayment.

Mr McRae—The view of the department is that there should be no impact on the gaps from that, because the only practices that have access to this are those which have signed up to the General Practice Access Scheme, and those who sign up to the General Practice Access Scheme will be those who do so because they will actually financially benefit from signing up. Fundamentally, in order to get access to the revised claiming arrangement they have to have signed up to the other program and they should actually be ahead before they start. So there would be no reason for any increase in charging simply because of the availability of this new modality.

Senator McLUCAS—Did you just make that assumption? Did you do tests with GPs to support that contention?

Mr McRae—The logic of the contention is very straightforward.

Senator McLUCAS—So if you get $3,500 because you are a participating practice you will therefore in no way be encouraged to take advantage of the fact that the copayment could increase without many of your practice's patients truly understanding that?

Mr McRae—I think the first thing is that you get the $3,500. Let me go back a step—

Mr Stuart—To go back to the beginning: it is an opt-in scheme for general practitioners. As we have discussed, the incentives are set in such a way that around three-quarters of GPs everywhere will be financially better off from opting in.

Senator ALLISON—No, 3,500.

Mr Stuart—For those doctors who are financially better off, there is no need for them to be changing their other billing practices as a result of the package.

Senator McLUCAS—So you did no analysis of whether there would be an impact on gap payments because of the introduction of direct billing to HIC at point of service?

Mr Stuart—There are two responses to that. The first is that analysis presumes that there is a lot of data that you can be looking at, whereas, essentially, the issue that we are discussing is the assumptions that you can make about behaviour of GPs.

Senator McLUCAS—Surely you could have modelled it and tested it with GPs—there is a whole range of ways that you make decisions about what behaviour may or may not change.

Mr Stuart—I have lost my train of thought as to the second response, but I am sure that it was an incredibly insightful point.

Senator McLUCAS—I am sure it was, too. If you remember it, I will get it later.

Senator LEES—Can I ask whether or not you considered that it would be easier for GPs to actually charge a gap, given that they simply have to link the patient, as you said, with the item number and the patient's Medicare number and therefore, if there is an additional $10 or $20, that can all be done on the spot? It is considerably easier than now, in that, if they want to charge a gap, there is quite a bit of paper shuffling and patients sending cheques back—or maybe two cheques, if the patient copayment cheque goes other than at the time. So the actual incentive to have no gap has gone.

Mr Stuart—There are a couple of things to say there. You have reminded me of the other point I wanted to make.

Ms Halton—Now we will find out whether it was insightful!

Mr Stuart—This is precisely the reason. There is a train of thought here to come to grips with in the policy sense. The way that has been done is to say, 'We will only provide this facility'—that is, direct billing with a gap—'to GPs that opt into the government's general practice access scheme.'

Senator LEES—But all they have to do there is bulk-bill concession card holders. For all the rest, it is now extremely easy for them to charge the extra $20 or whatever. One of the incentives to bulk-bill under the previous scheme, or the scheme that is currently in place, is the fact that it is easy. Doctors do not have to wait days for money to come in—or months, if some patients lose cheques.

Senator Patterson—If you talk to people in the community, they say, 'Why do I have to go to Medicare'—

Senator LEES—I understand that, Minister—

Senator Patterson—That is what they are asking: 'Why do I have to go to a Medicare office?'

Senator LEES—That is not the point.

Senator McLUCAS—That is not the point of the question.

Senator LEES—It is not about how the patient feels; it is the doctor's behaviour that we are trying to track.

Senator Patterson—For a lot of doctors now, you can fill out the Medicare form in the office and they post it off for you, if they can afford to wait for the cheque, so they are only paying the gap. The issue is waiting for the rebate or going down to the Medicare office. If you go down to the Medicare office, people there are saying, 'I don't know why I have to come down here to get my Medicare rebate back.' That is what people are saying. They would all like to have HIC Online without waiting. The way to control that is to insist that doctors bulk-bill health care card holders. But they now can bulk-bill many more than the health care card holders. You are implying that doctors will take the opportunity to charge a gap.

Senator LEES—I am talking about the ease of the opportunity, Minister.

Senator Patterson—That is implying that doctors are going to use this. Again, I am sure that they will be very interested in reading the *Hansard*.

Senator LEES—I am sorry, Minister, but when you talk to doctors, some of the practices that sign up have a very large number of cardholders. I do not know where your figures have come from but a lot of them are not convinced that the extra dollar or so in metropolitan areas is going to make a huge difference.

Senator Patterson—They also have to take into account that 800 practices will benefit from an indirect incentive of having a practice nurse. They have to factor that in.

Senator LEES—They are outer metropolitan practices; they are not the practices under pressure within the metropolitan areas that you are not going to differentiate or distinguish.

Senator Patterson—The officers have indicated to you how that assessment was made. I think that, when doctors sit down and have a look at the package in detail, they will see that the department's modelling indicates that the vast majority of them will be better off.

Senator ALLISON—I would like to ask a question about assumptions again. Doctors tell me that those who do bulk-bill some patients do not bulk-bill all concession card holders, for a range of reasons, and that many of them bulk-bill those who might be on low incomes or who might have chronic illness in the family at particular points in time. What work have you done with doctors to understand the pattern of bulk-billing within practices where both bulk-billing and private fees—that is, an increased copayment—are common?

Mr Stuart—The department has done analysis of billing patterns by GPs as part of preparing the estimates for this package.

Senator ALLISON—Is that analysis available?

Mr Stuart—We had a discussion about this earlier. The analysis is based on information supplied by the HIC which comes with very strict confidentiality requirements.

Senator ALLISON—In general terms did it find that most GPs bulk-bill concession card holders, or was it something other than that?

Mr Stuart—In general very few GPs bulk-bill nobody—it is a number less than 10 per cent. Very few GPs bulk-bill everybody—it is a number less than 10 per cent. The great majority of doctors bulk-bill some patients. The national average is still at close to 70 per cent because a very a large number of doctors bulk-bill nearly all, or all, of their concession card holders and a significant proportion of their other patients.

Senator ALLISON—That was not my question. My question was: do they typically bulk-bill concession card holders, or is it a range, as I have suggested, of other people?

Mr Stuart—On average, across Australia in the 2002 calendar year doctors were bulk-billing 80.7 per cent of all their patients.

Senator ALLISON—Again, that was not my question.

Mr Stuart—All their concessional patients. I am trying to answer your question, Senator.

Senator ALLISON—Thank you. So it is 82 per cent of concessional patients.

Mr Stuart—On average, across Australia, doctors are bulk-billing 80.7 per cent of all their concessional patients. I should clarify that that is at the concessional services level.

Senator LEES—Is that for all doctors, or is that just GPs?

Ms Halton—Unreferred services.

Mr Stuart—That is for GPs.

Senator LEES—GPs?

Ms Halton—It is for GPs.

Senator ALLISON—For those doctors who do have a combination of some bulk-billing and copayments, what is the average number who would selectively bulk-bill people on low incomes or people with chronic sickness in the family? Can you make some judgments about the frequency within which that happens, based on the analysis that you have?

Ms Halton—I think we have already tabled the table that shows that 85.8 per cent of concessional services in metropolitan areas are bulk-billed.

Senator ALLISON—That was not my question, Ms Halton.

Ms Halton—The point that Mr Stuart was making to you is that we do not have line by line information on every individual doctor's charging practice.

Senator ALLISON—That is not what I asked you, Ms Halton.

Ms Halton—The point I was making to you, and that Mr Stuart was attempting to make—and possibly we are not understanding your question terribly well—is that in a situation where 85.8 per cent of services to concessional patients in metropolitan areas, for example, are bulk-billed, it is basically only the residual that are not. If you are saying that the doctor chooses which of those patients to bulk-bill, that is correct. I think the minister is on record as saying that this package is asking doctors to bulk-bill all of their concessional patients.

Senator ALLISON—I understand that. All I am suggesting to you is that anecdotally at least—because I do not have the advantage of your analysis, which you are obviously not going to give us either—it would appear that there are many GPs who do not bulk-bill all of their concession card holders, and you have already demonstrated that, and for whom this will be a major change in the way that they do business because there is another group of people that they make judgments about providing bulk-billed services to. That is my question: on average, what is the analysis of those who currently bulk-bill outside the concession card holders for whom this new package is not attractive? What does the analysis tell us about those GPs?

Ms Halton—I do not understand your question; it is possible that I am extraordinarily obtuse.

Senator LEES—In terms of GPs who are bulk-billing people who do not have concession cards, there is no incentive in this package for them to keep doing that. In fact, the incentive is for them to swipe the card and ask the patients to pay an extra $20, $10 or whatever. There is no incentive in the package to bulk-bill anyone other than card holders. Is that right or do practice nurses come if you bulk-bill everybody? Isn't the incentive only for concession card holders?

Mr Stuart—Financially the package is neutral as to bulk-billing or not bulk-billing patients other than concession card holders.

Senator ALLISON—That is not the question.

Ms Halton—There is no requirement in this package in respect of nonconcessional patients. The minister is on the record as saying there is no reason, under this package, for doctors to change their behaviour because this package in fact provides more money to the system than is currently there.

Senator ALLISON—But this discriminates against those doctors who might bulk-bill the majority of their concession card holders. That is what they tell me: they bulk-bill age pensioners, but there are some on higher incomes who they do not think should be entitled to bulk-billing and there are others not on concession cards who they think should be entitled to bulk-billing. So they are making judgments all the time about who should and who should not be bulk-billed. They will miss out on this package if they do not agree to bulk-bill all concession card holders. That is correct, isn't it? My question to you is: how widespread is this practice amongst GPs? What have you discovered in your analysis in terms of how many doctors would take that approach—that is, bulk-bill some of their concession card holders and bulk-bill other people who are on low incomes, who might have sick kids or who might have chronic disease?

Mr Stuart—I think I understand your question now. What the doctor is doing in terms of their gap charging behaviour now is the starting point for the analysis. The incentives are there to invite them to opt into the package to change their behaviour. So I think we are essentially having a debate about the extent to which doctors will opt in and agree to change the billing practice that they have. I do not think that is an issue that leaps up at you out of the starting point analysis; it is a matter of thinking about how doctors might decide to opt in or not opt in to the scheme.

Senator ALLISON—Again I ask you: what analysis has been done of those doctors? Maybe what you are saying is, 'It is our policy that they should not continue with this practice because we'd sooner they bulk-bill concession card holders who are on $80,000 a year or whatever instead of families who might have very high health costs at a particular point in time.' Is that what you are saying?

Ms Halton—No, I have to say that, firstly, it is not us. There is a government policy in this regard. The government policy as espoused by the minister is quite clear—that is, there are positive incentives in this package to ensure that if you are a concession card holder and you attend a participating practice, you know that you will be bulk-billed.

Senator ALLISON—I understand what the government's policy is; what I want to know about is the analysis of GP practices to see whether the ones that I have met and talked with about whom they bulk-bill and whom they do not are common or not. If they are common then the policy has probably got it a bit wrong. That is the reason for my asking you about this.

Ms Halton—Essentially, what I understand you to be saying is that practices have put to you a position where they should be allowed the discretion, if you hold a concession card, as to whether you should be bulk-billed. The government's policy is that that decision about who

should be bulk-billed under this package is a function of whether an incentive is payable in respect of a concessional attendance and that if you sign up to this package all concession attendances would be remunerated and bulk-billed.

Senator ALLISON—I understand. So your analysis does not enlighten us; is this the answer to the question?

Mr Stuart—No. The analysis provides you with a starting point for estimating for whom would it be in their financial interest to take up the package. It does not illuminate the philosophical basis on which doctors may or may not make a choice.

Senator ALLISON—I am not interested in the philosophical basis; I am interested in the practice.

Mr Stuart—I believe the basis of your view, Senator, if I can be permitted to say so, is that the government's package ought to play to the structure of what doctors do now. I think I am arguing—

Senator ALLISON—I did not make that contention at all. I am asking you about your analysis.

Ms Halton—And as Mr Stuart has indicated, our analysis goes to which doctors there would be advantage for in participating. As I think we have already indicated, a significant proportion of doctors would be financially advantaged. There are other benefits—to wit, practice nurses, which we have already covered—from participating. The issue that you go to goes to whether doctors should be able to access these incentives and retain a discretion to choose not to bulk-bill a concession card holder. The government has decided that they do not believe that that discretion should be allowed for people who participate.

Senator ALLISON—I gather that. I do not think we are going to get any further with this. Maybe I need to talk to more GPs to find out what they do at present, since you do not seem to know.

CHAIR—Much of this is going to be handled in the select committee. I am a little confused as to why we are sawing sawdust here.

Senator Patterson—I take objection to Senator Allison saying that the department does not know. Mr Stuart said that some doctors bulk-bill. Fewer than 10 per cent do not bulk-bill anybody; fewer than 10 per cent bulk-bill everybody. I take objection to Senator Allison saying that the department does not know. Doctors have as many patterns as there are doctors in terms of the percentage of those in between those extremes.

CHAIR—I think the department has given very comprehensive answers.

Senator Patterson—I believe so, too.

CHAIR—I do not think it is fair to suggest that they have not.

Senator McLUCAS—The chair said that she thought the department had given a succinct answer to the question that Senator Allison, Senator Lees and I are trying to get to of whether there was any work done that would give you an indication one way or another that there would be a change in the charging of gap payments by doctors, participating or not, to non-concessional card holders. The answer that you have given, quite succinctly, is no, and you

have given a set of reasons why. Last week's *Australian Doctor* quoted a general practice manager, who said:

… the key advantage of the Coalition plan was that participating practices could offset the cost of bulk-billing concessional patients by charging other patients extra.

He identified that that is where the internal practice balancing would occur. He said:

Although the Federal Government has repeatedly claimed its package would not induce doctors to increase their fees … this was nonsense and that by charging non-concessional patients a gap, GPs could gain significant extra income ...

Senator Allison has had that presented to her as what will occur. I have as well. It has been commentated fairly broadly in the health and general media. Did the department at no time do any analysis of whether there would be an increase in gap payment for non-concessional patients as a result of the introduction of the package?

Senator Patterson—I will bring some figures up—I have not got them here—to talk about the increase in gap in the first half of the 1990s and the second half of the 1990s. We are going to talk about increases in gaps. When you freeze the rebate, the gaps go up. You might be interested in how gaps went up in the first half of the last 10 years and the second half of the last 10 years. I will get my office to get that data. It might be quite informative in this discussion.

Senator McLUCAS—Once again, it would be very interesting but completely irrelevant to the question.

Senator Patterson—It is not irrelevant to the question.

CHAIR—It is quite relevant to the whole issue. History forms part of the comparison that you are wanting to deal with now.

Senator McLUCAS—Did the department receive advice from the government that they were not to do that analysis? Was the department directed not to do any analysis of the inflationary effects of gap payments on non-concessional recipients?

Mr Stuart—The department undertook a wide range of technical modelling on what kinds of incentives would be required to remunerate GPs for a change in their billing practices towards bulk-billing concessional patients. The assumption underlying that is: let's produce a package where it is economically rational for GPs to opt into the scheme and where most GPs to opt in. Given the funding to GPs that opt in to make that economically rational, the other underlying assumption has been that other doctor behaviour in respect of their billing does not need to change; there is no need for that behaviour to change. So in terms of further analysis, you would need to be making starting point significant assumptions about what you would expect in terms of behaviour change in undertaking any analysis. There is no logical basis for the department on which to assume any particular nature or change in the behaviour of those doctors in respect of their non-concessional patients.

Senator McLUCAS—So you are predicting that there will be no change in gap payments for non-concessional patients.

Mr Stuart—There is background change currently ongoing with doctors changing their billing practices in various ways in the community.

Senator McLUCAS—Yes, I am aware of that. The question I am asking is: is the department predicting that there will be no significant change in the gap payments to non-concessional patients?

Ms Halton—Consequent on this package. In terms of the way the costings for this package were done, you would appreciate that our colleagues in the Department of Finance and Administration take a great deal of interest in those issues. The issue that you are going to, I think, is medical inflation: whether there will be a significant medical inflation issue as a consequence of the package. It is fair to say that the issue was debated by us and the Department of Finance and Administration and the consensus was that we did not expect, as a consequence of this package, a significant medical inflation effect.

We know, for example, there are other things that influence charging behaviours. One of the reasons why bulk-billing has stayed at a relatively higher rate in metropolitan areas than it has in rural areas in particular is as a consequence of competition between doctors. Similarly, we know that doctors now have access to different technology than they had when Medicare was introduced in relation to how they actually charge their patients. For example, when Medicare was introduced, it would have been almost unheard of to use your credit card to pay. Now people quite regularly choose to pay for everything with their credit card—groceries, doctors' bills et cetera. We do not believe—and the estimates which were discussed with Finance do not show—that, as a consequence of this package, there will be a significant medical inflation effect.

Just to make one other point, we were not instructed in any regard by the government in the construction of those estimates. Those estimates were discussed by the number-crunchers in our place with the number-crunchers in Finance.

Senator McLUCAS—You said that you had discussed a series of estimates with Finance. Is that a document that describes the package—what is that document?

Mr Stuart—The department, in the budget context, undertakes costings of all proposals put to cabinet and Finance signs off on those costings. It has the final say on whether or not the costings are accurate. So that is the process that was undertaken in relation to these estimates.

Senator McLUCAS—Does that include modelling of the various proposals?

Mr Stuart—Yes, that is right.

Senator McLUCAS—Is that document available to the committee?

Mr Stuart—As I said, that information is a part of the process of advising cabinet on budget policy and, as such, is not publicly available.

Ms Halton—I now have the table that we indicated we would get for you, so I table that.

Senator McLUCAS—Thank you.

Senator HARRADINE—Is the department aware of the article in *Good Weekend* of 31 May detailing how the 'big drug companies woo doctors with junkets, cash and dancing girls'?

Ms Halton—Is that a question under this program, Fairer Medicare?

Senator HARRADINE—That program is about access through Medicare to cost-effective medical services, which includes the behaviour of doctors.

Ms Halton—I think the question you are asking goes beyond Fairer Medicare. We had agreed, I thought, that we would deal with the Fairer Medicare package first. If we are now off the Fairer Medicare package—

Senator HARRADINE—It says that the therapeutic package is first.

CHAIR—No, we are dealing first with the Fairer Medicare package that was announced by the government. I think the question you are asking comes under a program further down that we can more specifically deal with later on.

Senator HARRADINE—Chair, I looked through all of these and I thought that it would come under here, because Medical and Pharmaceutical Services Division—

Ms Halton—That is true, but the question is whether or not we have finished Fairer Medicare, because we have been dealing with Fairer Medicare.

Senator HARRADINE—I am in your hands, Chair.

CHAIR—If there are no further questions on Fairer Medicare, you can be first cab off the rank. But I have a slight suspicion that there might be one or two more questions on Fairer Medicare.

Ms Halton—That was our suspicion too.

Senator McLUCAS—You are an intuitive bunch today, aren't you? I would like to go to the measure that instigates the $1,000 out-of-pocket expense with private health insurance. The minister's press release of 28 April, the day that the package was launched, says that it will cost families less than a dollar a week for the new protection—this is the $1,000 gap insurance through private health cover—and that the federal government's 30 per cent private health insurance rebate will apply. Does that mean that the product will cost families 70 per cent a week? I am trying to work out where the dollar comes from. Is it before or after the application of the private health rebate?

Mr Maskell-Knight—The dollar a week is before the 30 per cent.

Senator McLUCAS—Could you explain that a bit more expansively.

Mr Maskell-Knight—I understood you to be asking whether the dollar a week was gross of the 30 per cent rebate or net of the 30 per cent rebate.

Senator McLUCAS—That is right.

Mr Maskell-Knight—It is gross.

Senator McLUCAS—Can I go to the implementation then. Can you explain to me what will be happening between now and 1 January, which is the point of implementation, please?

Mr Maskell-Knight—I guess there are two streams of activity. One is the legislative and legal stream. Contingent on passage of the legislation, the health funds will have to submit to the department changes to their rules to encompass the new product. Assuming there is nothing in those rules that breaches the legislation and they have been notified that the rules will not be disallowed, they will then be able to embark on marketing the product and

enrolling members. There is also activity at the Health Insurance Commission end in designing a system to administer this new product and establishing the protocols for communicating with health insurance funds. The Health Insurance Commission will probably be better able to answer you about the details of that stream.

Senator McLUCAS—Mr Andreatta, do you want to add any comments about what HIC has to do to ensure delivery of this program by 1 January?

Mr Andreatta—The administrative arrangements that we are putting in place are basically looking at a registration process for health funds to supply the HIC with details of the members that are covered under this new initiative. Once that is done, there is also a claiming component, whereby patients will be able to claim from the HIC both the Medicare component of the rebate and the out-of-pocket expenses covered by their private health fund. That will be delivered for the 1 January start.

Senator McLUCAS—In fact sheet No. 4, the word 'extensive' is used again. I just want clarification of what services will be included and what might be excluded.

Mr Maskell-Knight—'Extensive' means everything which is covered by Medicare and is not an in-hospital service.

Senator McLUCAS—So the answer is the same as for the previous question?

Mr Maskell-Knight—Yes.

Senator McLUCAS—Also in fact sheet No. 4 you go to saying that this will be $1 a week, so it goes back to that question. Were any actuarial analyses done? How did you get to that notion of $1 a week?

Mr Maskell-Knight—We did receive actuarial advice. I should say that the fact sheet says that preliminary indications are that it will be less than $1 a week, rather than saying $1 per week. Essentially, it is an estimate based on the costs of the potential claimants divided by a reasonably conservative estimate of how many people are likely to take the new product up.

Senator ALLISON—Did that involve consultation with the private health insurance system?

Mr Maskell-Knight—We did discuss the concept with the private health insurance industry before it was announced, yes.

Senator ALLISON—The concept of around, or not more than, $52 a year?

Mr Maskell-Knight—We did not discuss costing with them, no.

Senator ALLISON—That was my question. Why not?

Mr Maskell-Knight—At the moment, I do not believe they have any data that would allow them to make a sensible assessment of what the costs might be.

Senator ALLISON—But the government have sensible data that allows them to make a judgment?

Mr Maskell-Knight—We do. Assuming the legislation is passed, in the stages leading up to that we are considering what sort of data we can supply to the industry which will help them to make a judgment.

Senator ALLISON—Would that be the time for informing people that it would be more likely to be some other figure, if that turned out to be the case?

Mr Maskell-Knight—That sounds like a hypothetical question.

Senator ALLISON—I am just trying to understand the process. If you have not asked the industry what they think the premiums would be, what do you do after you have asked that question?

Mr Maskell-Knight—The industry will have to notify the government of the rules they propose to put into their organisation that give effect to the new product, and part of that rule will be the price they intend to charge. If an organisation came along saying, 'We're going to charge $500 a year rather than $52 a year,' I imagine that we would have a conversation with them about how they came to that costing. We might challenge the reasonableness of whether or not that was an actuarially fair value. As I said, this is very much in the realm of speculation; it has not happened yet.

Senator ALLISON—The actuarial data takes into account the likely shift in out-of-hospital treatment in, for instance, oncology. What did you factor into that equation?

Mr Maskell-Knight—It reflects the current situation. The estimates of the cost to the government assume the same sort of inflation in premium costs that apply for in-hospital services.

Senator ALLISON—As I understand it, the shift between out-of-hospital services and GP practices is fairly significant.

Mr Maskell-Knight—I do not believe there is any data which would suggest that. Radiation oncology, for example, has been commonly provided as an outpatient service for quite a number of years now. I do not think there is an ongoing shift in that particular area. There has been a shift from overnight admission to receive hospital services to day only admission, but those are still counted as hospital services.

Senator McLUCAS—Is the date of the actuarial advice that was provided available to be given to the committee?

Mr Maskell-Knight—It was part of government consideration of the policy options; I do not believe it would be appropriate to make it available.

Senator McLUCAS—Just going back to the point that Senator Allison was progressing, one of the assumptions you used was that there would be in-hospital services growth in costs. Is that right? Did I hear that correctly?

Mr Maskell-Knight—In estimating government expenditure under this proposal, we assume the same rate of increase in premium costs that we assume for other health insurance premiums.

Senator McLUCAS—What other assumptions were used in the request you made to the actuary?

Mr Maskell-Knight—We outlined the scope we wished the product to cover. We provided them with current Health Insurance Commission data at a very high level about how many

individuals and families were faced with those sorts of gaps. It was a sort of distribution of the gap payments that individuals and families make.

Senator McLUCAS—Is that data about the number of families that you predict will reach the $1,000 threshold available to the committee?

Mr Maskell-Knight—We imagine that there will be 30,000.

Senator McLUCAS—Is that 30,000 individuals or families?

Mr Maskell-Knight—Individuals or families, yes.

Senator McLUCAS—In the same way that we have described individuals and families throughout this estimates today?

Mr Maskell-Knight—Yes.

Ms Halton—Yes, exactly the same.

Senator McLUCAS—So 30,000 families will reach the $1,000 threshold in Australia?

Mr Maskell-Knight—Yes. The minister has just reminded me that that excludes those who have a health care card. So it is the non concession card holders.

Senator McLUCAS—Yes, these are people who are privately insured.

Senator Patterson—No.

Mr Maskell-Knight—They are people who wish to become privately insured.

Senator McLUCAS—So 30,000 people will go over $1,000.

Ms Halton—Or families.

Mr Maskell-Knight—Individuals or families.

Senator McLUCAS—What are you predicting the take-up rate of this product will be?

Mr Maskell-Knight—We assume that there will be a fairly large take-up. The closest analogy is with things like ambulance insurance, which is very similar in that it has a relatively low premium against a very unlikely but potentially quite catastrophic cost. As well as the eight or so million people who have ancillary insurance which covers ambulances, there are another 300,000 people who have ambulance insurance as a stand-alone product.

Senator McLUCAS—Have you got a total figure that describes that large take-up then?

Mr Maskell-Knight—We are assuming that it will be around five million people.

Senator McLUCAS—Just coming back to the statistics we were talking about of the number of people who will hit the $1,000 out-of-pocket expenses, what is the average total out-of-pocket expense for those people who actually get to that figure?

Mr Maskell-Knight—I will need to take that on notice and get back to you later. I do not have that with me at the moment.

Senator McLUCAS—But that is available?

Mr Maskell-Knight—Yes.

Senator McLUCAS—Thank you, that would be good.

Senator MOORE—I have been advised that if you have out-of-pocket expenses for this kind of thing over $1,000 you can make a claim on your tax. I am just wondering whether this has any impact on that provision.

Mr Maskell-Knight—It is true that there is a medical expenses taxation rebate which covers not only medical expenses, narrowly defined, but a whole range of other items. This will, other things being equal, reduce the number of people that are able to claim the tax rebate.

Senator MOORE—So it would be either/or. If you had actually claimed under private health insurance, you would not be able to claim it on your general tax?

Mr Maskell-Knight—That is right, because you would not have an out-of-pocket expense; you would have been reimbursed.

Ms Halton—You cannot double dip.

Senator MOORE—No, but you can make a choice.

Senator Patterson—If you have not taken out insurance.

Senator MOORE—That remains your choice.

Senator Patterson—Yes.

Ms Halton—Yes.

Senator McLUCAS—Did the information I am looking for that you will provide, Mr Maskell-Knight, about the average out-of-pocket expenses for those who go over the $1,000 inform the decision to use $1,000 as the threshold?

Mr Maskell-Knight—I think it is essentially a policy decision about where to set the limit. I do not know that it was particularly informed by the distribution; there were a whole range of decisions that could have been made and the government decided that $1,000 was the appropriate level.

Senator McLUCAS—Is that the average out-of-pocket expense for non concession card holders?

Mr Maskell-Knight—No.

Senator McLUCAS—So it is much higher?

Mr Maskell-Knight—Yes.

Senator McLUCAS—What is the average out-of-pocket expense for non-referred services? You might need to take that on notice.

Mr Maskell-Knight—We would have to take that on notice.

Ms Halton—We will come back to you on that.

Senator Patterson—Do you mean non-referred services?

Senator McLUCAS—Yes.

Ms Halton—We will have to come back to you. I do not know whether we can get that answer today. So that is the average out-of-pocket expense for non-referred services for items not bulk-billed?

Senator McLUCAS—Yes.

Mr Maskell-Knight—For non-cardholders.

Senator McLUCAS—I might come back to you with a very specifically worded question that truly identifies the bit that I want.

Ms Halton—That might help. Is that all right?

Senator McLUCAS—Yes. I will take it on notice!

Senator Patterson—I think what you are asking for is the average cost of referred and non-referred out-of-pocket expenses.

Ms Halton—For non-bulk-billed items?

Senator McLUCAS—Yes, for non-bulk-billed items.

Senator Patterson—So, if you get to $1,000, what does the average get to—is that what you are asking?

Senator McLUCAS—Yes, I want the average after $1,000—so we are just talking about those people who do hit the threshold—but I also want the average for all of those patients who are not bulk-billed concessionally.

Senator Patterson—Before we say yes to that—if it is an easy figure to find, that is fine. But if it is a hard figure to find I think we need to tell you it means trawling through massive data to get that average.

Senator McLUCAS—Let us have a discussion about that afterwards.

Senator Patterson—If it is an easy figure to find, we will get it for you; if it is not, we will tell you it is not easy, and you can decide whether you want to pursue it—because I have a list of some of the costs on the questions we have been asked, and some of you would not like to hear those answers.

Ms Halton—Senator McLucas, if you can come back to us in writing to confirm the precise question, we will see what we can do.

Senator McLUCAS—Thank you.

CHAIR—Maybe we can lead off with that revised question after lunch so that officers can actually start working on it if need be. If you can have the final wording done by then, Senator McLucas, we can do that.

Senator McLUCAS—Okay. The measure is expected to cost $89.6 million over four years. Can you give me a breakdown over those four years and for the different components of the measure?

Mr Maskell-Knight—Yes. Something like $28 million is for Health Insurance Commission set-up, implementation and administration costs. The remaining $61-odd million is for the 30 per cent rebate costs. Is that enough detail or do you want it year by year?

Senator McLUCAS—Could you give it to me in the out years as well, please?

Mr Maskell-Knight—The Health Insurance Commission costs are $1.2 million this financial year, $8.7 million in 2003-04, $6.9 million in 2004-05, $6.1 million in 2005-06 and $6.2 million in 2006-07. The balance, which I must confess I have not subtracted yet, is the 30 per cent rebate.

Ms Halton—The balance is 59,227 for the administrative item and 1,345 for the departmental component.

Senator McLUCAS—That was 59,227and 1,345?

Mr Stuart—That is in thousands.

Ms Halton—He is trying to get me to say that it is $59,227,000 and $1,345,000!

Senator McLUCAS—Thank you.

Ms Halton—So the annual cost of the administered full year is about $17 million.

Senator McLUCAS—You said that 30,000 families were expected to take up the product. Is that in the next financial year?

Mr Maskell-Knight—What we are saying is that, based on current experience, we think there are 30,000 potential claimants.

Senator McLUCAS—Pardon me—five million was the take-up figure.

Mr Maskell-Knight—Yes.

Senator McLUCAS—Can you tell me if there is any change in take-up? Are you expecting that take-up to be immediate? What are your predictions?

Mr Maskell-Knight—We are assuming that that will be in the first few months of the product.

Senator McLUCAS—And then you predict that that level of take-up of the product will be maintained?

Mr Maskell-Knight—Yes.

Senator McLUCAS—So, essentially, five million over the next four years is the principle that we are working with?

Mr Maskell-Knight—Roughly, yes. We have not made assumptions about increases or decreases over time.

CHAIR—I think it would be appropriate if we called a halt to proceedings here and resumed at two o'clock.

Proceedings suspended from 12.51 p.m. to 2.01 p.m.

CHAIR—I call the meeting to order and call on Senator McLucas to encapsulate the rather complex question that she was putting before lunch.

Senator McLUCAS—It is very simple. The question is: what are the average out-of-pocket expenses which would be subject to the new private health insurance cover? It relates back to the third dot point in fact sheet No. 4, and uses the language around that.

Ms Halton—Do you mean for non-concession?

Senator McLUCAS—Non-concession.

Ms Halton—That may be hard to do, but let us go away and get some advice on whether we can do it quickly.

CHAIR—Thank you very much.

Senator HARRADINE—Does the department acknowledge that Australia's haemophiliac community has been devastated by blood-borne viruses?

CHAIR—I would have thought that that was asking a personal opinion. Would you like to relate it to policy in particular?

Senator HARRADINE—How many of those in the haemophiliac community have been affected by blood-borne diseases?

Dr Morauta—We do not have information of that type with us, but it may be possible to get it for you. Can we take that on notice and get back to you?

Senator HARRADINE—Yes, thank you. Is the department aware that, of the 2,000 Australians who suffer the lifelong inherited blood-clotting condition of haemophilia, 80 per cent have been infected with hepatitis C and 260 people have been infected with HIV through contaminated blood and blood products harvested by the Red Cross transfusion service and processed by CSL?

Dr Morauta—That is a question of the same ilk as the previous one, and we need to take it on notice to check the details you are providing and see if we have the information available.

Senator HARRADINE—Can the department explain why haemophilia sufferers do not have access to recombinant products, which contain little or no human product and therefore carry less risk to recipients?

Dr Morauta—There is some access to recombinant products now. I think basically about 30 per cent of factor 8 and factor 9 is currently being provided in recombinant form. As you are probably aware, there are some recommendations from a working party which go to this issue and which are being actively considered by state, territory and Commonwealth governments at this time.

Senator HARRADINE—I will come to that in a moment, but is the department aware that around 70 per cent of people with haemophilia must use plasma-derived factor 8 or factor 9 because of government policy?

Dr Morauta—That is correct.

Senator HARRADINE—Will the department continue to facilitate the production of plasma-derived products, which will mean that people with haemophilia do not have access to safer recombinant products?

Dr Morauta—I think I already covered that ground by saying that, as a result of the work of the factor 8 and factor 9 working party, governments are actively considering whether there is a need for change in policy on the use of recombinant products.

Senator HARRADINE—As to the time frame recommended by the working party, is it possible to have it brought forward, so that, by 1 January 2004, all people with haemophilia will have access to recombinant products?

Dr Morauta—I cannot prejudge how this matter will be finally resolved by government at this stage.

Senator HARRADINE—What is the reason for the delay of almost three years in the tabling of the factor 8 and factor 9 working party report and the implementation of its recommendations?

Dr Morauta—I will give a broad answer, but I might ask Mr De Graaff to give any additional material he has. The report was received finally from the Blood and Blood Products Committee in the department around two weeks ago. It was considered by the jurisdictional blood committee in its meeting last week. Peter, can you anything on the timing?

Mr De Graaff—I would add that, for the time before the Blood and Blood Products Committee took the report from the working party, there was detailed consideration going on. The Blood and Blood Products Committee made the decision that the final report was ready to go to governments for consideration.

Senator HARRADINE—At the present moment, would you not agree that it is discriminatory that some patients are selected to be eligible for the safer recombinant products, whilst others must use the less safe plasma products and that some have treatment rationed because they require an expensive product?

Dr Morauta—Those outcomes are the result of government policies which are currently under review.

Senator HARRADINE—Has the working party made a recommendation?

Dr Morauta—It has made a recommendation, which is now being looked at by a group of officials from the Commonwealth and state who advise state health ministers on such matters.

Senator HARRADINE—When is that likely to take place? When is the new regime likely to be introduced? Is it possible to have that introduced by 1 January 2004?

Dr Morauta—I am reluctant to speak on behalf of all governments, including state and territory governments, and say that there would be a particular time when that matter would be resolved.

Senator HARRADINE—Has the department, CSL and the Red Cross Blood Service sought legal advice as to the adequacy or otherwise of the assurance that these bodies give, which is that all reasonable steps are taken to safeguard the blood pool, premised with the proviso 'based on current knowledge'? Have any of those agencies or the department obtained legal authority as to the adequacy of that particular qualifier?

Dr Morauta—I am thinking hard, but can you just read that again?

Senator HARRADINE—Those bodies—that is, the department, the CSL and Red Cross Blood Service—give an assurance that all reasonable steps are taken to safeguard the blood pool, but it is premised with a proviso that it is 'based on current knowledge'.

Dr Morauta—I cannot speak for the CSL and the Red Cross; they would have to take those issues separately. But I think it would be true to say that governments across Australia are very anxious that they keep up with current knowledge and take reasonable steps in the light of it to safeguard the blood supply.

Senator HARRADINE—I am also concerned that doctors, hospitals and other groups may be exposing themselves to potential claims for compensation premised on negligence in the event of a new virus or illness emerging. I assume that the matter of the danger to health professionals was considered by the working group?

Mr De Graaff—I do not believe that was a specific issue addressed in the working party report, but I do not know for sure whether the working party in its deliberations considered that issue.

Dr Morauta—We are talking there about dangers to health professionals, aren't we?

Senator HARRADINE—Yes.

Dr Morauta—I think it would be generally true that as the security of blood supply improves, as it does with scientific advances, both the health professionals and the patients would be better protected.

Senator HARRADINE—Going to this question of the danger, is it the department's view that CSL could have liability under the defective products regime of the Trade Practices Act? Has the department sought, or will it seek, legal advice on this?

Dr Morauta—With respect to what particular matter might they have liability, Senator?

Senator HARRADINE—I mentioned to you about the department, the CSL and the Red Cross Blood Service and whether they had sought legal advice as to the adequacy or otherwise of the assurance that you have given that all reasonable steps were taken to safeguard the blood pool, premised on the proviso that it was 'based on current knowledge'.

Dr Morauta—The relationship of government to processes within CSL are partly within the context of the Therapeutic Goods Act as well as in the context of general funding—in fact, I think that may be the main interception you are talking about. But we would not know what legal advice CSL has taken on these matters.

Senator HARRADINE—Or TGA.

Dr Morauta—TGA are here, Senator, if you want to take it up.

Senator HARRADINE—They are coming on tomorrow, aren't they?

Dr Morauta—No, we have them here today.

Senator HARRADINE—When does CSL's current 10-year contract for the fractionation of plasma expire?

Dr Morauta—It expires on 30 June 2004.

Senator HARRADINE—When will the contract be decided for the supply of such plasma after the June 2004 date?

Dr Morauta—I could not put a time on that.

Senator HARRADINE—Will that be determined by the minister, by the National Blood Authority or by some other body?

Dr Morauta—I think it will be decided by the National Blood Authority, within whatever parameters the government across Australia gives to the Blood Authority in that matter, if we are talking about future plasma fractionation arrangements.

Senator HARRADINE—Has the department identified any problems with CSL during the time that they have had—or are continuing to have—the contract?

Dr Morauta—I think it is a matter of record—and there have been a number of audits pointing to this; I will get somebody if you need more detail—that there are difficulties with the current nature of the contract with CSL.

Mr De Graaff—There have been two ANAO audits of that contract and there has been one JCPAA inquiry on that contract in about the last five years

Dr Morauta—They go to the terms and conditions of the financial and administrative arrangements in the contract.

Senator HARRADINE—What particular problems have they identified?

Dr Morauta—In the broad, the problems have been with the administrative detail of the contract, problems with the pricing arrangements. Christianna, are you able to help with the problems with the current CSL contract that have been identified by the two audits by the ANAO?

Mrs Cobbold—The principal problems that the audits by the ANAO have dealt with have been around the payments under the contract around the nature of invoicing and reconciliation. Another audit dealt with some matters around a mid-term price review, which was provided for in the contract.

Senator HARRADINE—What problems, other than financial problems, have been identified with CSL?

Mrs Cobbold—I am not aware of any particular problems that you might be referring to.

Senator HARRADINE—Are you aware of the numbers of people who have been infected as a result of the use of blood plasma?

Dr Morauta—That goes to matters covered by the Barraclough report, in part. Are you talking about that?

Senator HARRADINE—Should I address these questions to TGA?

Dr Morauta—I think it might help. Obviously, the Barraclough report was set up to look at a particular set of matters, and there were findings in relation to those matters in the report. The department is aware of those and of what the findings of the report were.

Senator HARRADINE—I may follow that up with the TGA then. Chair, I have a number of other detailed questions. I think it might suit the committee and the department if I were to put those on notice and they could respond to them.

CHAIR—Thank you.

Ms Halton—We have the TGA people here today. A number of the officers who are relevant to blood are only here for today. The TGA have just arrived, so if there are other issues in relation to blood we would probably need to deal with them now.

CHAIR—Senator Harradine said that he was going to put the remaining questions on notice.

Ms Halton—That is fine.

Senator HARRADINE—I will be asking the Therapeutic Goods Administration other sorts of questions as well, so I would be happy to—

Ms Halton—Senator, in relation to your question about HIV transmission we will get the page of this particular report photocopied and distributed.

Senator HARRADINE—I have got it.

Ms Halton—There is a table—the annual surveillance report 2001—which goes to that question.

Senator HARRADINE—I have the report. I would have hoped that the authority might have summarised the problems, for the benefit of the committee.

Senator McLUCAS—Page 157 of the PBS describes the establishment of the National Blood Authority. Would you explain to the committee how those costings are affected and how the new Blood Authority is proposed to work?

Dr Morauta—I might start off. Behind the new blood authority is an intergovernmental agreement between the Commonwealth and the states about the revised arrangements. It includes a completely new set of funding mechanisms for the blood sector. The NBA will manage those funds on behalf of the Commonwealth, state and territory governments in a central way, purchasing nationally and having national agreements with the providers of services in the sector. The role of the NBA is to ensure that there are consistent national arrangements in the blood sector financially and, importantly, in quality and service delivery too.

Senator McLUCAS—Has that intergovernmental agreement been signed?

Dr Morauta—There is one just one jurisdiction, the ACT, which have not signed at the moment—all the other states and territories have—and we believe they will be signed relatively soon.

Senator McLUCAS—Is the agreement of the ACT required before this can progress?

Dr Morauta—I think the basic requirement was the Commonwealth legislation, and that has been passed and royal assent has been given.

Senator McLUCAS—You say in the document that the states and territories will 'manage the clinical use and administration of blood and plasma products more efficiently and effectively'. Can you explain how that will work practically?

Dr Morauta—The change in the financing arrangements has thrown new light on how blood products are used in Australia, particularly the products that come from CSL, which were previously fully paid for by the Commonwealth. Now the states will pay 37 per cent of

everything that they use, and this has drawn to their attention a number of matters in relation to the use of plasma products as well as other products. We have already seen quite a lot of examination of the use of blood products, which had not occurred previously, driven by these new arrangements. But I would also say that there are other sources of efficiency, which include national purchasing arrangements and national provider agreement. They also, by replacing some state based provider arrangements, stand to deliver efficiencies to governments over the medium term.

Senator McLUCAS—So essentially there are administrative efficiencies that will accrue?

Dr Morauta—Yes, that is right.

Senator McLUCAS—There will be national purchasing. States will obviously maintain a level of involvement. Are there any other safeguards that need to be applied to ensure the safety and availability of the blood supply? Is it simply an administrative change?

Dr Morauta—I think it is, very largely. But it has a number of availability and other benefits. For example, before there were very firm boundaries on the landscape. If the blood was collected here, it could only be used here. Now in a national system if somebody is running short of something the product can be moved around the country. I think the availability side is probably going to improve as we have a national system and we look to move product around if it is required. I think availability will improve. There is a very strong quality element in both the intergovernmental agreement and the NBA's charter, and their job will be to deal with it not just as dollars and cents but as quality product and quality processes in Australia and to check that they improve on a continuous basis.

Senator McLUCAS—Are the states and territories generally embracing these changes? Would that be your assessment?

Dr Morauta—Yes. I think it is a really good thing that so many cabinets around the country have agreed to sign and let their ministers sign these agreements. It is a sign that people did see the benefit of these new arrangements, wherever they were sitting.

Senator HARRADINE—I have a question which the department may be able to answer now—that is, in keeping with government policy in a number of other areas about cost competitiveness and commercial transparency, is the government considering selecting the next supplier of fractionated plasma through a process of competitive tendering?

Dr Morauta—I cannot comment on the matter, which is under consideration by government.

Senator HARRADINE—Minister, would it be appropriate for me to ask you at this time whether fractionated blood plasma is going to go out to competitive tender?

Senator Patterson—I do not think it would be appropriate at this time, Senator Harradine.

Senator HARRADINE—For the record, I do not know how it is that CSL got the contract in the first place. Was that through competitive tender?

Dr Morauta—Sorry, were you asking a question, Senator, or just making a comment?

Senator HARRADINE—I am asking a question.

Mrs Cobbold—The current plasma fractionation agreement with CSL Ltd was signed prior to the privatisation of the company, at which time it was a government business enterprise.

Senator HARRADINE—And were there any tenders called?

Mrs Cobbold—It was the sole supplier available.

Senator HARRADINE—There are other suppliers now, are there not?

Mrs Cobbold—At the time of signing that agreement, CSL was the only body with fractionated plasma available in Australia.

Senator HARRADINE—Yes, but now there are other bodies, are there not?

Mrs Cobbold—Other bodies able to do what, Senator?

Senator HARRADINE—To provide fractionated plasma.

Mrs Cobbold—Not in Australia. There are no other fractionators of plasma in Australia.

Senator HARRADINE—You have a situation where one of the problems I raise is that about 20,000 people have been affected by contamination blood.

Dr Morauta—Can I understand the question?

Senator HARRADINE—I am trying to see how seriously this matter is being considered by the department. When I asked the department about problems with CSL, you responded about financial problems, what the Auditor-General had said about various matters, cost issues. I am more interested in getting a straight answer about the numbers of people who have been infected by the use of blood plasma.

Ms Halton—Senator, that is why we had the TGA people in before. We will get them back again.

Dr Morauta—There are probably two separate issues here: one is the policy of government with respect to any particular safety measure and the blood supply and the second is how that is implemented by the provider arrangements that governments may have. That second part of that is for TGA to comment on.

Senator HARRADINE—I was asking about what will occur when the contract is about to expire. I am told that the contract with CSL expires on 1 July 2004. What steps are being taken to have a competitor tendering system whereby others involved in the fractionation of—

Ms Halton—That is a financial question about contracting. The TGA can answer questions about quality and the regulatory environment. The officers at this end of the table can answer questions about contracting.

Senator HARRADINE—Thank you; I understand that now. I am clear now—no financial matters. Mr Slater, have there been any problems with CSL?

Mr Slater—There have been issues that the TGA has taken up with CSL over the life of its exercise of regulatory authority over CSL, of course.

Senator HARRADINE—What have they been?

Mr Slater—They have related to compliance with good manufacturing practice. They have related to safety issues around particular products.

Senator HARRADINE—Has the matter of the receipt by a number of haemophiliacs—20,000 of them—of contaminated blood products originating from CSL cropped up in your discussions?

Mr Slater—Yes. The TGA makes recommendations about the regulatory system for standards to governments. Those standards are based on best practice available in comparable countries. The TGA is responsible for implementing standards and for the operations of CSL complying with the good manufacturing practice codes that they are obliged to comply with. We also assess what I call the state of the art as to testing and other safety processes and take those matters up with CSL as appropriate.

Senator HARRADINE—What was raised with CSL to prevent further occurrence of contaminated blood products? The 20,000 people who have received contaminated blood products have been caused a great deal of concern and pain. Did the TGA raise that matter with the suppliers of blood plasma?

Dr Morauta—Just going back a step, you mentioned how safety standards are set according to current medical and scientific knowledge. Quite a number of these people who, unfortunately, have been infected with hep C were infected during a period when scientific knowledge was not such that it could have been avoided. I do not think it is right to paint a picture in which all the people who got hep C got it as a result of error. A great deal of this is about the movement of scientific knowledge through a field and improved knowledge which enables us to prevent further infections occurring.

Senator HARRADINE—When was surrogate testing for hepatitis C introduced?

Mr Slater—I think Australia was either the first country or amongst the very first countries to actually introduce a test for the hepatitis C virus. We did that several years in advance of the FDA, for example. Countries like the USA had surrogate marker testing, which was a far less efficient system for identifying hepatitis C positive donors. In hindsight, the application of marker technology may well have been a mechanism that Australia could have considered at the time.

Senator HARRADINE—The US Food and Drug Administration advised that testing could and should be used to guard against hepatitis C and, in fact, a surrogate screening test for hepatitis C was used in the US from 1986.

Mr Slater—That is true.

Senator HARRADINE—When was it introduced here?

Mr Slater—It has not been introduced here. But, if you consult your records, you will find that the US was very slow to introduce testing. The first series of tests that was available for hepatitis C—

Senator HARRADINE—When was ours available?

Mr Slater—It was 1989, I think.

Mr De Graaff—The first mass screening test was introduced in Australia across the country in February 1990.

Senator HARRADINE—The test was introduced in Queensland in 1988.

Mr De Graaff—That is correct. The surrogate test was introduced in Queensland then.

Senator HARRADINE—How does that square with what you have just said?

Dr Morauta—Just to clarify—and I am going to page 42 of Professor Barraclough's report—by 19 February 1990 all Australian transfusion services had commenced universal screening for the anti-HCV antibody. The relevant dates on which similar things occurred in other countries were, for example, June 1990 in Canada, May to November 1990 in the USA and dates in 1991 for the UK and Denmark.

Senator HARRADINE—So surrogate testing was nationwide in 1990?

Mr De Graaff—No, surrogate testing was not nationwide in February 1990. Surrogate testing was introduced only in Queensland, in 1988. The first mass screening test across the country to detect the HCV antibody was introduced in February 1990.

Senator HARRADINE—But in Queensland they did it in 1998. Why didn't the nation follow? In other words, I am concerned about how many haemophiliacs were given contaminated blood could have been saved from that through action by the government, the department and TGA.

Mr Slater—I think it is important to note that the TGA was not the regulator of fresh blood back in 1988.

Senator HARRADINE—So I have the wrong person.

Dr Morauta—As I understand it, the first test designed to measure anti-HCV antibodies became available commercially in late 1989. It is those tests that were introduced nationally by 19 February 1990. Prior to that, there were no commercial tests available.

Senator HARRADINE—Except that Queensland had obviously introduced a test which was required and made sure that blood was clean in that state. I just raise this matter because there are number of people with haemophilia who have suffered because of this particular problem.

Dr Morauta—As I understand it from Professor Barraclough's report, on a lay reading, surrogate testing was the subject of studies in Australia, but the evidence produced conflicting advice about the best course of action. Professor Barraclough, in his report, discusses some of this conflicting advice. It was not that there was a clear-cut scientific case. In fact, it was rather the opposite—that it was a confused situation—and it was not until the next year that a commercial test became available that had more general support.

Ms Halton—If you go to page 39 of Professor Barraclough's report, he actually deals explicitly with the question of what happened in Queensland surrogate ALT testing and it goes explicitly to the reasons. He says:

There were several reasons why surrogate testing was not conducted routinely in Australia.

I just draw your attention to that page and the subsequent paragraph, which goes to a particular study indicating that they were lacking in both sensitivity and specificity.

Senator HARRADINE—I am not going to argue the specific points. There are responses to that as well. I will leave it at that for the moment and put the other questions on notice.

Senator McLUCAS—I want to go back to clarify some of the figures that we had just before lunch to do with the new private health information safety net measure. I think, Mr Maskell-Knight, you told us that $89.6 million over five years was going to be expended on that measure and that there are two parts to it: moneys to the HIC and moneys that would go to the rebate on that measure.

Mr Maskell-Knight—As the secretary has already indicated, there is also a little over a million dollars for departmental costs.

Senator McLUCAS—Essentially, am I right to say that about $60 million over four years is the contribution to the private health insurance rebate—is that ballpark?

Mr Maskell-Knight—Yes.

Senator McLUCAS—Which works out at about $15 million a year?

Mr Maskell-Knight—In a full year, it is a bit over $17 million.

Senator McLUCAS—You also said that the take-up rate would be about five million Australians and you predicted that that would be fairly standard right across the period.

Mr Maskell-Knight—The estimates are based on that being a stable number, yes.

Senator McLUCAS—I have just done a bit of maths. At $50 a year—that is a dollar a week—that gives us $250 million, which is the total premium income. Am I still correct?

Mr Maskell-Knight—You may be. I am not quite sure where you are going. We are saying the five million people will be made up of family groups. You are saying a maximum of a dollar a week per family.

Senator McLUCAS—That is where the error in my maths may be. So how many families are we talking about? We said five million Australians—how many families is that?

Mr Maskell-Knight—It will depend on what the mix is. I do not have the exact numbers with me and we do not know what they will be. It will be dependent on what the mix of families and single people is. But, as a broad approximation, you would probably expect something like two to 2½ million memberships in that.

Senator McLUCAS—So five million turns into 2.5 million if you aggregate them by family?

Mr Maskell-Knight—Probably. We can look at the existing pattern of membership as opposed to persons covered, but again we would be extrapolating the future of this particular product from the current pattern. If I can just interpolate, you asked what the average out-of-pocket cost was for people spending more than $1,000. It is $2,584.

Senator McLUCAS—Thank you. I want to get back to finishing off this dilemma for myself. Even if there were 2½ million families that took up the option, 30 per cent of the total premium by my figuring is a lot more than $17 million.

Mr Maskell-Knight—I can only say that there must be a mistake in your arithmetic.

Senator McLUCAS—Let us start with you answering the questions rather than me. You say that the take-up is about five million individuals.

Mr Maskell-Knight—Perhaps I can go back a step. Having worked out the cost of the likely claimants is, then in working out the 30 per cent rebate it does not really matter how many people take up the product. The take-up rate is only relevant in determining what the premium per person taking it up is. So if there are 30,000 singles or families likely to claim, and they are likely to claim something like $1,500 or $1,600 a year, multiplying that gives the amount of benefit which will have to be paid out. On the back of my envelope, allowing for some administration costs for the health funds, that works out at around $55 million a year. So 30 per cent of that number is about $17 million, which is the 30 per cent rebate.

Senator McLUCAS—So that figuring is on the payment of out-of-pocket expenses?

Mr Maskell-Knight—Yes. As I said, if the total amount paid out is around $55 million a year, then if one million people take it out the premium will be X, if two million people take it out the premium will be a smaller number and so on.

Senator McLUCAS—You are working at it from the point of view of the insurance provider; I am working at it from the point of view of the total potential cost, given those base figures.

Mr Maskell-Knight—But if you assume that everyone that is going to claim takes it out then the total potential cost will not vary depending on how many people take it out. We have effectively taken a very conservative estimate by saying that there are 30,000 families or individuals, on current estimates, that are likely to claim. If the system were in place this year, or had been last financial year, there would be 30,000. That is instead of assuming that all the people that are likely to claim are going to take it out. It is a most conservative consumption in that it assumes a 100 per cent adverse action. The issue then becomes what 30 per cent of that cost is. The number of people that take the product out does not matter once you assume that all the sick ones will.

Senator NETTLE—My questions probably go back to some stuff we have touched on already today. The first one is a data question. You tabled table 1 before about bulk-billing rates for concession card holders. I am wondering whether you have similar data available for the percentage of bulk-billing for non concession card holders.

Mr Stuart—By induction I think we do. We have total and we have concession card holders in a one-off special dataset which we used for the purposes of estimating. So subtracting the one from the other would give us some high-level estimates of that.

Senator NETTLE—Would it be possible to get a copy of that?

Mr Stuart—What would you like?

Senator NETTLE—We had a discussion earlier today about how that data is collected, and I understand that it is done on an individual GP basis and that that is not available. I think on the data formats we were talking about before for the concession card holders we had the data by statistical local area. Is that available for the percentage of bulk-billing rates for non concession card holders?

Ms Halton—We can produce the obverse of this table, which will show by deduction—in other words, we can turn the part of the equation missing into a mathematical identity—the figures for non concession card holders.

Senator NETTLE—Okay, that would be great.

Ms Halton—But not down to SLA level. So we can do it at this higher level.

Senator NETTLE—So only at a national level. I do not know in what datasets you have that information. I suppose I was picking up on SLA because that is where we were earlier in the discussion today in terms of the concession card holder data. That is why I was asking for the SLA level data; I am not clear whether you collect that per state, per RRMA—

Ms Halton—We do not collect that. I think the discussion earlier was about a process of statistical matching that had occurred in the department. Essentially, it will be an estimate. What we can do is give an estimate by the table which we tabled earlier. We can do the kind of balancing item of this more expansive table which we tabled earlier. That would give the non-concessional part of that table.

Senator NETTLE—Was the table you held up then the one in relation to the safety nets?

Ms Halton—No. I am sorry, I have scribbled on mine, but the one we tabled earlier went to non-hospital concession card services involving GPs for unreferred attendances. It gave information by RRMAs, number of services, number bulk-billed and then bulk-billing rate of concessional services. What I am saying is that we can put an extra box on the bottom of that table to show the non-concessional part. That was tabled earlier today.

Senator LEES—So you can show the bulk-billing rates for non concession card holders.

Ms Halton—By estimation. It is kind of by deduction, if you see what I am saying. We would have to give that on notice, because we do not have that here.

Senator NETTLE—I appreciate that. Could you tell us whether the department has done any modelling to forecast the impacts of the government's Medicare package on bulk-billing rates for concessionary and for non-concessionary patients?

Mr Stuart—There have been no official estimates of that produced. There has been no advice to government on that matter at all. There were some early attempts at playing with this in the department and we decided that it was not a feasible thing to do.

CHAIR—Senator, we have been through much of this this morning. I am wondering what is to be achieved by going back over it again, given that there is much more to be done.

Senator NETTLE—Having been here this morning but not having had the opportunity to ask questions on this, I thought we were coming to this part later whereas it now appears that we have covered it.

CHAIR—We have already covered what you are covering now.

Senator NETTLE—I have not have the opportunity to be involved in that. I have a couple more questions and then I am happy for us to proceed to another area.

CHAIR—If we could proceed quickly, that would be appreciated.

Senator NETTLE—Mr Stuart, on the basis that the modelling has not been done, how then does the department make determinations as to whether the implementation of the policy has been successful?

Mr Stuart—Over a period of time, the department will track a number of pieces of information, which are set out in the portfolio budget statements, as the indicators in relation to this policy. They include, for example, the number of general practices taking up the General Practice Access Scheme and the proportion of GP attendances by concessional patients where no gap fee is charged—that is, bulk-billed. So we will be monitoring a range of trends.

Senator NETTLE—Where my questions differ from those asked this morning is that I am particularly interested in the impact of bulk-billing rates for non concession card holders, which is something we have not discussed here.

Senator Patterson—Yes, it was discussed at length.

Senator NETTLE—I understand the process, and you have explained the impact on concession card holders. I am more interested in whether the department has in place processes for monitoring the impact of bulk-billing rates on non concession card holders.

CHAIR—Senator, this was all discussed this morning. I do not see where we are going when we have so much more to do in two days. If you have new material, that is fine, but I am not going to allow a rerun of this morning's debate. We have already had the answer to all of these questions thus far. Senator Nettle, if you have more questions that have not been asked today—and you were here all morning—I am happy to let you proceed.

Senator NETTLE—Where I am trying to get to—and, as you say, I have been here, and when I was not here I listened for the points—is what processes are there for determining whether the implementation of the policy is successful. What I might do is come back to any further questions on this area.

CHAIR—No. We finish one area then we move on to another. That is part of the problem: we are not going to go backwards and forwards. We have officers here to deal with a section. We will conclude that section so that those officers can return to doing productive work back in the department, and then we will move on.

Senator McLUCAS—I think it is productive here too, Chair.

CHAIR—I do not think sitting around waiting to be recalled 10 times is particular productive. I have to disagree, I am sorry. Are there any further questions?

Senator LEES—I have a general question. What was the estimate for the financial year 2002-03 of the total amount that would be spent on non-referred attendances, on GP attendances?

Ms Halton—Are you talking about the last budget?

Senator LEES—Yes, that is right—in other words, up to the end of this month. What was the forecast?

Mr Stuart—Noting that the financial year is not yet complete, there was an estimate in the last budget for this. We are going to see whether we can find it.

Ms Halton—We were not expecting questions about last year.

Senator LEES—I am looking at the expenditure for this year as well as the forecast: what is your forward estimate for spending on non-referred, unreferred, for the financial year 2003-04? I am wanting to get some comparison, given the changes.

Mr McRae—I certainly do not have with me any forward estimates for next year and obviously this financial year is not yet complete.

Senator LEES—But you have had an amount allocated in the previous budget for it.

Mr McRae—Because the Medicare payments are in fact a special appropriation, while obviously we estimate them there is not an amount allocated as such.

Senator LEES—The estimated amount. Will you take that on notice?

Mr McRae—I would have to. Sorry, I did not think to bring it with me.

Senator LEES—What about for the financial year 2003-04?

Mr McRae—Again, we have to estimate those things. The modelling works very well for Medicare as a whole, but obviously some of the components can bounce around. We do not normally put out forecast estimates for Medicare by its components; we normally put them out in the aggregate, because the nature of the modelling allows for some ups and downs between GPs and specialists, and this and that. Clearly we do model it at that level.

Ms Halton—This has been our practice for quite a long time.

Senator LEES—So that is why I could not find the figures!

Ms Halton—When I was in the Department of Finance about 15 years ago, looking at the estimates from the other side, this was always the case. As Mr McRae says, this is in toto a moderately precise science. In the micro it becomes less precise. We do tend to adjust all the way through the year, as it happens. So we can certainly go back, for example, and look at what we are expecting for—

Senator LEES—Are you able to provide the committee with the figures on notice?

Ms Halton—Yes, we will come back with those. I suppose the point I am trying to make is that the variations as they occur, up and down, within the Medicare aggregate are not necessarily of themselves meaningful or otherwise, simply because the way we estimate tends to be very imprecise at that more micro level. But we can certainly give you the figures for the current year and the year ahead.

Senator LEES—So you are not expecting, if you model that way, any changes due to the new package? You would expect the number of non-referred visits to remain constant?

Mr McRae—Certainly in the short term. In the long term, as the work force measures—which no doubt will be discussed later—work through, things will change.

Senator LEES—Can I ask questions on the enhanced primary care package now, Chair, or shall we just continue going through Medicare and come back to that later?

CHAIR—We will continue going through Medicare.

Senator LEES—I will come back to that later then.

Senator NETTLE—Has the department examined what might be the impact on bulk-billing rates of lifting the patient rebate across the board for all consultations?

Mr Stuart—No.

Senator NETTLE—In April the Prime Minister said that a $1 rise in the rebate would cost $100 million.

Mr Stuart—That is correct.

Senator NETTLE—Is that based on work the department has done in modelling what the impact would be of raising the rebate across the board?

Mr Stuart—No, that is a very simple calculation. There are on average in Australia per year about 100 million general practice services delivered. An extra dollar on the rebate is therefore one dollar multiplied by 100 million, which is $100 million.

Senator NETTLE—So that is the basis for that comment?

Mr Stuart—Yes.

Senator NETTLE—So the department has not done any more complex analysis of what would be the impact of increasing the rebate across the board?

Senator Patterson—Just increasing the rebate does not do the thing that I am trying to do in the package. You can have a bulk-billing rate of 70 per cent or 75 per cent across the board—that is of visits to doctors. That hides an inequity where there are people with health care cards living in some areas who have no access to a bulk-billing doctor and people like me who can go down to a bulk-billing office in Camberwell and be bulk-billed. Just increasing the rebate across the board is not going to actually get an outcome of making it fairer for people who are on a very low income, particularly those with a health care card or concession card.

Senator NETTLE—I suppose that is the nature of the question. I am trying to see what other proposals the department has looked at to increase the bulk-billing percentages of GPs in the development of the package the government announced—

Senator Patterson—You miss the point, Senator Nettle. It concerned me when I became health minister that there were people on health care cards getting maybe $11,000 or $12,000 a year who had never seen a bulk-billing doctor since the inception of Medicare. If we were to do something, by increasing the number of doctors in rural areas and outer metropolitan areas and increasing the number of nurses assisting those practices in areas of work force shortage we would increase the probability that people on a health care card or concession card would be bulk-billed. That was the task I set the department. I thought that was a responsible thing to do, because I was concerned about it.

Senator NETTLE—That is absolutely right to be concerned about the impact of bulk-billing rates on concession card holders. I have concerns about the impact of bulk-billing rates on non concession card holders. That is the nature of my questions.

Senator Patterson—Nobody has expressed a concern—ever—about the fact that there are people on health care cards living in rural and outer metropolitan areas who had never seen a

bulk-billing doctor. You have not been here for very long, so I excuse you, but there are a lot of people here pontificating who have never been concerned about that.

Senator NETTLE—How will the package ensure that all concession card holders will have access to bulk-billing services?

Senator Patterson—We cannot ensure anything. We cannot make doctors charge a certain fee. What we can do is give incentives to increase the likelihood. Since the inception of Medicare, it has always been the case that some doctors have chosen to charge more than the rebate.

CHAIR—That was the Labor health minister's position.

Senator Patterson—Yes. That was how Medicare was brought in. There was no cap. Look at what Dr Blewett said when Medicare was brought in. It was not intended that everyone would be bulk-billed.

Senator McLUCAS—How is the implementation program for additional medical school places going to occur?

Mr Wells—The places will be distributed across medical schools around Australia. We have had discussions with the Committee of Deans of Australian Medical Schools about the selection processes and that sort of thing. We are still working that through. The students who are selected to take up these places will be bonded by means of a contract with the department. That contract will specify what their requirements are. The bonding arrangements will be that when the student has completed their medical training—that is, either right through to finished specialist or general practice training—that is when the bonding period will commence. The bonding requirement will be to work for six years in an area of work force shortage, which is not just rural; it also includes outer metropolitan or wherever defined areas of work force shortage are. The penalty for not complying with the bonding requirement will be to repay either all or a proportion, depending on what period of time they have worked in an area of work force shortage, of the government's contribution to their medical training when they were at medical school.

Senator McLUCAS—You said you have had discussions with the Committee of Deans of Australian Medical Schools. When was that?

Mr Wells—That was last Friday.

Senator Patterson—I met with them as well.

Senator McLUCAS—Is that process going to identify which places will go to which schools?

Mr Wells—The two ministers, Minister Patterson and Minister Nelson, will determine ultimately the distribution of those places. But we have invited the deans to give us their perspectives and also we have invited the medical schools to let us know if they do not have the capacity to take additional students.

Senator Patterson—The bonded places will be distributed on a pro rata basis, so a university will not end up with a disproportionate of those bonded places. I think it is only fair that those places are distributed fairly across all the universities.

Senator McLUCAS—So they are just a straight pro rata—

Senator Patterson—If a university is, say, due to get five bonded places and they say they do not want them—if they indicate that to the deans—they would go down five places and we would put them somewhere else.

Senator LEES—Is there any waiting in those states that are particularly short of doctors, such as WA?

Senator Patterson—Do you mean places?

Senator LEES—Yes.

Senator Patterson—All those things will be taken into account. The sooner estimates are over the sooner I can have a long discussion with Dr Nelson.

Senator McLUCAS—It is a shame that democracy is so time consuming, isn't it! Will we have medical school places available from 2004?

Mr Wells—The timetable is for the intake of 2004.

Senator McLUCAS—The total number is 234. Do you know how many will be allocated as of next year?

Mr Wells—234.

Senator McLUCAS—So they are all allocated?

Mr Wells—There are 234 each year. They are ongoing.

Senator McLUCAS—I understand that there were applications for registration for status as a medical school from two private universities. Have you considered the potential for Notre Dame and Bond to come online in the life of the program?

Mr Wells—First of all, those two medical schools are currently going through the process of accreditation with the Australian Medical Council. Certainly we are factoring the potential existence of two new medical schools into the overall equation.

Senator McLUCAS—You said pro rata. Is that pro rata to the size of the university?

Senator Patterson—No, pro rata to the number of medical school places that they have.

Senator McLUCAS—Mr Wells, you were talking about the bonding.

Senator Patterson—They are the bonded places we are talking about being pro rata.

Senator McLUCAS—Yes. How does the person with the bonded place know the area that they are going to be located in? Is there the possibility of a movement between areas of work force shortage? How will you manage those sorts of questions?

Mr Wells—We will need to work through the fine detail of that as part of drawing up our contracts, because the students will need to know what they are entering into before they sign the contract. The contract will have to specify the defined areas of work force shortage as at the time of the contract. That would then be what applies to them six years, or whatever, down the track. Students are not required to work in a particular area; their contract simply requires them to work in an area of work force shortage. So they can move around between the areas

of work force shortage. That is not a problem. And it is not just general practice either; it applies to specialists as well.

Senator McLUCAS—What consultation have you had with the medical student organisations?

Mr Wells—We have had representations from them. We plan to include the Australian Medical Students Association, AMSA, in our consultations as part of the implementation process, but we have not yet got to the level of detail where we would formally approach them.

Senator McLUCAS—And that will be in establishing some of the detail of being able to transfer between areas of work force shortage?

Mr Wells—That is right, around some of the contractual arrangements, around how we define the areas of work force shortage—full consultation with AMSA.

Senator McLUCAS—Have you made any decisions about rural areas of work force shortage in outer metropolitan areas—where the split is—or will we have to wait six years, until they are—

Mr Wells—No, the principle we apply is that an area of work force shortage is where the supply of doctors per population is worse than the national average. The national average is currently one doctor for about 1,400 people, so areas that have a ratio worse than that would be defined as areas of work force shortage.

Senator McLUCAS—So you are not differentiating some areas of greater work force shortage than others?

Mr Wells—Not for the purposes of bonding.

Senator McLUCAS—It would just be everything over the average?

Mr Wells—That is right—not for the purposes of bonding. We are not bonding people to specific areas; we are bonding them in a personal sense. They can move across. We are not saying, 'You go to town X and you go to town Y.'

Senator McLUCAS—How will you actually spend the $42.1 million? Can you explain that for me?

Mr Wells—It is set out in the program budgeting statement. Most of that is in fact to the Department of Education, Science and Training for funding the places. I think it is $3.7 million to the department for departmental costs to administer the bonding arrangements. I will just get the page reference for you.

Senator McLUCAS—234.

Mr Wells—Yes, that is right. All those costs in that table for the Department of Health and Ageing are departmental costs, and for the Department of Education, Science and Training are administered costs which go to the universities to fund the places.

Senator McLUCAS—That is all the questions I have on that section.

Senator MOORE—When you said that the places were generally defined into areas of need, is that limited by state. So, if you happened to do your training at James Cook

University, it is not expected that you will do your areas of bonding in Queensland—and the same for New South Wales or Victoria?

Mr Wells—No, any area of work force shortage. If you train in Queensland you can work in a Victorian area of work force shortage.

Senator MOORE—And that will be negotiated through the term of the—

Mr Wells—That is up to the student and where they decide to go when they have finished their training.

Senator MOORE—I just wanted to clarify that.

Senator ALLISON—I want to ask a question about medical indemnity insurance. Is this a good time for doing this?

CHAIR—We will just carry on with the package for the moment.

Senator McLUCAS—I have some questions about the additional GP training places. Once again, the implementation of the measure was to start in 2004? What is the process of implementation?

Mr Stuart—The process of implementation is that the existing mechanisms are being used to expand, from 450 to 600, the number of general practice registrars who will commence next year. The organisation called General Practice Education and Training manages that for the government. It has already advertised for the additional 150 above the 450 that it previously advertised and is currently seeking interest from doctors wishing to become GP registrars.

Senator McLUCAS—So, essentially, that is the nature of the implementation from the department's perspective—simply talking to the GP registration body?

Mr Stuart—GPET is advertising for the additional places.

Ms Halton—They have already advertised.

Senator McLUCAS—They have already advertised?

Ms Halton—Yes.

Senator McLUCAS—When were those advertisements placed?

Ms L. Smith—The advertisements were placed very shortly after the announcement was made by the minister and Prime Minister. Advertisements had already gone out for this year's selection process. However, GPET advertised again and extended the deadline for applications in the light of the announcement.

Mr Stuart—We can find the date, if you wish. It was a couple of weeks after the announcement, I believe.

Senator McLUCAS—That is sufficient, thank you. How many of those places will be targeted to areas of work force shortage?

Ms L. Smith—GPET and the department have met on a number of occasions to discuss how best to allocate the additional places. For the 150, there have been areas of work force shortage identified and those have been provided to GPET. They will allocate the places using

the areas of work force shortage; however, they do need to take into account other variables such as the numbers of training practices available in particular places, the numbers of GPs et cetera. But the areas of work force shortage are, if you like, their first selection criteria for the 150 additional.

Mr Stuart—So it is a fairly flexible matching process, taking into account a number of variables.

Senator McLUCAS—Is the issue of the number of training practices available a significant deterrent to moving trainees into areas of work force shortage? It has been put to me that that is an issue.

Ms L. Smith—If there are no training practices available, then it is not possible for GP registrars to go into an area. However, under the outer metropolitan initiative, for example, this was an issue that came up and the department and GPET are working to provide assistance to practices to become accredited training practices.

Senator McLUCAS—How are you doing that?

Ms L. Smith—Under the outer metropolitan initiative there is specific funding for that.

Senator McLUCAS—Do you have a state by state breakdown of those 150 new places?

Ms L. Smith—Of where they are going?

Senator McLUCAS—Yes.

Ms L. Smith—Not with me but we can provide that, once it is available.

Mr Stuart—It remains to be finalised.

Senator McLUCAS—Through discussion with GPET.

Ms Halton—When we have it, we will give it to you on notice.

Senator McLUCAS—Thank you. I would like to see a separation between the new 150 and the current 450. We will put that on notice.

Ms L. Smith—Yes.

Senator LEES—Just looking at the current numbers, have they all been filled this time round?

Ms L. Smith—Yes. All the training places have been filled for this year.

Senator LEES—Are they all Australian doctors or are there some overseas trained doctors in some places?

Ms L. Smith—There was a larger proportion this year of overseas born doctors.

Senator LEES—Do they all continue to work in Australia? Is there any link between their training and continuing to work here?

Ms Halton—They were trained here.

Senator Patterson—When you say overseas born, you mean they were born overseas but educated in Australia.

Ms L. Smith—They were overseas born, but they are being trained in Australia.

Senator LEES—So they have all been trained in Australia and they are all staying in Australia.

Senator Patterson—We cannot make them stay. Like Australians who are born here, we cannot make them stay.

Senator LEES—As we have students coming into our universities from overseas, I am just wondering whether any of them were staying on, or able to stay on, and doing GPET.

Senator Patterson—These people are Australian residents or citizens who did medicine here. We just happen to know they were born overseas, because that proportion is increasing. By any use of the word, they are Australians who did their course here; they just happen to have been born overseas.

Senator LEES—And they are staying?

Ms L. Smith—The reason that people join the vocational training program is so that they can obtain the FRSEGP, which enables them to practise in Australia.

Senator McLUCAS—What is the start date for the additional nurses and allied health professions program?

Senator Patterson—You could tell us that, Senator McLucas.

Senator McLUCAS—I can?

Mr Stuart—The intended start date is linked to the start date of the General Practice Access Scheme and therefore dependent on the passage of that legislation. The government has in mind in 1 November.

Senator McLUCAS—Once again, in relation to the implementation process, what are you doing in order to meet that 1 November deadline?

Ms L. Smith—This fits into our more general discussions around the General Practice Access Scheme. The intention is that we will be speaking with doctors' groups about the best way to implement this and implement it in a way that fits with their practice arrangements.

Senator Patterson—We have done it before with the rural incentives, to get doctors into rural areas, by giving them nurse practitioners. So the department has experience of doing it once already, and the aim is to relieve pressure in areas of greatest work force need.

Senator McLUCAS—What areas will be identified for additional—

Senator Patterson—Areas of greatest work force need.

Senator McLUCAS—Areas of greatest work force need were explained to me a minute ago as anything over the average. Is that the same rule of thumb that you are using for this program?

Mr Stuart—It is the same formula that was described by Bob Wells previously. Because there are up to 800 practices that will benefit, depending on the take-up level we will begin with a group that we expect conservatively might take up a nurse. We will see what the take-up is and then we will move further in if possible.

Senator McLUCAS—So you are going to rank them from the worst?

Mr Stuart—We will begin with the areas with the greater work force shortage from within areas that are not currently targeted under the current practice nurse initiative, which is already available in rural areas. We are looking at outer urban and outer metropolitan, and then reaching further in.

Senator McLUCAS—The cost is $64.2 million. Can you provide me with a breakdown of those costings?

Mr Stuart—The cost overall is about $84 million. The administered costs are estimated to be at about $65 million for RRMAs 1 and 2. There is an expense of about $15 million for outer metro.

Senator McLUCAS—I am sorry, Mr Stuart, is that $15 million for outer metro additional to existing programs?

Mr Stuart—Yes.

Senator McLUCAS—Thank you.

Mr Stuart—There is about $5.5 million for retraining of nurses re-entering the work force, for upskilling and things of that kind. It is important to try to expand the nursing work force as a part of this initiative. There is an offset of $20.9 million from the MBS, which was from the outer metro initiative, that has been redirected towards this initiative. So the budgetary cost is $64 million.

Senator McLUCAS—So that is how it mixes with last year; I understand. The budget cost is $64 million, and then includes that $20 million from the outer metro program from last year.

Mr Stuart—That is right. So there is $84 million worth of practice nurse initiative but a net budget cost of $64 million.

Senator McLUCAS—I understand that. Have you predicted a take-up rate? Have you done any work on what the take-up rate might be, given our experience with the outer metro?

Senator Patterson—With country.

Senator McLUCAS—I am sorry, with the country program.

Mr Stuart—We think that practices taking up the general practice access scheme would be very likely to want to avail themselves of this scheme also. In rural areas the take-up from the eligible population of practices is about 65 per cent. But we are not assuming any particular take-up; I do not think that we need to. We will just work through practices, beginning with the areas that are the most needy in terms of work force, until the 800 practices have taken up the practice nurse initiative.

Senator McLUCAS—Do 800 come online immediately? What is the staging?

Ms L. Smith—It would depend on whether practices are joining the general practice access scheme.

Senator McLUCAS—But the 800 are available from 1 November.

Ms L. Smith—That is right. The funding that is there will fund nurses to cover 800 practices.

Ms Halton—The estimates do not show a gradual staging of these. The estimate is there so that, if there is sufficient subscription on day 1, that can be funded. Our experience in rural areas is in fact that these nurses are very popular.

Senator McLUCAS—Good.

Senator MOORE—I am interested in the fact that this is about nurses or allied professionals but, in this case, everyone always talks about nurses. The briefing statement and the budget papers talk about allied professionals, although the budget paper refers to practice nurses or physiotherapists, which is quite exclusive. My understanding was that there was an option of using a whole range of allied professionals; there is no peculiar favouring of physiotherapists.

Mr Stuart—No. I believe that was originally used as an example and became a word on its own. The intention is that physiotherapists are an example and there would be a range of possible allied health professions.

Senator MOORE—Your experience in the rural area indicated that there were sufficient nurses available to take up these places and they were keen to take the training.

Mr Stuart—As a blanket kind of assurance I could not tell you that there are not individual practices in individual places that would have difficulty acquiring a practice nurse. But practice nurse positions are reasonably attractive to people—for example, those re-entering the work force after a period. The upskilling that is provided assists, but also there is not a lot of heavy lifting and so forth involved; it is a general practice environment.

Senator MOORE—With standard working hours too, I would suspect.

Ms Halton—Certainly the conversations I have had with nursing organisations—for example, at the college—indicate their strong view that the nurses who are attracted to this kind of work tend to be demographically a bit different to the nurses in hospitals and that, exactly as Mr Stuart says, they are attractive positions. I think he had little inverted commas around 'heavy lifting', but literally there is an issue there as well. The kinds of nurses and people at certain family formation stages who will be attracted to this kind of work means that these positions are fairly popular. Certainly the college are saying that they think they will be particularly popular and oversubscribed with people looking for an opportunity.

Senator MOORE—I am interested in the previous work in rural areas and also, as the uptake comes through with these practices, in the spirit of the nursing people moving into them as opposed to the people, particularly the Aboriginal health workers—whether the positions are taken up in some of the inner city areas in particular where there may be some shortages.

Ms Halton—One of the reasons we are keen to have a bit of flexibility is that it is not a one size fits all model and not all practices want a nurse or need a nurse. Sometimes there will be some other form of professional who will be relevant to their needs and we will be keeping an eye on that as well. We would be happy to illuminate you as we go along with implementation.

Senator MOORE—Do psychologists fit into this heading?

Mr Stuart—Yes.

Ms Halton—As far as the minister and I are concerned, yes.

Senator Patterson—We have to declare a vested interest on behalf of us both.

Senator MOORE—In some areas it could be particularly useful to have someone with a psychology background.

Ms Halton—Absolutely.

Senator McLUCAS—I think we covered benefits for general practice earlier today, so we will move on to veterans' health measures.

Senator Patterson—Maybe we do not need to have the inquiry now that we have done all that.

Senator McLUCAS—I am sure there are far more questions that need to be asked—

CHAIR—We have now handled that section of the inquiry.

Senator McLUCAS—and answers to be found. Once again, the start date of this measure is associated with the GP access program.

Ms Halton—Veterans, unfortunately, are not something we can talk about. This is a matter for the Department of Veterans' Affairs.

Senator McLUCAS—I will leave that to them. Around $21.1 million has been budgeted for information to the public and the medical professions. How much of that has already been spent and what has it been spent on to date?

Dr Wooding—Of the $21.1 million, $1.9 million was allocated for this financial year. We are still in the process of spending it and finalising that expenditure, so I think I would rather give you are complete picture of that at the next estimates, if that is okay.

Senator McLUCAS—When you say 'this financial year' do you mean the current financial year, 2002-03?

Dr Wooding—Yes. There is $1.9 million there and in the next financial year there is the remainder, which is $19.1 million or $19.2 million, depending on how you round it.

Senator McLUCAS—The $19.2 million, shall we say, is in 2003-04?

Dr Wooding—Yes.

Senator McLUCAS—I take your point about the year not being complete and the program not being complete, but could you give me an indication of how much has been spent on advertising in the print media to this point?

Dr Wooding—There was a series of public notices placed in newspapers, which were about the 1800 information line and the department's website. The cost of the advertisements was $148,000. Furthermore, there was some translated material, which cost a further $19,008, and related to that were some audio recordings that were produced, which cost $1,200.

Senator McLUCAS—The other information project that we have been given information about today is the mail-out to GPs that the minister did. Was that included in that?

Dr Wooding—No, the letter to GPs was separate and cost $16,733.

Senator McLUCAS—$16,733?

Dr Wooding—Yes.

Senator McLUCAS—What other elements to the program have there been?

Dr Wooding—In general terms, other elements include the following. We did some market research to develop the initial approach to announcing the package. We have a communications planning consultancy with Gavin Anderson and Co., who were engaged to assist us with the planning around the announcement of the package and the follow-up public discussion of the package.

Senator McLUCAS—Is the consultancy with Gavin Anderson different to the market research that was undertaken?

Dr Wooding—The market research was undertaken by Worthington Di Marzio.

Senator McLUCAS—How much did that cost?

Dr Wooding—That cost $39,050.

Senator McLUCAS—Is it available to the committee?

Dr Wooding—It is the nature of these things that while they are still being used for policy development and policy work we do not supply them.

Senator McLUCAS—What were the principal items you were testing in that market research?

Dr Wooding—It was about the way that the package would be announced and the title of the package.

Senator McLUCAS—The title?

Dr Wooding—Yes, and way it would be announced.

Senator McLUCAS—When you say 'the way it would be announced' do you mean the manner in which it would be announced—for example, by the Prime Minister in a ministerial statement?

Dr Wooding—It was more the title that was the main thing.

Ms Finlay—The Worthington Di Marzio research focused on two elements. The first, as we have just discussed, was looking at the question of the potential title of the package. The second element was to examine the awareness amongst the groups of Medicare and what Medicare stood for. That in turn informed the titling of the package.

Senator McLUCAS—Can you go through the second part again?

Ms Finlay—The second part was about awareness of Medicare and the view of Medicare which was held by the groups that were tested.

Senator McLUCAS—In terms of the total cost of nearly $40,000, is there a split in terms of how much was attributed to each part, or not really?

Ms Finlay—Those two parts were intertwined, because one informed the other.

Senator McLUCAS—So it cost us $40,000 to come up with A Fairer Medicare?

Ms Finlay—It was not $40,000 simply for the title. As I was saying, it enabled us to get some background information on views in the community about Medicare, which informed the way in which, for example, we set out information in the fact sheets that were supplied which described the package.

Ms Halton—Senator, it is probably a fair observation. We all struggle with understanding the ins and outs of how Medicare works. We have discussions here where sometimes we discover we are talking at cross-purposes and we are a relatively informed audience. The reality is that issues like gaps—what people understand by what their entitlements are under Medicare—are quite complicated. Our intention always is—I hope—that when announcing anything we announce it in a sufficiently clear manner which is accessible to the broad range of people in the population. It is fair to say that we do not always succeed with that objective, but that is what we try to do. This work that was undertaken went to that broad question of how you explain in fairly simple terms and in a way that is accessible to the broad community. The research was designed to attempt to ensure that we did not confuse in the information provided and that the information was clear and was able to be understood by the majority of people who would come in contact with it. One by-product of that was the name. Essentially, it is about how you get people to understand the proposal.

Senator McLUCAS—Slightly different from Dr Wooding's intent. Then you had a consultancy with Gavin Anderson.

Dr Wooding—That is around the strategy for announcing the package and then for continuing our communications in the period after the announcement.

Senator McLUCAS—How much was that?

Dr Wooding—That was on a basis that a bill was for the amount of work they had done. They were selected through a tender process and then they billed us for the work they had done. As of 16 May, they had billed us for around $100,000, but the contract is continuing.

Senator McLUCAS—What was the sort of work that Gavin Anderson undertook in that consultancy?

Dr Wooding—It is largely advisory work. They are advising us on approaches to communication and some strategies around the communication.

Senator McLUCAS—Is that communication with the broader public or with the stakeholder, such as letters to GPS?

Dr Wooding—Both of those, Senator.

Senator McLUCAS—What is the estimate for expense on that consultancy for this financial year?

Dr Wooding—There is no estimate. That is one of the reasons I cannot give you a total figure so far. We will see what happens. We have them engaged until the end of this financial year and then we will also reconsider whether we will continue using them beyond that point.

Senator McLUCAS—What other items fit in with the expenditure under this program?

Dr Wooding—We had a stakeholder briefing on 28 April when we introduced the stakeholders to the elements of the package. That event cost $7,427. We have an information

line, which is another one where there is an ongoing cost. I cannot give you an exact figure but so far, as of mid-May, we had spent approximately $190,000 on the information line.

Senator McLUCAS—That is the one that was advertised right at the beginning of the program?

Dr Wooding—Yes.

Senator McLUCAS—Do you have any data on how many calls we have had on that line?

Dr Wooding—I would have to take that on notice.

Senator McLUCAS—Thank you. Could you tell me the hit rate, maybe week by week, since it has been established—the number of phone calls received on that line from then until probably the end of this month would be useful.

Ms Halton—This month, June, or last month, May?

Senator McLUCAS—Make it until May.

Senator Patterson—Maybe we should have a look at the hit rate on the days that the two state premiers put taxpayer funded ads in the paper which were incorrect.

Senator MOORE—What kind of data is kept from the help line? Is it just how many calls or is it the nature of the calls? What kinds of sheets do your operators keep on a daily basis?

Ms Finlay—I can answer that. Basically, we provide information on the conclusion of the call—whether the person, for example, requested some information sheets to be sent to them or whether they were satisfied with the answers they received when they were talking on the line. We collected information about their gender and also the type of inquirer—for example, whether they were a concession card holder, a veteran or whatever. This information that is collected is voluntary when we asked for information on the phone.

Senator MOORE—Is it possible, when you provide Senator McLucas with the data on the numbers, to get a composite view of those kinds of issues?

Dr Wooding—We will see what we can do.

Senator MOORE—Whatever you can give us would be useful.

Senator McLUCAS—Dr Wooding, are there any other components of the advertising expenditure—

Dr Wooding—At this stage, there is internal departmental work, including on the web site and on managing the process within the department. Obviously, there will be other things as we move along. There was some material produced in our normal budget package as well which related to these measures—the fact sheets that you have been working off—and others. Certainly a whole lot of internal work goes on as well that will be part of that expenditure. That is another reason. We will give you a complete picture of that at the next estimates.

Senator McLUCAS—That is good. What sort of work have you done to this point on planning for the 2003-04 expenditure of $19 million?

Dr Wooding—I think we will just be starting to work on that now. Really, most of the expenditure there will depend on the passage of legislation through the Senate. So we will probably begin our major efforts in that area once that process is complete. But we are

thinking about it and will obviously be reviewing what we have done so far and looking at what we feel we have learned from that and taking that into consideration in the next stage of the process.

Senator McLUCAS—Is there any expenditure planned between now and the passage of the legislation in the Senate?

Dr Wooding—I think that during the day you have heard about possible further communications with stakeholders and strategies around that. We may also, as I suggested, continue to receive some assistance from Gavin Anderson, and there may be some other things of that nature. But the campaign as such, as defined, would not begin until after the passage of the legislation.

Senator McLUCAS—That is all I have on advertising. On 20 May there was a announcement that the government would make payments to GPs to assist them in improving the electronic management of patient records.

Ms Halton—Can we assume we have moved off A Fairer Medicare?

Senator McLUCAS—That is correct. We have finished with A Fairer Medicare.

Senator ALLISON—No.

Senator McLUCAS—No? We are not.

Ms Halton—I just thought I would check.

Senator ALLISON—I want to talk about radiation oncology, on page 96 of the budget papers.

Ms Halton—That is not A Fairer Medicare either. Radiation oncology is a different matter.

Senator ALLISON—Well that was in the budget papers.

Ms Halton—It is Medicare proper but it is not the A Fairer Medicare package. That is why I asked the question.

Senator Patterson—We are not going off Medicare; we are just going off the package. We have to go off the package to move onto that.

CHAIR—Is there anything more on the package before we move onto general issues in outcome 2?

Senator HARRADINE—The question I started asking before lunch—

CHAIR—If there is nothing more on the package—

Senator LEES—I have some questions on enhanced primary care, but that is not the package either.

Senator HARRADINE—I have got a couple of questions on A Fairer Medicare that I will put on notice.

Senator ALLISON—I have a question about practice nurses and that package and wondered what work was done prior to that announcement on establishing which GP practices typically had practice nurses already and whether research has been done into the degree of uptake across the sector.

Mr Stuart—This is essentially an extension of the current scheme, which is working well in rural areas, so the department has a fair amount of experience in this particular area. In terms of metropolitan practices and what they do with practice nurses, the practice nurse initiative for rural areas and the new one associated with the package operate by paying practices a subsidy towards the salary of the practice nurse. Where such a subsidy is not paid, we do not know about practice nurses in practices other than through higher level data.

Senator ALLISON—The reason I raise it is that I was talking with a rural doctor recently. I asked him if he was pleased about this package and he said, 'I use a practice nurse in any case. This just means I get a bit of extra money to cover it.' So with this measure what do you expect to be the result in uptake of practice nurses? The money is not actually tied to their employment—or is it?

Mr Stuart—The money is specifically for payment of a practice nurse or an allied health worker.

Senator ALLISON—What is your estimate of the number that are already there which would simply be covered by this? In other words, of the number of nursing full-time equivalents you are expecting this package to deliver, how many are already there anyway and will this measure not result in extra being employed?

Mr Stuart—We have data from a few years ago which suggests that there is a level of practice nurse employment in RRMAs 1 and 2—that is, capital cities and other large towns.

Senator ALLISON—What is that level?

Mr Stuart—I am advised that it is 26 to 28 per cent. In rural areas the experience is that practices do take up the practice nurse initiative. It adds to the income of the practice. There must be a practice nurse for the initiative to be claimed. More anecdotally, there are increases in the employment of practice nurses in rural areas as a result of the initiative.

Senator ALLISON—So what would you say the net benefit was in increasing the number of practice nurses? Would that suggest that it is somewhere between 70 and 80 per cent?

Mr Stuart—I do not think we can be specific on that. We would expect an increase in the net employment of practice nurses, but we do not have enough information to be able to say by how much.

Senator ALLISON—Where is it assumed that these nurses will come from? What would be the equivalent full-time positions in this measure? Assuming they are all taken up, how many extra nurses are we looking at?

Ms L. Smith—The funding amounts to funding that would enable 457 full-time equivalent practice nurses to be funded.

Senator ALLISON—So given that there is a nursing shortage at present, from what sector do you expect these to be recruited?

Ms Halton—If I could make a comment about this: there is a shortage being experienced by a number of institutions in finding nurses to work in those institutions. You are probably aware that there are a very significant number of people in the community who have trained as a nurse in the past—

Senator ALLISON—That is my question—do you expect them to come from the group that has been trained and is now doing something else?

Ms Halton—We would not be surprised if a significant proportion of these people came back to the profession. They have made an active choice that they do not wish to work in an institutionalised setting, but the nature of the work—the regular hours and a series of other things about it—make it an attractive proposition for people to come back in and retrain.

Senator ALLISON—Is that just guesswork or have there being studies done?

Ms Halton—It is certainly what the profession is telling us.

Senator ALLISON—Is this the nursing federation?

Ms Halton—And the college.

Senator ALLISON—Thank you.

CHAIR—As there are no further questions on the package, we will move on to general items and outcome 2.

Senator HARRADINE—Chair, can we move to the question I raised before lunch?

CHAIR—Yes.

Senator HARRADINE—Is the department aware of the article in the *Sydney Morning Herald Good Weekend Magazine* on 31 May detailing how 'big drug companies woo doctors with junkets, cash and dancing girls'?

Ms Corbett—Yes, the department is aware of that article.

Senator HARRADINE—Is there concern that drug companies spend more than $1 million a day on promotions in Australia to influence the prescribing patterns of doctors?

Ms Corbett—That is certainly of a general concern. That particular data relates to companies overseas and it is certainly not specific to their operations in Australia. Many of the allegations in the article do relate to activities a number of years ago.

Senator HARRADINE—The way it was stated was that in Australia the drug companies—leaving aside what they spend elsewhere, which is a huge amount—spend money to influence the prescribing patterns of doctors. Have you investigated the impact of such marketing where companies may attempt to convince doctors to use a high-cost name brand pharmaceutical rather than a low-cost alternative?

Ms Corbett—We have certainly been interested in low-cost alternatives to the pharmaceuticals produced in Australia. As you would be aware, we are very actively supporting the use of generic medicines. Indeed, at the moment we are involved in an information strategy to improve consumer, prescriber and pharmacy knowledge of generic medicines. Through that and other operations of the Pharmaceutical Benefits Scheme, I believe we are promoting brand choice and we are certainly interested in competition. That assists in keeping the costs of pharmaceuticals down.

Ms Halton—Can I make a comment about the whole way in which the industry regulates its approach to sponsorship, particularly that part of the article that you read out. I think the article failed to acknowledge that the local industry code changed with effect from 1 January

this year. The change to the code provides guidelines for the ethical marketing and promotion of prescription pharmaceutical products.

It is important to note that the code of conduct includes provisions relating to promotional material, activities of medical representatives and sponsorship, with significant sanctions for breaches. Those sanctions, I understand, can go up to $200,000 worth of fines for Medicines Australia for breaches. My understanding is that Medicines Australia has said publicly that it wants the code to be able to withstand public and professional scrutiny. It has been amended to reflect that. It says explicitly that sponsored professional health care activities must conform to community standards and enhance quality use of medicines. In particular, it prohibits the inclusion of entertainment in any interactions between companies and the doctor.

I think we are all aware that a number of years ago there was quite a lot of scrutiny of arrangements between pharmaceutical companies and doctors. To be fair to Medicines Australia, this new code of conduct goes explicitly to those issues. As Ms Corbett says, there are things we are also doing in relation to ensuring that people understand those kinds of issues, but the article did not acknowledge that explicit change since 1 January this year.

Senator HARRADINE—But who are Medicines Australia?

Ms Halton—They are the industry body.

Senator HARRADINE—Exactly. So they are the industry—they are the drug industry.

Ms Halton—Correct.

Senator HARRADINE—They have a self-regulatory regime—a code of practice?

Senator Patterson—Which they have changed. Medicines Australia were also very aware—more aware, most probably, than some people on the other side who opposed the changes to the legislation last year—that the PBS was unsustainable, and I think I made it fairly clear that the government had a concern that the PBS was growing at an unsustainable rate. Encouraging the industry to change its self-regulation was part of an overall suite of reforms and changes to try to bring the growth of the Pharmaceutical Benefits Scheme to a sustainable level. It was not sustainable at that rate. Even at its current rate, I think it is going to be something like $7 billion in 2007.

Senator HARRADINE—Could we have a copy of the code of conduct?

Senator Patterson—I think it is on the Medicines Australia web site. I think they sent it out to every member of parliament.

Ms Halton—We actually tabled it at the last hearings, but I am happy to table another copy.

Senator HARRADINE—Thank you. Who is monitoring that code of conduct?

Mr Rennie—The industry itself.

Senator HARRADINE—So the industry itself is monitoring the code of conduct. Who is on the board of Medicines Australia?

Ms Corbett—The board of Medicines Australia is made up of representatives from the industry and the CEO, who is a full-time officer of the organisation.

Senator Patterson—One part of the code—which they did not do—was to place on the advertisements the PABC guidelines for prescribing a medication. I have to say to you that I monitor those advertisements very closely.

Senator HARRADINE—Are Pharmacia and Pfizer on the board of Medicines Australia?

Ms Corbett—I would need to check. We should be able to find that out fairly quickly.

Senator Patterson—It would be on the web site.

Ms Corbett—I think neither of them is currently on the board, but I may be incorrect.

Senator Patterson—That should be on their web site, Senator. It is an industry body; we do not control who is on the board, and it really is not appropriate for the officers to provide that information. What used to be called the Australian Pharmaceutical Manufacturers Association, the APMA, is now called Medicines Australia.

Senator HARRADINE—Are you aware that some drug companies also bought expensive prescribing software for thousands of doctors, which allowed the drug companies a direct influence on doctors' prescribing patterns? Is that appropriate? It is an ongoing gift from the pharmaceutical industry.

Ms Corbett—I believe the major software providers are not directly related to the manufacturing companies. I would need to check to be absolutely certain that no software is provided directly by companies. The major software providers assisting prescribers are run by other groups. Perhaps the largest one is the one that runs Medical Director, known as HCN. As far as I am aware, it is not directly related to the pharmaceutical manufacturing companies, but we could take it on notice to find out what sort of relationship exists between the two. I should perhaps clarify that we are aware that they get some of their income from advertising, and this is an area that we have been discussing with them and that we discussed with Medicines Australia. Those discussions have led to a recent commitment to improve the relationship between what is advertised on software and the actual restriction or target patient group that is consistent with the PBS listing for particular drugs. The companies have undertaken to line that up rather better than it has been at times in the past.

Senator HARRADINE—Thank you. This information technology comes at a cost, which is borne, as I understand it, in some manner by the pharmaceutical companies—either directly or indirectly.

Ms Halton—I think what the officer is saying is that that is not consistent with our understanding.

Senator HARRADINE—No, I am saying, directly or indirectly, the officer said that advertisements are placed—presumably advertisements for certain drugs and the manufacturers of those drugs. What I am getting at is that this is a backhanded gift. Is that consistent with the code of practice of Medicines Australia?

Ms Corbett—I am not quite clear what you mean by 'backhanded gift'. Our understanding is that the prescribers pay for the software, the software is provided by a private company and that private company does do some business in advertising. Obviously you are correct that there are advertisements in the software that relate to particular pharmaceuticals, But I do not

think there is what you might see as a kickback to doctors involved in that. There is a direct purchasing relationship between prescribers and the software company.

Senator HARRADINE—When you see an ad, you know that somebody has paid for it. In this case it is not the doctors; somebody has paid for it. And what is the payment? Part of the payment is surely the provision of this material at least at cost price, if not less, by the company that is providing the information technology and systems. Is that consistent with the code of practice of Medicines Australia?

Ms Halton—We will take that question on notice. At the end of the day, the fact that there may or may not be a commercial relationship in some of these cases does not take away from the fact that, as I think the minister just indicated, we have an agreement with the pharmaceutical manufacturers in relation to all of the products they advertise that they now include relevant information about appropriate prescribing of those products. In all of their advertisements for a product, they must include information—and in fact they do on my observation when I read *Medical Observer* and other similar publications—about when a product is appropriately prescribed.

Senator HARRADINE—Minister, I know you have great concern about this particular matter. Do you feel that it is appropriate for the department to keep an eye on whether or not appropriate codes of practice and conduct are observed?

Senator Patterson—We are all concerned about it.

Senator HARRADINE—I know you are.

Senator Patterson—As I said to you, those guidelines are very clearly outlined. I would encourage you to look at the guidelines and raise it with the department if you think are being breached. For example, if you see advertisements that do not—

Senator HARRADINE—I keep away from doctors as much as I can.

Senator Patterson—Senator Lees wanted them not to meet with them. Short of investigating every restaurant in Australia, it was very difficult to do that. We have tried to impress upon the pharmaceutical industry, when we are looking at medications that cost $6,500 per person per month and others lining up of that order of magnitude, that it is everyone's responsibility that the Pharmaceutical Benefits Scheme is sustainable. It is theirs, ours in policy making, prescribers, the public and everyone's responsibility to ensure that what is a fantastic system remains sustainable. So I do not think you need to impress it upon the department or upon me. We have made it very clear—and I have made it very clear—to Medicines Australia that reasonable growth is acceptable, but when that growth is unsustainable it threatens the whole system. That is a message for all of us, including people who waste their medications and give them to other people, doctors who do not prescribe by the guidelines, pharmaceutical companies and those of us who demand pills when we could do something else. It is the whole community's responsibility to treasure what is a great gift from the public, and most Australians do not appreciate how much it is.

Senator HARRADINE—I will make a clarifying comment about my keeping away from doctors. I meant personally and in the family, but I think I have seen more doctors recently than I have in my whole life.

CHAIR—Are there any further questions on outcome 2? I call Senator Denman.

Senator Patterson—You have been very noisy today, Senator Denman; you ask far too many questions!

Senator DENMAN—The PET scanner is my favourite subject. Are there statistics available on the number of Tasmanians who travelled to Victoria for a PET scan in the last 12 months?

Mr Sheedy—I do not have those statistics with me, and I am not sure whether they are available. We could try to get some information for you.

Senator DENMAN—If they are available, could I have them? I guess the next set of figures are not available either. How many people should have travelled to Victoria but, for various health reasons or reasons of inconvenience, did not? Are those sorts of figures available?

Mr Sheedy—It would be exactly the same position. As a matter of fact, those sorts of figures would be even more difficult. I could not give you any guarantee at all that we would have anything of that nature.

Senator DENMAN—I have a report on the review of the positron emission topography. Recommendation 18 related to the need for the MSAC to approve studies to enable more long-term decisions to be made regarding the use of PET in Australian clinics. Are those studies occurring?

Mr Sheedy—They are occurring in conjunction with those facilities which have eligibility to provide PET services at present. The Australian-New Zealand association of nuclear medicine providers is working with us in developing the studies and data collection methods to enable that MSAC consideration to proceed.

Senator DENMAN—What mechanisms are in place to make sure that there is an independence in those studies?

Mr Sheedy—The studies are proceeding in collaboration with the Medical Services Advisory Committee to ensure that, when the data arrives and the study is completed, it is sufficient for MSAC consideration. MSAC consideration always take account of the quality of the studies that are available to support the use of any given intervention.

Senator DENMAN—When is the data collection expected to conclude?

Mr Sheedy—In July 2005.

Senator DENMAN—Thank you.

Senator LEES—On page 100, you mention the Pathways Home program. Could you give me some further information on how it is going to operate? I take it that it is a step-down process for elderly or general patients?

Dr Morauta—We are hoping that we will be able to discuss with the states how best to implement this program. The target area is people leaving hospital and needing extra care before they are ready to go to their home environment; hence the name of the program. There has been quite a lot of work done between the Commonwealth and states on this gap in services. The idea is for the Commonwealth to put in an investment which enables the states

to increase their level of services in this area. Some states may use it in one particular way and another state may use it in another way, depending on the way they structure their own services.

Senator LEES—So there will be flexibility there, looking at some of the successful programs that various states have trialed at different times, some of which apparently are no longer operating due to questions of who actually pays. Some costs or cost cutting of hospitals have seen those disappear. So you do not have a model about which you are going to say to the states that this is it; it is going to be a process of discussion?

Dr Morauta—We can have those discussions with the states. Some of them have already indicated the type of thing they would like to do. We were particularly interested in one-off investment to increase the level of services: for example, refurbishing, rebuilding or capital investment in new services. There could be other kinds of one-off investment in the training and recruitment area and things like that.

Senator Patterson—I am fairly keen for this to have a long-lasting effect and for some innovative changes in the states in dealing with that step-down. There have been some interesting studies done. There was one done in a major hospital in Melbourne with one of the facilities—I do not know where it went to in the end—where they demonstrated that they could actually have people spending a longer period of time in a rehab facility for less money than the acute care and therefore for longer still using the DRG from the hospital. They were able to subcontract the facility and extend the period of care once the person had passed through that acute phase. I can remember the exact details, but instead of having, say, eight or nine days in hospital they had five days in hospital and then another five, six or seven in the facility. So they got a longer period of care. They were actually up and dressed and not lying in bed as patients.

Senator LEES—So may this involve pathways back to the nursing home, which may mean a quicker return to the nursing home? I realise this may involve a higher level of nursing care, for example, rather than seeing people stay in those acute care beds. Is that part of the vision as well?

Senator Patterson—We are not assuming anything. This is about people who are in a nursing home; they may be younger people who are just not stable enough to leave the hospital.

Ms Halton—They could be nursing home residents.

Senator Patterson—Yes, they could be nursing home residents, but I am talking about people who are not ready to leave the hospital but need wound management.

Senator LEES—Nursing homes do not have sufficient nurses who can cope with people coming home earlier, but they should be able to if they could cope some of those funding issues.

Ms Halton—As Dr Morauta has already said, what it is that we are trying to do with our money here is to build some capital infrastructure to entrench these sorts of services. You have been around these issues for a long time as well. We have had various goes at getting better at this. We keep referring to step-down—and the community does not necessarily

understand what we mean by step-down but we mean step-down care. Our experience in the health care agreements of the past when we put money just into the delivery of service is that when our money is not there any more the service disappears. The intention here is that the program be flexible depending on the service infrastructure.

As you well know, in Adelaide the service infrastructure is different to what happens in Victoria. By getting that infrastructure in place, which is congruent and works well with the health service in a particular state or territory, in time we would hope to entrench that general philosophy and that general approach to care. It might, for example, go to the earlier discharge of nursing home residents. I have had, over the years, many DONs say to me that they want to get their older residents back as quickly as they can from hospital because they come back with infections and are more dependent and all the rest of it. So our money, which will go to one-off investment, would look to try and entrench that broader approach to care, which I think we would all support.

Senator LEES—Where do you see the role of GPs in this? Will you be mandating in any way where GPs are to fit or requiring that in terms of at least communication and involvement of GPs in whatever the states do?

Ms Halton—Certainly you would be hoping as we move to a more integrated approach to primary care that there would be better discharge arrangements working in conjunction between hospital and general practitioner to make sure that that segue, if you like, for a patient works efficiently and effectively. It is hard for us to enforce or mandate behaviour in every instance, but in discussions we have with the states—and I have to say that we have been talking to them about those broader age care boundaries in some considerable detail—I think there is an acknowledgement that general practitioners are a crucial part of that equation. I suppose it is fairly early days, as Dr Morauta says. We have not got to the kind of detailed conversation yet; we will see how that goes.

Senator LEES—So there is no model you can show the committee as yet that any state has suggested or presented? You are not up to that stage of discussions with the states?

Senator Patterson—I do not even think there will be a one size fits all for every state. It may be that in some parts of a metropolitan area you have one thing and in another area another thing. For example, my conception is that you may have a facility in a rural area that bids for one slow rehab bed so that a person who comes from a regional area can go home from an acute hospital to a facility closer to home. There are innovative ways which will arise, and I do not think there will be formula for each state or a formula for each area within a state. It will depend on what sorts of services there are. Different states have different structures, as you know. Western Australia has a very different service in delivering its HAC and those sorts of programs. Some have hospital in the home. What I am looking for and will be signing off on is that it has some long-lasting effect—we do not just have a blast and then you do not see an ongoing effect. It ought to be investment in a long-term strategy for dealing with people who are not quite well enough to leave an acute facility.

Senator LEES—What is the time line, Minister? Is this going to be part of the aged care agreement?

Senator Patterson—We are waiting for the states to sign up to the health care agreement.

Senator LEES—So it is quite separate from any aged care funding within the health care package; there is no set time line of when you expect to hear from the states with any of their proposals for how they would spend their share of the money?

Senator Patterson—As soon as they sign up, I am looking forward to discussing this with them. The sooner they sign up, the sooner we can get on with it.

Senator LEES—Are you in a position to give them a briefing note as to the criteria or the priorities from your end?

Senator Patterson—When they have signed up, because I will need to know what they are going to spend on their public hospitals in the next five years and what their growth will be.

Senator LEES—I am just concerned about this particular package. You are not discussing it with them until—

Senator Patterson—This package is part of the health care agreements.

Senator LEES—they are ready to sign up to the health care agreement.

Senator Patterson—When any state or territory signs up to the health care agreements, I will be there with bated breath to discuss with them the Pathways Home for their state or territory.

Senator DENMAN—Does hormone replacement therapy come into this section or later?

Ms Halton—What is the nature of your question, Senator?

Senator DENMAN—I just want to know about the latest research in America and whether we are looking at that and so forth. Do we do it now or later?

Ms Halton—At the risk of getting a doctor too close to Senator Harradine, we will ask the Acting CMO to come and answer those questions. I am going to ask the CMO to come to the table, Senator Harradine. You said you did not want to get too close to doctors. I am offering to put him down this end.

CHAIR—We are ever helpful here, Senator Harradine.

Ms Halton—Absolutely. Very obliging—that is us. We just have to find him.

Senator LEES—I want to ask about enhanced primary care. Where would you like to deal with it? Let us do enhanced primary care while we are searching for Senator Denman's witness. Just looking at the success or otherwise of what you have already done in this area and at some additional measures, you have continued funding for the enhanced primary care as part of your focus on prevention. How has the evaluation you have done to date gone?

Mr Stuart—There is an evaluation in the final stages of being prepared for release and, hopefully, it will be released soon.

Senator LEES—Can you give us any understanding as to how any particular area has gone in relation to what you have been doing?

Mr Stuart—The evaluation is set in the context that when EPC was implemented we were trying in a policy sense to broaden out the activity of GPs towards prevention, towards over-75 health checks and towards working better with other professionals in teams. Essentially, the evaluation is saying that that is proving to be effective for the GPs who are taking it up.

There is systems change occurring, there is cultural change occurring and there is a change in the nature of the way those doctors are practising.

Senator LEES—What about the patients? Have you done some assessment on the benefit to patients?

Mr Stuart—The evaluation also looks at patients from the point of view of their experience of EPC. There has not been a double-blind intervention study on patient outcomes, but my memory of the evaluation is that the patients reflected positively on the benefits they received from enhanced primary care items.

Senator LEES—So you have not looked at indicators such as before and after hospitalisation rates under some programs of, say, a particular patient or for a particular type of prevention of a particular illness?

Mr Stuart—That would require a randomised control trial where some patients are given the benefit of what we think is a step forward and others are denied the benefit of what we think is a step forward; so in this area that has not been a part of the evaluation.

Senator LEES—So you basically ask GPs for their opinion on how patients have fared.

Mr Stuart—We have asked GPs for their views and my recall is that in the evaluation—and I am working from recall, from having read a draft a little while ago—there was also consultation with patients by the evaluators.

Ms L. Smith—Overall the evaluation found that the items had made a significant contribution to improving the quality of care for patients with chronic and complex conditions.

Senator LEES—I thought something had been done for asthma, looking at children in particular and at various levels of intervention, the reduction of hospitalisation and the costs of treatment if the whole package—for example, parents, schools, GPs—was put together and everyone was aware of the child's needs and a preventive program was put in place; it actually had an outcome. Do you have any documented material yet?

Mr Stuart—The enhanced primary care items—and I think you may be moving more towards the chronic disease initiative as well—were evidence based at their implementation. So they were based on Australian experience but also based on international evidence as to what works well and they then went through an implementation path in Australia. That kind of information was taken into account at inception.

Senator LEES—I understand that GPs are required to do care plans as a part of this. An earlier audit showed that there were some difficulties with completing those care plans. Do you have any further evidence on that?

Mr Wells—Is that with respect to asthma?

Senator LEES—Yes.

Mr Wells—This is the 3+ Visit Plan. The officers with all that detail will be here under outcome 9. If you wish I can answer some general questions now.

Ms Halton—I think your question probably goes to another issue, which Ms Smith can answer.

Senator LEES—My question was not necessarily specifically related to asthma; it was more general.

Ms Halton—No. I think it was at the estimates before last when we did have a conversation about this particular audit, but perhaps Ms Smith can illuminate you.

Ms L. Smith—An audit of the EPC care plans was requested by the department in early 2002. It was an information-gathering exercise, so there was never any recovery action anticipated or planned for. The audit fieldwork occurred from May through to July in 2002 and around 50 GPs were contacted as part of that work. In the end, the audit found that none of the care plans assessed were fully compliant, but the audit only tested compliance against all of the criteria and did not go to the degrees to which particular care plans were meeting some of the criteria. The department, though, in May 2002 made changes to the descriptors for the care planning items and these addressed a lot of the concerns that were raised as part of that audit process.

Senator LEES—That was going to be my next question: how are you supporting very busy GPs to be able to put it together? If indeed we do find through the audit that it appears to be very successful, how do we then make sure it is working properly?

Ms Halton—I think that the last time we had this range of questions the point that we were trying to make was that we had done an audit to look at implementation, to see whether in fact there were inadvertent problems in administration and we were perhaps causing some difficulties for doctors. I think what Ms Smith is indicating is that we did find a number of things with those audits. It was a targeted audit to try and find, if you like, those issues.

Senator LEES—You have found them and you are sorting through those issues?

Ms Halton—We are always aware that the question of administrative burden on doctors is an issue. You would know, presumably from our public announcements, that we have set up a red tape task force just recently to try and address these issues. Clearly, there is always a balance to be struck, but excessive and unreasonable requirement is not something that we are particularly interested in pursuing. So yes, this is an issue we are aware of.

Senator LEES—When can we expect the full package of measures to be released?

Mr Stuart—I cannot give a definite date, but it is well on its way.

Senator LEES—A month; two months?

Mr Stuart—I could not say, but it is being produced for release.

Senator LEES—Thank you.

Ms Halton—Senator Denman, Professor Mathews, who hereafter is going to be referred to as the Scarlet Pimpernel of the department, has been located.

Senator DENMAN—Professor Mathews, you are aware of the study recently connecting women over 65, HRT and dementia—the American study?

Prof. Mathews—Yes.

Senator DENMAN—Does the department intend to investigate the reported link between HRT and the risk of dementia?

Prof. Mathews—The PBA has had an expert committee looking at the evidence that has been accumulating on the risks of HRT. Professor Martin Tattersall has commented on the most recent studies as well as on the previous studies. The short answer from the studies that were published about a week or 10 days ago in the *Journal of the American Medical Association*—JAMA—is that women over the age of 65 randomised to receive a combination of progestogen and oestrogen over a period of several years and were observed to have a high incidence of dementia, which is quite concordant with the earlier work showing that that same combination of HRT was associated with a higher risk of heart and cardiovascular complications. The authors of the studies have suggested that the mechanism by which the HRT might be producing the effect is through very small vascular events in the brain.

The important thing to comment on with this study is that it is high-quality evidence because it is a randomised study and much of the confusion in the literature previously about whether HRT would be good for mental function or not was because of studies which were observational, those looking for associations. Of course, those studies are only valid if the women who are using a certain medication are equivalent in all other respects to those who are not. The only way to really achieve that is with a randomised study with placebo control.

Senator DENMAN—Are there any Australian figures on women suffering from dementia who have been on HRT?

Prof. Mathews—I could not quote any figures, Senator.

Senator DENMAN—So what you are telling me is that for any report or any studies that are released, you have a committee in place that will investigate those things?

Prof. Mathews—Yes. The TGA committee has a watching brief. The Chief Medical Officer, other medical officers in the department and I clearly follow up when matters of public import such as this appear. Obviously, we look at the validity of the studies that have been carried out and it is a very important issue. We are now living in the era of international research. This was a multicentre study in North America, funded by government, with the cooperation of a big pharmaceutical company but not funded by the pharmaceutical company. Increasingly, these very important questions of costs and risks of medication are going to need very large and collaboration studies, and to get good evidence of that kind studies have to be collaborative either in a large country or even between many countries.

Senator DENMAN—I was going to ask: does Australia work cooperatively with other countries on some of these studies?

Prof. Mathews—Yes. The National Health and Medical Research Council has been funding for some years a clinical trials centre at the University of Sydney, which is involved collaboratively with people around Australia and some international studies looking at controlled trials. Of course, there are other studies which involve pharmaceutical companies to a greater or lesser extent in the design and funding of studies.

Senator DENMAN—Thank you, Professor Mathews. I have one other question which I will put on notice. It is about treating doctors' reports and Medicare assignment numbers—I have a case here from a constituent. That is all I have, thank you.

CHAIR—Any further questions on outcome 2.

Senator NETTLE—I have some questions relating to the Pharmaceutical Benefits Advisory Committee. Perhaps someone could outline what the PBAC currently costs.

Senator Patterson—It is in the papers.

Senator NETTLE—Can you point to where, please?

Ms Corbett—I am sorry; I do not think we have that easily available. It is within the expenditures for the appropriation and then there is a departmental component. I am not sure that we have a neat aggregation of the expenses of the PBAC. It might be better that I take that on notice.

Senator NETTLE—So it is not in the papers?

Ms Corbett—I do not think it is as a separate line.

Senator Patterson—I apologise if it is not. I thought it was broken into the aggregated figure.

Ms Corbett—You did, Senator Nettle, mean the actual activities of the expert advisory committee?

Senator NETTLE—Yes.

Ms Halton—You are talking about running costs, basically?

Senator NETTLE—Yes.

Ms Halton—We think it is aggregated in one of the other items, so we will give to you on notice.

Senator Patterson—I apologise, Senator Nettle, I thought it was disaggregated.

Senator NETTLE—I will give it to you on notice. I am not sure now whether these questions will need to go on notice as well. Can you tell us what the proposed expansion of Pharmaceutical Benefits Advisory Committee will cost?

Ms Corbett—I am not sure exactly what you mean. I presume you mean an extension in the number of members of that committee?

Senator NETTLE—That is right. In relation to the bill—the proposed health and ageing legislation.

Ms Corbett—Again, it would be easier for us to get you an accurate figure if we do that on notice.

Senator NETTLE—In the context of the proposed expansion through that proposed legislation, my understanding is that the justification has been to address the increasing workloads of medical practitioners on the committee.

Ms Corbett—That indeed is one of the reasons. All the experts on our PBAC put in an enormous amount of time and effort, but we particularly rely on the clinicians within the committee, so that was one consideration, yes.

Senator NETTLE—So that was one, but there were others as well? It was not the main—

Ms Corbett—The workload of the PBAC is, in some senses, an increasing workload. The complexity of modern drug technologies, the expense, the need for us to carefully look at a

wide range of evidence about clinical as well as economic considerations—it has not been easy and it is not getting easier, so we are anticipating a need to work with a good broad base of professional expertise to continue to guarantee the evidence base of our decisions.

Senator NETTLE—If part of the expansion is to have that medical expertise to carry out tasks—which we understand are complex and difficult—what mechanisms are in place, or are proposed, to ensure that the additional appointments will be filled by people who have that medical expertise and knowledge to fulfil that particular role within the PBAC?

Ms Corbett—The way in which those appointments or recommendations to the minister would be gathered would be through the PBAC's own processes. We would put together a list of possible people and the committee would put proposals to the minister about who she might appoint. The committee, understanding very well its own workload and the demands on its particular members, would come up with a balance of expertise in that way.

Senator NETTLE—Are there any mechanisms in place or proposed to ensure that the ratio of representatives of various groups—as opposed to ministerial appointees—is maintained in the proposed expansion of the PBAC? My understanding is that the proposal has some impact on that ratio. The question is: is there an intention to maintain the ratio between representatives of various groups and ministerial appointees?

Ms Corbett—The committee structure is a matter for the minister to decide. There is not any driving formula or approach to representation within that committee and my understanding is that there has not, at any point, been any agreed representative structure. We obviously want a balance of people on that committee, but I do not think that there is an issue there about representation in that way.

Senator Patterson—I take advice from the committee on the fact that they may, at one point, say that there are a significant number of oncology medications and they really need more advice from oncologists—that is the sort of level you have. The sorts of drugs that are coming through now are much more complex and much more detailed than I think they have ever been before—very specific, for very targeted groups of people, a handful of people in Australia, for example—and so the PBAC would be recommending people with that level of expertise.

Senator NETTLE—I understand that you take that advice in relation to specific areas; is that for the permanent appointments to the PBAC, or do you mean on a—

Senator Patterson—It is the permanent appointments. I do not know how tall some of the applications are, but they are metres high. When an application comes in, people take different chunks—different drugs that they take leadership on—and the PBAC advises me on the level of work that is involved. It may be that the PBAC as a whole, or its chairman, believes that a particular area needs boosting in terms of expertise.

I would like to say on the public record that some of those people give enormous amounts of time. I am very grateful, as all Australians should be, for the enormous amount of work that the people at the PBAC put in—it is very many hours.

Senator NETTLE—At the February estimates hearing, I asked a question about a replacement for the industry representative on the PBAC, and I think that at the February

hearing you advised me it was expected that someone would be appointed to that position soon. Has that appointment been made and, if so, who is it?

Ms Corbett—I recall your question from February. At that point in time there had not been a formalisation of the new appointment. It was not an industry representative position. Very unfortunately, the previous incumbent, Pat Clear, died last year and he is much missed in the industry. The minister has since appointed Andrew Wilson, who has been chairing the economics subcommittee of the PBAC for some time. He is a very well-qualified health economist and expert, from the University of Queensland, who has contributed a lot to the committee's processes through his role on the subcommittee.

Senator NETTLE—I am sorry, I did not realise that that was not an industry representative position.

Senator Patterson—From the furore that went on you would have thought that was the case, but it was not.

Senator NETTLE—I think that answers the questions I had on that. I would like to stay on the issue of the PBS, and I will move to discussion around the negotiations for a free trade agreement between Australia and the United States. What is the department's understanding of the changes that the United States is seeking in relation to the Pharmaceutical Benefits Scheme as part of the negotiations for the free trade agreement?

Ms Corbett—I will start by saying that the United States has not formally put any proposal forward around the PBS at this stage of the negotiations. There have been general discussions about the nature of the PBS, but the United States delegation has put forward no specific agenda in relation to the PBS. Ms Smith has been working closely with the Department of Foreign Affairs and Trade on behalf of the portfolio, and has attended both of the stages of negotiation that have happened so far.

Ms C. Smith—We have had two rounds of discussions with the United States on a free trade agreement and, at this point, the US have just sought information on how the PBS works. They acknowledge that it is a fairly complex scheme that they are trying to understand and, as Ms Corbett said, there have been no formal proposals put by the US. In fact, they are actually formally on the record as recognising the importance of the PBS to the Australian community and as saying that they are not seeking to undermine or alter the fundamentals of the PBS.

Senator NETTLE—The US pharmaceutical industry has made comments about, in particular, the price control mechanisms that exist within the PBS. I presume you are aware of the report by the Australia Institute on the implications of a free trade agreement for the PBS. Would you agree with comments made in that report that, if the price control mechanisms in the PBS were removed through the negotiations, we would be looking at increases to the Australian taxpayer of between $1 billion and $2.4 billion?

Ms Halton—You are asking the officer a hypothetical question which she is not in a position to answer.

Senator Patterson—Senator Nettle, we are very aware of the importance of the PBS to the Australian public. As health minister I will be keeping a very watchful eye on it.

Senator NETTLE—And I appreciate that. It is fantastic to have Carolyn Smith here and that the department is sending people along to be involved in and aware of those negotiations.

Ms Halton—To reinforce the minister's point, one of the reasons I have seconded a senior officer of the portfolio—who is very experienced in the portfolio—to the negotiations is to ensure that the issues that we regard as being very important about the PBS are appropriately represented and we are kept fully briefed on what is happening.

Senator ALLISON—Have the US put the PBS on the table?

Ms Halton—I think the officers have indicated that the United States have not raised it with us.

Senator ALLISON—Not according to most of the reports that have come out about those free trade agreement negotiations. It seems to be very clearly on the table.

Ms Halton—We have all read speculation in the press and things that have been put out. I think Senator Nettle is going to some of the statements that we understand have been made by the big companies in the United States. But the officer is saying to you that it has not been put on the table by the Americans; on the contrary, the comment she just made suggests the opposite—and that reflects what the Americans have said to us so far.

Senator NETTLE—As you say, the US pharmaceutical companies have been quite clear in their comments on the Pharmaceutical Benefits Scheme about their desire to have the opportunity to charge the Australian government greater prices for their pharmaceuticals through that scheme. I imagine that, in sending representatives to those negotiations, it would be quite useful to have the information to be able to say, 'This is the value of the PBS to the public health care needs of Australia'—focusing just on the price control mechanisms—'and if the Australian government were to yield to the demands of the United States pharmaceutical companies, it would cost the Australian PBS X amount of money, and therefore we do not want to put it on the negotiating table.'

Ms Halton—But we have not been in a position where we have been required to make that kind of declaration. They have not raised it with us. We fully understand the advantage to the Australian community of the Pharmaceutical Benefits Scheme—it is something we are intimately familiar with—but, as Ms Carolyn Smith has indicated, it is not an issue they have put on the table and it is not something we intend to put on the table.

Senator NETTLE—So it would only be if the United States negotiators put the PBS on the table and wanted to discuss components of the PBS that you would perceive there was a need to provide costings or an analysis of how that might impact the PBS?

Senator Patterson—Let me just say that the US has reinforced the position that the FTA will in no way affect the basic framework of the PBS or the way medicines are delivered to Australians. I think that is what Carolyn Smith said. I think we should leave it at that. We are very aware of the issue, and there is no more we can add.

Senator ALLISON—As I understand it, it is not the way that PBS medicines are delivered to the Australian public that is on the table but the way the government negotiates the pricing of the PBS. Are you ruling that out as well?

Senator Patterson—I said it did not affect the basic framework of the PBS.

Ms Halton—It is not on the table, Senator. It is quite clear it is not on the table—the Americans have not raised that issue with us.

Senator ALLISON—And, if it were raised, we would not agree to changes to either the way the PBS is delivered or the way government purchasing keeps the prices down?

Senator Patterson—Senator Allison, you and I both know the value of the PBS to the Australian public—

Senator ALLISON—Indeed. Why don't you just say, 'No, it is not on the table; Australia would not agree'?

Senator Patterson—and, as we have said, the US have reinforced the position that the FTA will in no way affect the basic framework of the PBS or the way medicines are delivered to Australians.

Senator ALLISON—Is challenging Australia's system for keeping prices down, for the purchasing the government does, what you would regard as being part of the framework?

Ms C. Smith—The United States have not put any proposals on the table.

Senator ALLISON—I know that. It is a fairly straightforward question. Is the way in which the Australian government purchases medicines for the PBS a fundamental part of the framework—yes or no?

Ms Halton—Perhaps I could make the point that the government—the trade minister—has said very clearly that the outcomes of the free trade agreement will not compromise our capacity to deliver fundamental policy objectives in health care and other important domestic policy areas. I think the government has said quite clearly that an FTA cannot compromise those things.

Senator ALLISON—My question remains. Why is there such reluctance to answer this question?

Senator Patterson—There is not. We have answered your question, Senator Allison.

Senator ALLISON—I will put it another way.

Senator Patterson—You can put it another way, but we will answer it in the same way as we have answered it before. I do not know how else we can answer it, other than to tell you that it will not alter the basic framework of the PBS or the way medicines are delivered to Australians.

Senator ALLISON—We know how medicines are delivered, but what about how medicines are purchased?

Senator Patterson—That is the basic framework of the PBS.

Senator ALLISON—So the Australian government would not countenance any change to the way in which medicines are purchased for the PBS through these trade talks?

Senator Patterson—You are now asking a hypothetical question. It has not been put on the table. What we have said, and what the US has indicated, is that the FTA will in no way affect the basic framework of the PBS or the way medicines are delivered to Australians.

Senator ALLISON—Has the department been asked to provide any advice to the United States on the pricing mechanisms and the reference pricing mechanisms which are operational in the PBS?

Ms C. Smith—What we have provided to the United States negotiating team is a whole range of documents, which are on the public record, about how the PBS operates.

Senator McLUCAS—Including the questions that I have just asked?

Ms C. Smith—That includes information on the listing process, the PBAC guidelines, the national medicines policy, the pricing policy—the gamut of policies.

Senator McLUCAS—Pricing mechanisms and reference pricing mechanisms?

Ms C. Smith—Yes.

Senator ALLISON—In what sense are they a negotiating team? What are they negotiating?

Ms Halton—I feel that is not a question this portfolio can answer. We are not responsible for the negotiation of the free trade agreement. I have seconded an officer to work with Foreign Affairs and Trade on the issue. But it is not, I think, appropriate for my officers to answer questions which go to the intention of the American negotiators.

Senator ALLISON—Ms Smith, you did say the 'negotiating team'. By that did you mean the Australian team?

Ms C. Smith—No, I meant the US negotiating team. We provided those documents to the US negotiating team.

Senator ALLISON—What were those documents?

Ms C. Smith—They were a range of documents, which are all in the public domain. We provided a copy of the national medicines policy and the PBAC guidelines. I cannot recall all of them completely, but they are all public domain documents that talk about how the PBS operates in its entirety.

Senator ALLISON—Why would we bother providing those documents, if there was no interest on the part of the Americans in looking at this question as part of the trade talks?

Ms C. Smith—It is quite normal for trade talks to start with an exchange of information on respective systems and policies.

Senator ALLISON—Even if the PBS is not on the table? Even if no-one is interested in the PBS being part of the trade talks?

Ms C. Smith—The US are also on the record as saying that they are keen to understand how the PBS operates. When we are in a negotiation with them, we are prepared to provide documents to help them gain that understanding and to gain an understanding of how important it is to the Australian community.

Senator NETTLE—You have talked about seconding a senior officer to be involved in the discussions. Perhaps you could explain to us the basis upon which you made the decision to involve the department of health in these negotiations. Did the issues raised by US

pharmaceutical companies form the basis of your decision to send representatives from the department of health to those negotiations?

Ms Halton—You are quite right in saying there has been a lot of speculation about this issue. We have been asked this question at a couple of estimates. I think, in that context, it was appropriate that we have one of our people actually there to understand what questions were being asked—and Ms Smith has given you an indication of what is being asked—and to be sure that we actually had an officer there with expertise who could answer any factual questions. As the minister is saying, the reality is that Ms Smith also has expertise in a variety of other areas—for example, in relation to food. That enables us to ensure that our issues are appropriately represented and also that we have a direct line of communication to what is going on.

Senator NETTLE—You mention that Ms Smith has expertise in the area of food. Is that relevant in terms of these negotiations, because of the discussion that has been in the public arena about the labelling of genetically modified food? Is that the reason that Ms Smith is particularly qualified to represent the department in those negotiations?

Ms Halton—When trying to identify an appropriate officer to represent the department's interests, obviously one looks for somebody who has at least a passing familiarity with issues that are in this ballpark. You would appreciate that it is a very big portfolio, and we have some officers who have made a career in the study of things that are unlikely to be relevant, and there are some officers who have had a career and experience in areas which are more likely to be germane. As it happens, Ms Smith was available and has expertise and experience in a number of the relevant areas. I would not want to say that we had a list of people, some of whom had particular experiences, and they were ranked on that basis. We were looking for an officer who we felt was well able to represent our interests, and Ms Smith was not only interested but had all those attributes—a happy coincidence.

Senator NETTLE—Would it be fair to say that the expertise that Ms Smith has in the areas of the Pharmaceutical Benefits Scheme and genetically modified food was around issues that were more likely to be relevant to the negotiations and thus the decision was made that she was an appropriate person to represent the department at those negotiations?

Ms Halton—Essentially, there are parts of our portfolio where—for example, we deal on a regular basis with the agriculture department—we deal with some of the parts of government that are more relevant to trade. As it happens, Ms Smith has had experience on that side of the portfolio and hence was regarded as being appropriate.

Senator ALLISON—I have a couple of questions I would like to pursue on the trade negotiations. If America was going to put the PBS on the table, how much notice would be expected of that process?

Senator Patterson—I do not think that is an estimates question. It is a hypothetical question. I do not know. I cannot tell, we cannot tell, what may or may not be likely to be discussed. I will say it again: the FTA will in no way affect the basic framework of the PBS or the way in which medicines are delivered to Australians. There are a number of other issues. As Ms Halton's reply has indicated, there are issues of food labelling, food standards, blood products and all the other issues to deal with when you are dealing with a trade agreement.

Senator ALLISON—It is not a hypothetical question; it is a process question.

Senator Patterson—It is a hypothetical question.

Senator ALLISON—Presumably, you need to prepare the team that goes there and so, presumably, there is some advance notice of the kinds of things the department would be required to talk about once they are there.

Ms Halton—But, essentially, the ground rules, if we can describe them in that way, that govern the operation of this kind of negotiation are not an issue for this portfolio. We are participating by way of a seconded officer, but any discussion between the American side and our side in relation to the broad operational conduct of these negotiations is not actually a matter for us. So I would have to say that that would be a question that would be appropriately asked of DFAT.

Senator ALLISON—You may be a passive player in all of this, but nonetheless there must be some advice given to your department about what you can expect in these talks.

Ms C. Smith—Trade agreements of this type are generally divided into a range of chapters. If you look at agreements that are already in the public domain, like Australia's agreement with Singapore or the agreements that the United States has with Singapore or Chile, you will see that they are divided into a range of chapters—for example, chapters on intellectual property, agriculture, goods and services. There are generally 20 or more chapters. We can predictably imagine that discussions will take place under each of those chapter headings. In terms of the specific requests that the US will make of the Australian government, it is highly speculative to make any conjecture about what they might be.

Senator ALLISON—So you do not know what is going to be on the table until you actually arrive there. Is that correct?

Ms C. Smith—The Department of Foreign Affairs and Trade and other departments can make educated guesses as to what the US might raise, but it is purely speculative.

Senator ALLISON—To say it is not on the table is not all that reassuring if it could be put on the table at any moment.

Ms C. Smith—I think you also have to look at what the US are on the record as saying, and I think the minister has indicated that.

Senator Patterson—I have repeated it 15 times.

Ms C. Smith—There are some subjects that have just not been mentioned, but on the PBS there have been some very clear statements from the US.

Senator ALLISON—If there are clear statements from the US to the effect that they are not interested in the PBS, whether it is our purchasing capacity or the capacity to deliver a system to people, why do we provide the US with briefing papers on the subject?

Ms Halton—As Ms Smith has indicated to you, there is a process in any free trade discussion of trying to understand how the totality of the other side operates. I think what she has indicated is that in understanding how our systems works people have sought to gather information across a vast array of issues.

Senator ALLISON—So even though America have been straightforward, upfront, and said clearly that the PBS is not on the table, we still turn up with PBS documents explaining how it works. Is that right?

Ms Halton—As a matter of courtesy, we respond to their requests for information; much as we hope they would, as a matter of courtesy, respond to ours.

Senator ALLISON—They say, 'It is not on the table, but we would like you to bring information'. They actually made a request of us to send information. Is that correct?

Ms C. Smith—That is correct. They have said that they do not have a formal position, but they want to understand how the PBS works.

Senator ALLISON—They do not have a formal position; I thought you said earlier that their position was clear.

Ms Corbett—It is very clear, and obviously you are aware, that the American pharmaceutical companies have been raising this issue. So there has been speculation in the media. In that context it becomes important that everyone understands what it is that is being discussed. So at the very early stages, when preparations were being made for discussions with the United States, a lot of areas of public policy were looked at. We have provided a lot of detail on the PBS to explain very clearly (a) how proud we are of it, (b) how well it works and (c) how fundamental it is to the Australian medical services approach. We have been quite happy to do that. If the US government were not informed about all of those issues then it may be more likely that there would be some speculative approach driven by the interests of pharmaceutical companies.

Senator ALLISON—Is your view similar to Ms Smith's: that there is no formal position but a clear position. Is there no contradiction in that?

Ms Corbett—At this point the United States' official negotiating team, made up of United States government representatives, have given us no indication that they want to put any proposals forward that would affect the PBS. That is the situation.

Senator ALLISON—Ms Smith said that the US have made it clear that they are not interested.

Ms Corbett—They have made clear statements about their understanding of the importance of the PBS and their commitment not to undermine the PBS.

Ms Halton—I actually do not know that there is much more we can tell you. We have told you what the Americans have said in relation to this area and we have told you what the Australian government is doing at present. To try to go further, to speculate or hypothecate, is very difficult.

We know what the Americans have said in public. Ms Smith has outlined that to you. That is the extent of what we understand. And, as Ms Corbett is rightly saying, it would strike us as not unreasonable that if Big Pharma are actually making certain comments—and we are all aware that they have—the US side try to understand what it is that we regard as being so important about the PBS.

Senator ALLISON—I am just trying to get through the doubletalk here, Ms Halton, which seems to be about not wanting to undermine the PBS system as it applies to providing people with medicines through our system while this other question of purchasing is something that you seem to avoid responding to in quite the same way.

Ms Halton—I think we should be very clear: there is no doubletalk. What we can tell you is what we know and what it is we are doing, and that is what we have done. The minister has said to you what has been said in the public arena about these issues.

Senator NETTLE—Perhaps I can ask Ms Smith a quick question about the timetable in which we will know whether or not the PBS is being put on the table by the US negotiators. I understand that, when that point is reached, obviously the department of health will be able to make a determination as to whether perhaps officers are on longer needed to be seconded to be involved in those negotiations. Do we have any idea of that time line in the negotiations where the United States team will put on the table their proposals and we can rule in or rule out their decision having been made about whether or not PBS is a part of that?

Ms Halton—Before Ms Smith answers that, can I say that Ms Smith's—can I say usefulness, without offering her any offence—work on this team is, as I think I have indicated, not just contingent on our particular interests in the PBS. Obviously, the PBS is a big interest of ours. So it is difficult for her to say that there will be a point at which she packs her bag and comes home. It is important for us as a portfolio—given, as I have outlined, our relationship with a number of other areas that are trade relevant—that we have a voice there and someone who can tell us directly what is going on.

Senator NETTLE—Thank you. I take your point: we mentioned the GMOs and the other agricultural issues. So perhaps just in relation to the PBS, is there a time line we can operate on?

Ms C. Smith—What we do have is a timetable for the negotiations as a whole. When the government kicked off the process in early March, the expectation was that the process would take around 12 months. There have been recent conversations between the Prime Minister and President Bush which are aiming for a slightly faster timetable, towards the end of 2003, and there are several negotiating rounds planned between now and the end of the year to bring the agreement to a conclusion. In terms of when specific issues will be resolved, I cannot speculate.

Senator NETTLE—So in early March, as you outlined in the time line, and now at the beginning of June we do not have proposals being put on the table. But if we are looking at having an outcome by, as you indicated, the end of 2003, would we expect to see those proposals put on the table in the coming two months, to take us halfway through those negotiations?

Ms C. Smith—Anything I say now is speculative, but I can say that the US have certain domestic requirements which mean that they could not negotiate on market access until the United States International Trade Commission had released a report on the impact of the FTA on their economy, and that report is expected in June. They will then be free to put forward proposals.

Senator NETTLE—Is the health department involved in any similar report in terms of the economic implications of the FTA from Australia's perspective?

Ms C. Smith—That is probably a matter more appropriate for the Department of Foreign Affairs and Trade, though I think you will have noticed on their web site that there are documents that the government has commissioned on the likely impact of an FTA on the Australian economy.

Senator NETTLE—So the department of health is not involved in any of those economic implications in relation to the PBS or GMOs?

Ms C. Smith—The Department of Foreign Affairs and Trade is the lead agency for the negotiations. We are involved to the extent that we are interested in hearing about it, but we are not the lead agency.

Senator NETTLE—Are you therefore not having to provide information to the Department of Foreign Affairs and Trade, as the lead agency, about implications in specific areas relating to health?

Ms C. Smith—We did not provide any information for those reports.

Senator McLUCAS—Has there been no work done by the Department of Health and Ageing on changes to the pricing mechanisms for new medications?

Ms Halton—No, there has not.

Senator McLUCAS—Ms Smith, did you attend FTA negotiations in Hawaii recently?

Ms C. Smith—I did.

Senator NETTLE—Ms Smith, I understand that the US trade representative's list of foreign barriers to US exports states explicitly:

Research-based U.S. pharmaceutical firm are disadvantaged by several Australian Government policies. These include a reference pricing system that ties the price of an innovative U.S. medicine to the lowest priced medicine in the same therapeutic or chemical group, regardless of patent status of the medicines.

That certainly appears to me to be a clear statement from the US trade tepresentatives about what they perceive as trade barriers that are in place around the reference pricing mechanism that exists within the PBS. Would that be a fair reading of that statement?

Ms C. Smith—That is certainly a statement of comments made by the US trade representative on this issue. But in the context of the current negotiations the US have not put any proposals to us in that respect.

Ms Corbett—I think that is a statement that the pharmaceutical companies have been saying to their government. It is not inappropriate for their government to reflect on what is being said to them by stakeholders in the United States. It is not surprising that that is there, just as it is out in the public domain and in speculative reports like the Australia Institute report. So it is there. We are not denying it is there. That does not mean that it is a negotiating point.

Senator NETTLE—I think we all accept that that is the position of the US pharmaceutical industry. For me is particularly interesting to hear those comments of the US pharmaceutical industry directly reflected in the comments of the US trade representative team that is

involved in these negotiations. For me, that rings alarm bells. Clearly, they are going to negotiate in their own national interests and in the national interests of the pharmaceutical companies that exist in the United States. When we have comments like that reflected in the negotiating team's comments, to me that raises concerns about perhaps the likelihood of those proposals being put on the table, as you say, in a time line which may begin in June, when the economic implications have been thoroughly discussed in the United States. The relevance of raising this issue here is, yes, those comments from the pharmaceutical industry are clearly reflected in the comments of the negotiating team.

CHAIR—I do not think there was a question involved in any of that little speech, so we will just move right along. Are there any further items?

Senator MOORE—I have questions on the business plan for the current Medicare, about office closures and things like that.

Ms Halton—The Health Insurance Commission?

Senator MOORE—Yes.

Ms Halton—Was that not covered earlier?

Senator MOORE—No, that was to do particularly with the new process; this is to do with ongoing processes within Medicare. But I am happy to put on notice these questions about that offices that have closed.

Ms Halton—You will probably find that the answers will be similar. We are happy to take those questions on notice.

Senator MOORE—I am happy to do that. The questions go to the offices that are closed and the joint servicing arrangements with the pharmacies and other places. It is all in this particular item.

Ms Halton—No problem.

Senator MOORE—A couple of estimates ago we had a discussion about the home medicines review—the domiciliary medication management review. We talked about how that worked and, hopefully, how well it was going to be accepted by the clientele. It is mentioned in this budget, so what is the time frame for the review, and who is going to do it?

Mr Rennie—The review will be undertaken in the first half of the next financial year, before Christmas.

Senator MOORE—And the process will involve all of the stakeholders?

Mr Rennie—All of the stakeholders will be involved—that is right.

Senator MOORE—And we would be hoping for a public assessment—

Mr Rennie—All of the stakeholders will be involved and that includes the pharmacists, the doctors and the consumers—the key stakeholders.

Senator MOORE—So it will be early next year?

Mr Rennie—Early next financial year, before the end of this calendar year.

Senator ALLISON—I want to ask about the Australian health care agreements. The budget documents say that the reductions of $108 million to $372 million over the forward estimates are as a result of 'a greater proportion of public hospital services provided to non-admitted patients and a reduction in public hospital usage growth beyond growth resulting from demographic changes'. What is the basis of those assessments? Can more information be provided to the committee about how they were arrived at?

Dr Morauta—To take the three elements in turn, a greater proportion of public hospital services provided for non-admitted patients. This means that cheaper forms of hospital care are replacing the more expensive admitted care activity. The latest data indicate that only 71 per cent of public hospital costs relate to admitted patient services. The balance is for non-admitted patient services.

Senator ALLISON—Compared with what, in the previous period?

Mr Eccles—The previous information we have is for the year 1998-99, where that figure was 74 per cent. So there has been a decline in investment in admitted patient services.

Senator ALLISON—What were the other aspects? You talked about three aspects.

Dr Morauta—The other aspect was a reduction in public hospital usage growth beyond growth resulting from demographic changes. As services move from admitted to non-admitted settings, the growth in admitted patient services slows. That growth rate is one of the main drivers of hospital costs.

Senator ALLISON—I can understand the mathematics of the first point, where you are dropping from 74 per cent to 71 per cent. Is that a simple calculation of applying the difference of three per cent to the total figures to arrive at that figure?

Dr Morauta—No, I think it is a bit more complicated than that, but this particular element I am talking about now is a reduction in the level of growth of inpatient services. That is composed of a number of elements in the Commonwealth position. There is a utilisation growth factor as well as a population growth and ageing index and also a price indexation factor.

Senator ALLISON—So there are other figures attached to whatever it is you are reading from that might tell us more about this?

Dr Morauta—I think there are growth factors attached. There is an indexation factor for price, which is based on one of the—

Senator ALLISON—I am just asking if the details of the mathematics of it can be provided.

Dr Morauta—I can provide the names of the indexes, for example, but they vary—they are estimates until the year in which they occur. It is the same with population and ageing. That is a factor that we have used for many years in different ways in the health care agreements. But we can give you a note which talks about those three elements of growth, if you like.

Senator ALLISON—What is the current status of negotiations with the states on the health care agreements?

Senator Patterson—I had a meeting with them all—I think it was on 2 May—and I put the Commonwealth's position. In the past, the Commonwealth has put down what it was going to spend for the next five years, which indicates the amount of money in the first year and then, by deduction, you work out the level of growth. It seems only fair that the states be required to do the same thing—that they indicate how much they are going to spend in the first year of the agreement and that they match our growth.

I met with them on 2 May and indicated to them what the arrangements would be: there would be a $10 billion increase—a 17 per cent increase over and above inflation—and if a state signed up to indicate how much they were going to commit to public hospitals and they would match our growth in a flexible way—we have put down a flexible process in matching that growth—we could continue discussions about the reform process. That is the stage we are at now. I am waiting for the states to come back to me, telling us how much they are going to spend in the first year and what their rate of growth will be—commit to a 17 per cent real growth over and above inflation.

One of the problems, Senator Allison, is that we have gone from the beginning of the last agreement to the Commonwealth contributing 45 per cent—I will not give you the point figures, but on rounded figures, it is 45 to 48 per cent—to public hospitals. At the same time, we have seen an increase in procedures being undertaken in private hospitals; we have seen 3,000 beds in public hospitals over the life of the last agreement closed and the last figures we have show a decrease in procedures being undertaken by public hospitals. So the states need to sign up to a commitment in the same way we are being expected to sign up and have done over the last umpteen years of having agreements. I think this is about the fourth agreement. I cannot remember the exact number of agreements. I think it is only fair that they put on the table what their spending will be on public hospitals.

Senator ALLISON—Are the two problem areas of the negotiation the basis of the assessments which deliver from minus $108 million to minus $372 million? Is that an area of dispute?

Senator Patterson—No.

Senator ALLISON—Do the states agree with you on those figures?

Senator Patterson—What we are doing is increasing the funding to states over the next five years by $10 billion, from $32 billion to $42 billion—

Senator ALLISON—But do they agree that that is the figure that—

Senator Patterson—Whether they agree or not, they are the facts. They are going from $32 billion to $42 billion—an increase of 17 per cent over and above inflation. All we are asking the states to do is to tell us what they are going to spend next year and to indicate that they will match that level of growth. We cannot have a situation where the Commonwealth keeps putting in a greater and greater proportion of the spending on public hospitals—have gone, as I have said, over the life of the last agreement, from a 45 per cent contribution to a 48 per cent contribution.

Senator ALLISON—You would think the states would be over the moon with this proposal, but they are not.

Senator Patterson—If I were a state health minister I would very much like to know what my spending was going to be for the next five years. That would enable public hospitals to make some plans into the future, rather than having money withdrawn and put back in and withdrawn and therefore making it very unpredictable to plan.

Senator ALLISON—So is it an all or nothing arrangement with the states or are you just waiting for them—

Senator Patterson—No. If the states do not sign up, they will be given what they were given last year, indexed by WCI 1.

Senator ALLISON—What does that mean in terms of this minus $108 million to minus $372 million?

Senator Patterson—It is not minus $108 million.

Senator ALLISON—That is what it is in the budget documents, Minister.

Senator Patterson—It means that, if they sign up, they will get a $10 billion increase—a 17 per cent increase over and above inflation. If they do not sign up, they will get what they got last year indexed by WCI 1.

Senator ALLISON—That is my question: if they do not sign up, what does the budget document look like? Currently there is a table which shows that in the next financial year there is a reduction of $108 million and progressively through to the end of that five-year period a reduction of $372 million. What would those figures look like instead of those figures?

Senator Patterson—Let us assume they are going to sign up. It is a 17 per cent increase over and above inflation. It is hypothetical about whether they will not sign up or whether they will sign up. It is a $10 billion increase. It is going from $32 billion to $42 billion—17 per cent over and above inflation—and the states need to ensure that their contribution to the public hospital health system is maintained and that the growth is maintained at the same level as the Commonwealth's growth.

Senator ALLISON—I think it is a fair question to ask you, Minister. These are Senate estimates, and we are supposed to be examining the government's budget documents. If there is a chance that the states will not agree to your package—and there appears to be a very strong chance—it is reasonable to ask you what figures would appear on page 106 of the PBS instead of those that are currently there.

Senator Patterson—You are assuming that the states are not going to sign up to a 17 per cent increase in real terms.

Senator ALLISON—I am just asking you what the figures would be if they did not. You have suggested that you already know what the figures are, because you have an index that applies and you would not put the extra money in.

Senator Patterson—It is a hypothetical question. Let us have a look and see at the next estimates how many states have signed up.

Senator ALLISON—Let me ask it in a different way. How would these figures differ if you were not contributing the extra funds for the health care agreements?

CHAIR—That is hypothetical as well, Senator Allison

Senator Patterson—I have answered the question.

CHAIR—It is all hypothetical, Senator. We do not have a crystal ball, unfortunately.

Senator ALLISON—It is not hypothetical, Chair, with respect. We are presented with two scenarios—

Senator Patterson—Some states may sign up; some states may not sign up. I cannot predict which states will. If I were a state health minister I would sign up to get that growth. It would be very difficult to explain to the public why you were not going to accept the growth. The only way you could explain it is by saying, 'They are not prepared to say what they are going to spend; they are not prepared to match our growth.' It would be a very difficult argument to put to the public in each state and territory. I cannot tell you what will happen. Some states and territories may sign up; some states and territories may not sign up. I am presuming in the budget statements that they will all sign up. It is 17 per cent real growth over and above inflation—a $10 billion increase over the next five years, going from $32 billion to $42 billion.

Senator ALLISON—I know you do not want to answer this question, but if I were to say, 'Tasmania will sign up but Victoria won't,' presumably you could work it out on the basis of that prediction?

Senator Patterson—You can do the sums and work out that they will get the same amount as they got last financial year, indexed by WCI 1.

Senator ALLISON—All I am asking is what that indexing by WCI 1 would mean.

Senator Patterson—Again, it depends on which states and territories sign up and which do not. I am presuming that in the end they will all see the light and sign up because otherwise they will not have the growth built in. All we have to ensure is that the states continue to carry their share of the load of public hospital funding. Over the life of the last agreement, they did not.

Senator ALLISON—I do not disagree with that, Minister. I am just trying to find out what will happen if they do not agree.

Senator Patterson—Our contribution went from 45 per cent to 48 per cent, while at the same time 3,000 beds were closed down and we reduced the strain on public hospitals through the number of people being treated in private hospitals.

Senator ALLISON—You are the one who said that, if they do not agree, they will get the same funding as last year with whatever the index was.

Senator Patterson—Those are the terms and conditions.

Senator ALLISON—All I am asking you is: what does that mean in dollar terms?

Senator Patterson—We can tell you state by state what it means in dollar terms and the outside—

Senator ALLISON—That would be excellent. Maybe you could take that on notice. On page 96 of the portfolio budget statement, it says:

The Department will work cooperatively with States and Territories to improve the delivery of radiation oncology services, including the development of models for radiotherapy …

Can you explain what that means?

Mr Davies—Following the publication last year of the Baume report into radiation oncology services, the health ministers jointly agreed to set up a radiation oncology joint implementation group, which brings together representatives from the Commonwealth and the states and territories. As the name implies, it is exploring the implementation of the Baume recommendations, so it is covering everything from how services are physically distributed around the country to developing a model for service provision and looking at issues such as funding. That group has met twice and I think will meet twice more before its final report to health ministers at the end of this year.

Senator ALLISON—What are the assumptions about the outcomes of that group and those negotiations or cooperative models?

Mr Davies—I think it is fair to say that there are no preconceptions or assumptions. The Baume report is our starting point and thus far, on the basis of two meetings—I chair that group—there has been a very cooperative and collaborative atmosphere, recognising that there is a significant agenda set by that report.

Senator ALLISON—So the purpose of it is not necessarily to save money on new models—or is it?

Mr Davies—I am not aware that that is part of our brief at all.

Senator ALLISON—What is the current cost of delivering radiation oncology services?

Mr Davies—I will pass you over to Mr Sheedy, who has that figure at his fingertips.

Mr Sheedy—At the moment the Commonwealth pays for radiation oncology in a couple of ways: through MBS payments and through health program grants, but those two mechanisms combined lead to about $1 million per linear accelerator as the cost of providing radiation oncology.

Senator ALLISON—I notice that radiation oncology has been included in the list of things the safety net will cover under the new arrangements. What sort of savings do you expect in terms of government outlays forgone if the private health insurance industry takes it up?

Mr Sheedy—I would not expect that there would be any savings at all. Perhaps I will let Mr Maskell-Knight answer this question.

Mr Maskell-Knight—What will happen is there will be a transfer from individual patients paying for those services to people who take up the insurance product paying for them. It is not a matter of private expenditure replacing government; it is a matter of insurance outlays replacing private individuals.

Senator ALLISON—But currently, is it not the case that it is likely that there will be a shift of these costs onto private health insurance and therefore members of the private health insurance industry?

Mr Maskell-Knight—I do not see why that should be the case.

Senator ALLISON—Are there any projections as to the trends in oncology and the likely increases in costs over the next five years or so? What predictions does the department make?

Mr Sheedy—I do not have any with me. My colleague Dr McLoughlin, who is not here, might have some of those projections. What I can tell you, though, is that there has been fairly steady growth in our expenditure on radiation oncology services over the last number of years. Since 1998, for instance, it has grown by about 100 per cent.

Senator ALLISON—One hundred per cent since 1998?

Mr Sheedy—Yes. We were spending about $50 million a year on the two mechanisms I outlined earlier; we are now spending about $100 million a year.

Senator ALLISON—And the projections over the next five years?

Mr Sheedy—I would expect the growth rate to be at least five or six per cent a year but, as I say, I do not have those projections.

Senator ALLISON—So you would not expect there to be another doubling in that period, which would be about the same from here to 1998 as from here to 2005?

Mr Sheedy—I am not in a position to answer that at the moment. There certainly was a fairly significant growth during that period. For instance, in 1998-99 there was a 26 per cent growth in our MBS expenditure and it was 29 per cent in 1999-2000. I suspect that those rates of growth were due to the increasing availability of radiation oncology facilities and you would not be seeing those rates of growth in the future. It is also the case that we are currently—

Senator ALLISON—Why do you believe that to be the case, Mr Sheedy?

Mr Sheedy—Because they are very significant rates of growth which have, in the subsequent period, declined. In the most recent two years growth has been about six per cent. Also, another thing to take into account is that we are currently providing radiotherapy to about 44 or 45 per cent of those people diagnosed with cancer. The consensus target—informal though it is' it is not based on a great deal of evidence—is treating about 50 per cent of cancer patients with radiation therapy. The back of the envelope calculations on that would indicate that we will not have the sorts of growth in the future that we experienced in recent years.

Senator ALLISON—Can you now go back over that period and understand why it is that there has been the growth? Has it been technology or new procedures, or is it just a growth in the number of cancer patients?

Mr Sheedy—It is a combination of all of those, I believe. It is also because the equipment is becoming more sophisticated and we are able to treat more patients with the existing machinery than we have been in the past. For instance, there is a technology called the mulitileaf collimator which enables the targeting of the beam more precisely than in the past and in a way that does not involve the radiotherapist coming in during the treatment and placing blocks and removing them in order to make sure the beam is well targeted. So the throughput in these machines is becoming much greater than has been the case in the past.

Senator Patterson—I just want to explain that the blocks had to be fitted and now they do it with computers. If you want to go and see one I am sure we can arrange it, because it really made it clearer to me. The computer determines the size of the area. Instead of having to make those blocks, design them, put them all in and change them for every patient, they just computerise it. I do not know what they call it—I am not a radiation oncologist or a radiotherapist—but the little thing that determines how much ray comes out now is computerised so it speeds up the changeover between patients. I can arrange a visit. I was just staggered when I saw some of the new equipment. It means you can get more patients through.

Senator ALLISON—That would suggest that the costs would go down, or are you saying—

Senator Patterson—The machines get more expensive.

Mr Sheedy—Yes.

Senator Patterson—The way it should work is that the states buy the machines and then we do the MBS and the—

Mr Sheedy—Health program grants.

Senator ALLISON—What has been the experience for patients in terms of costs? Is it the case that inpatient and outpatient costs are increasing for oncology? What are the trends? Do we have any figures to show what the extra cost to patients has been?

Mr Sheedy—I do not have any timeline figures with me. I can tell you what the costs to patients are at the moment. It is roughly $2,500 per treatment and perhaps 20 or 30 doses are received during the normal course of treatment.

Senator ALLISON—That is the cost to the patient?

Mr Sheedy—They get $2,100 of that back from MBS, so the cost to the patient, on average, is about $400. I believe they are the 2001-02 figures.

Senator ALLISON—Under the arrangement proposed in the new measures, how would that change? Can you explain how it works?

Mr Sheedy—The work of the radiation oncology joint implementation group and the implementation of the Baume report are about a couple of things. One is to make sure there is better cooperation between the Commonwealth and the states, because these are issues where we both have a very significant interest and we want to make sure that we coordinate far better and do our planning together as much as possible. There is also the ability, given the budget measure from the year before last, to provide more funding for the states for more machines or for other measures that might assist in improving access of oncology patients, particularly those in rural and remote areas, to radiation therapy services.

Senator ALLISON—I am just trying to understand how that will vary under a situation where you can take out private health insurance for that $400.

Mr Sheedy—Right.

Senator ALLISON—Will there still be a rebate provided through oncology services for the full amount, or is this working group looking at that question?

Mr Davies—Are you asking how this interacts with A Fairer Medicare package?

Senator ALLISON—Yes.

Mr Davies—As you can gather from the figure you have just heard, $400 is an average out-of-pocket payment, so obviously for a concession card holder that will get them a good way towards the $500 threshold. If they have had a few GP visits with out-of-pocket payments as well or other specialist services—we hope that GPs would bulk-bill—that will be the $500; therefore the 80 per cent rebate on any future out-of-pocket costs would cut in. This does not exist at the moment because the current safety net, as you probably know, only covers the gap up to the scheduled fee.

Senator ALLISON—So the rebate will remain the same.

Mr Davies—The rebate will remain the same.

Senator ALLISON—Regardless.

Mr Davies—The rebate will grow as rebates grow.

Senator ALLISON—With the CPI or whatever. What does the increase in costs of oncology tell us? Like my question before, is it likely we are going to see more expensive treatments? In that case, would the rebate be adjusted for the cost of those treatments over and above the CPI, or would you expect those patients who have private health insurance would have that extra cost picked up by that cover?

Mr Sheedy—We can expect increases in costs through technology. But this is the case everywhere in our portfolio and we have mechanisms for incorporating those additional costs into our systems.

Senator Patterson—It is not only with radiation oncology. There are other areas where there are significant increases in costs—prostheses.

Senator ALLISON—I am just using this as a case study to try and understand how the system would work in relation to it.

Mr Davies—In terms of the safety net, to the extent that radiation oncology services are charging above the scheduled fee at the moment, which is more than the rebate level, then that cost is met in full by the patient whether they are a concession card holder or not. The effect of the new safety net will be to refund 80 per cent of all out-of-pocket costs for concession card holders once they have reached the $500 threshold. So it is a much more robust safety net than the current MBS safety net.

Senator ALLISON—The rebate is increased through CPI. Is it ever adjusted as a result of—

Mr Davies—It is not strictly CPI.

Senator ALLISON—Does that take into account new technology and possibly new, more expensive treatment?

Mr Davies—I think Ian is probably the person to answer this.

Mr McRae—The way in which the Medicare schedule is taken forward is, as we say, fees or rebates go up with WCI 5 each year. Other changes are made are when we need to change

the items because a new technology has come along and it gets added to the system. Most of the more sophisticated new technologies get assessed through the Medicare Services Advisory Committee these days and work through from that. Should the committee recommend that they be put on to the schedule, then we negotiate with the profession for the new fee.

Senator ALLISON—Can I ask a question about medical indemnity.

Senator NETTLE—I just thought while we were on radiation oncology, I would stay there. I noticed, Minister, you put out a media release on 8 May about the opening of a radiation oncology facility—the Epworth Cancer Centre—at one of Australia's largest private hospitals. Did any public funding go towards the centre for the establishment and costs of that service?

Senator Patterson—It was a joint venture between the Peter Mac hospital and the Epworth, with a large chunk of funding from the Uniting Church. I said it was a perfect example of the community, the public system and the private system working together. There will be public patients treated there. It is a place that I suggest to Senator Allison that she visits, because it gives some examples of the latest equipment also. If I had been a little bit more on the ball before, I would have talked about that equipment, and being able to change the aperture of the device so that you can direct the radiation, or the ray, not using a metal guard which has to be designed just for you. One of the reasons I went there was because it reflects that strong public, strong private hospital system that we are encouraging. It is exemplified by that project.

Senator NETTLE—You say it is a partnership. How much public funding went towards that project? Maybe that is something I could ask on notice.

Mr Sheedy—It gets exactly the same public funding through the HPG and the MBS as any other radiation oncology facility, which is on average about $1 million a year.

Senator NETTLE—Just to clarify: it gets the same amount of funding as any other radiation oncology service in the public or in the private system. We are talking about an instance of a private hospital here—

Senator Patterson—We are talking about the rebate. It works out at about $1 million per machine. I think there happen to be two machines at the Peter Mac. One has a CT scanner associated with it and the other one does not, because if you are having radiation therapy on your breast you do not get so many daily or diurnal changes, but if you are having it done on your prostate it might depend on whether your bowels are full or your bladder is full. It shifts, and they can use the CT to accommodate for that and make sure that you require less radiotherapy. I have learnt a lot about radiotherapy in the last 18 months. They have a double machine, with CT and the radiotherapy machine, and the other one. I think two radiotherapy machines will cost about $1 million each in MBS. You may be a private patient getting your MBS rebate or you may be a public patient through the Peter Mac. I think that is how it works.

Senator NETTLE—So the rebate is the same for the machine, regardless of what kind of hospital it is located in. Is that correct?

Mr Sheedy—There is a small difference.

Mr Davies—There are minor differences in the mechanisms, but essentially the same mechanisms operate. There is a capital component.

Mr Sheedy—Just to clarify: the Commonwealth does not contribute any direct lump sum to the establishment of a private facility. We currently have, I think, 17 private radiation oncology providers around the country. The Commonwealth's contribution is in the form of a fee-for-service payment split into MBS and HPG. Both those components are paid to radiation oncology providers, whether they are public or private. The only difference is that the private gets a slightly higher rate of HPG to reflect their different cost base. It is just like any other privately provided service. It is like the situation with GPs: we do not pay GPs to set up their surgery; we assume they will recover that capital cost through their fee for service over time. It is the same in radiation oncology.

Senator NETTLE—That makes sense. It is not an establishment cost, it is a fee-for-service cost, which is higher for private hospitals.

Senator Patterson—No.

Mr Davies—The HPG component of it is.

Senator NETTLE—The HPG component is higher for private hospitals as opposed to public hospitals.

Senator Patterson—It takes into account the different costs that they have.

Mr Davies—They have costs of borrowing, essentially, which public facilities do not.

Senator NETTLE—Borrowing capital?

Mr Davies—Yes.

Senator Patterson—If they borrow to buy the machine, they have interest rates that a public hospital does not have. You take those into account to even out that effect.

Mr Davies—It is about a level playing field.

Senator NETTLE—It does not sound like a particularly level playing field when the private provider gets some more.

Senator Patterson—It costs the private provider more to get the equipment.

Mr Davies—They have higher costs.

Senator NETTLE—I want to go back to a comment that Mr Sheedy made in terms of this particular facility.

Senator Patterson—Is it okay for me to go to the 'F' word?

Senator NETTLE—I do not know that I was passing judgment on your activities; I was merely trying to understand what we were discussing here. Mr Sheedy, you said before that, in particular in relation to the Epworth facility, it was available for public patients to access that service at the private hospital. Is that correct?

Mr Sheedy—I understand that it is up to the Victorian government to negotiate with the hospital if they want to use that facility to treat public patients. We understand further that they may well do that.

Senator NETTLE—You are not sure at this stage. Would that be correct?

Mr Sheedy—Yes.

Senator NETTLE—Negotiations are taking place to make the facility in this particular private hospital available to public patients as well as those with private health insurance. Is that correct?

Mr Sheedy—Yes; or people who attend as private patients, not all of whom may have private health insurance.

Senator NETTLE—Yes, I understand that. Those are all the questions I have. Thank you.

Mr Davies—For the record and for the clarification of a possible misunderstanding, Senator Nettle, you said you referred to private health insurance covering radiation oncology. Under current policy settings, radiation oncology delivered on an outpatient basis—as most of it is—cannot be covered by private health insurance. At the moment, private health insurance can only cover admitted patient services, and that is obviously one of the reasons for the proposed change with A Fairer Medicare.

Senator NETTLE—Thank you.

Senator ALLISON—Mr Sheedy, I would like to clarify what you said about the $1,000 and $400 that patients pay out of pocket. Is that per episode or per treatment?

Mr Sheedy—That is per course of treatment.

Senator ALLISON—So someone going through a course of treatment would quickly get to the $500 if they were on concession and, possibly, relatively quickly get to the $1,000 if they were not.

Mr Sheedy—Possibly, yes. At those figures, $400 is most of the way towards the $500 for one course of treatment and I believe that, generally, people have only one course of treatment.

Senator ALLISON—I would like to ask some questions about medical indemnity insurance.

CHAIR—Senator Allison, as medical indemnity is probably going to be a little longer, can I ask Senator Greig whether he would like to go through some of his questions, followed by Senator Bishop, who has some community pharmacy questions that are probably a little shorter.

Senator GREIG—I want to ask some questions about Australia's HIV-AIDS strategy.

CHAIR—I think that is under outcome 1, Senator Greig.

Ms Halton—Unless we are misunderstanding you, Senator, do you want to tell us in which broad area you want to ask questions. It is not likely to be program 2.

Senator GREIG—I want to talk about infection rates, the response and the minister's review.

CHAIR—That is outcome 1, isn't it?

Ms Halton—Yes.

CHAIR—We will get to that later on tonight.

Senator MARK BISHOP—Are the officers from the community pharmacy group available?

Ms Halton—Yes.

Senator MARK BISHOP—Is it Mr Rennie or Ms Corbett who is the senior officer of ACPA?

Ms Halton—Ms Corbett is acting first assistant secretary in the relevant division. Mr Rennie is one of the assistant secretaries. Ms Corbett, when she is in her normal position, is also one of the officers responsible for pharmaceutical benefits, so you have the combined, double-barrelled expertise here.

Senator MARK BISHOP—Thank you. My questions are relatively confined. I want to talk about the processes deriving from some activity concerning Karratha Pharmacy in Western Australia and the Federal Court case and developments post that. That is my interest in this session. I will ask the question of Mr Rennie if he is the right person, and if he is not someone else can answer. In the time leading up to the initial consideration of the application by the second pharmacy up there, interests associated with Mr MacKenzie, were any representations made to the department and ACPA by the proponents?

Mr Rennie—Representations were made supporting an additional pharmacy in Karratha.

Senator MARK BISHOP—When were those representations first made to ACPA or to the department?

Mr Rennie—I do not have the details of the actual dates with me.

Senator MARK BISHOP—Do you have a rough monthly figure?

Mr Rennie—I might go through the chronology I have in front of me. In July 2002 Mr MacKenzie's application was lodged with the ACPA. In August 2002 an objection was lodged from the existing pharmacist—Ms Wood, I believe. On 20 September 2002 the ACPA recommended approval under rule 6A of the ministerial determinations covering the relocation of pharmacies into rural areas in exceptional circumstances. On 17 October 2002 the Federal Court issued orders to stay the delegate's decision in respect of the ACPA's recommendation. A Federal Court hearing was held on 19 November 2002. Justice Lee handed down his decision on 19 December 2002. On 24 January 2003 the ACPA, at its meeting, deferred reconsideration of the application to allow the existing pharmacist to respond to claims made against it. On 21 February 2003 the ACPA recommended that the application not be approved on the basis that the requirements of subparagraph 6A(5)(c) were not met. The latest date of relevance here is 19 May this year, when the ACPA secretariat received notification that an AAT appeal had been lodged by the applicant, Mr MacKenzie.

Senator MARK BISHOP—I was not aware of that last development. On 19 May—

Mr Rennie—Mr MacKenzie lodged an appeal with the AAT. That is still active.

Senator MARK BISHOP—An appeal from the decision of ACPA?

Mr Rennie—That is right, the second appeal—appealing against the decision of the ACPA on 21 February not to approve it.

Senator MARK BISHOP—Going back to prior to the decision of Justice Lee on 19 December, what was the nature of the representations made to the department and ACPA by interests associated with Mr MacKenzie?

Mr Rennie—The vast majority of the approaches to the department were in support of an additional pharmacy in Karratha.

Senator MARK BISHOP—Was all of this done at departmental or agency level, or was there also involvement at this stage with the minister's office?

Mr Rennie—This was all in the department, and particularly within the ACPA secretariat part of the department.

Senator MARK BISHOP—So there was no involvement of the minister's office prior to the decision of Justice Lee?

Mr Rennie—No. There was no involvement at all with the minister's office.

Senator MARK BISHOP—Were any representations made—also prior to the decision of Justice Lee—to the minister's office, the department or ACPA by any member of parliament?

Mr Rennie—Yes, there were. There have been representations to all three bodies you mentioned over a period of time, ranging from before and after the decision of the ACPA.

Senator MARK BISHOP—Can you outline the nature of the representations by individual members of parliament to each of those bodies?

Mr Rennie—I do not have those details with me.

Ms Halton—We would have to take advice on whether we are enabled to release the identity of particular people who have made representations or indeed the content. When we are asked about what particular industry bodies have said on matters in correspondence to us, we always have to go back and discuss with them their views about that. We will take advice and come back to you.

Senator MARK BISHOP—I understand. Could you take this question on notice. Could you provide a summary of the detail of the representations made by individual members of parliament to ACPA, the department or the minister's office prior to the decision of Justice Lee on 19 December and, similarly, subsequent representations in the same fashion post 19 December? You will take advice as to whether it is improper to respond.

Ms Halton—Obviously, the department has information about administrative detail. We do not collect information about what representations are received by the minister or the minister's office. To the extent that something is forwarded to us as a 'ministerial', we may or may not be aware of correspondence the minister receives. But I would be surprised if we were privy to all of the correspondence the minister received. In fact, I would be highly surprised. I think that might be the part of the question we would have trouble with. As I said, the other issue will go to privacy, but we will see what we can get you.

Senator MARK BISHOP—Privacy is not such a great concern because a lot of the detail is on the records available from ACPA and, of course, were submissions made by all parties to the Federal Court decision and in the public documents.

Ms Halton—I understand that. I am just being prudent in not promising something I may not be able to deliver.

Senator MARK BISHOP—I understand that. You do understand what I am asking for.

Ms Halton—Yes, we do.

Senator MARK BISHOP—The Federal Court decision of Justice Lee, when you read the decision, was very straightforward and clear and there was what I would call significant criticism of the conduct of ACPA in coming to its decisions that were the subject of a later court decision. What investigations were made by either the department or ACPA of the allegations made against the existing pharmacist?

Ms Halton—Can you clarify what you mean by investigations? That sounds like a formal process.

Senator MARK BISHOP—Formal or informal. I am aware from Justice Lee's decision that a series of allegations were made concerning the operation, administration and servicing of local interests by the owner of the existing pharmacy in Karratha going to matters of trading hours, maintenance of stock levels, opening after hours, servicing existing clients, servicing of emergency situations, servicing of outlying depots that needed receipted drugs and that all of those allegations were put to ACPA prior to Justice Lee's decision. The Federal Court examines, in considerable detail, each of those allegations and makes a finding of fact that they had no substance at all. So my inquiry here is what, if any, investigation was conducted by ACPA or the department to test the veracity of those allegations prior to acceptance of the veracity of those allegations?

Mr Rennie—It might assist to go to the ministerial rules which the ACPA must work under. Those ministerial rules are determinations that have some legislative basis. In those rules, one of the criteria that the authority must look at is whether the authority is satisfied that the provision of pharmaceuticals by the existing pharmacy in ACPA is substantially inadequate. In looking at that, there are a number of guidelines given to the authority to which they should be looking. One of those criteria is whether the existing pharmacist has not complied with his or her obligations under the National Health and Pharmaceutical Benefits Regulations made under the act concerning presentation of prescriptions in trading hours—that is, regulation 27 of the act; the presentation of urgent prescriptions, regulation 28; and proper stocks to be kept, regulation 33.

My understanding is that, in considering the application, the authority took into account letters received from particularly medical practitioners in Karratha which would appear to have substantiated that there might have been a concern about those regulations. It is my understanding Justice Lee felt that procedural fairness had not been given to the existing pharmacist and that was one of the key reasons that he said that the ACPA should relook at this particular application and that is why it went back to the ACPA on 21 February.

Senator MARK BISHOP—That is partially correct Mr Rennie. There was certainly a lengthy discussion on procedural unfairness in the last three or four pages of his decision, but in the previous half dozen pages particularly at paragraphs 27 and 28 and 30 through to 37 of his decision, which I have read, he addressed each of those issues that you just identified there and said that there was lack of evidence, lack of particulars, lack of consideration or comment

by ACPA. That is all of the allegations were made in writing but none of the allegations were supported by any evidence, any particularisation, any comment or any consideration. So my question to you is: did ACPA or the department do anything other than accept the written complaints?

Mr Rennie—My understanding is that there was also correspondence from the existing pharmacist that was taken into account in making that initial decision to approve the application. However, as a result of Justice Lee's decision, the matter went back to the authority and that is when they, in reconsidering it and taking into account Justice Lee's opinions on certain matters as you were pointing out, then rejected the application.

Senator MARK BISHOP—That is also correct but are you obliquely telling me that this correspondence was received from interest associated with the second pharmacy and that serious allegations were raised as to how the existing pharmacy in a large number of elements was conducting her business there but none of those allegations were independently examined or assessed or tested by ACPA? Is that your advice to me?

Mr Rennie—Certainly that was the opinion of Justice Lee in handing down his decision.

Senator MARK BISHOP—And you do not challenge his finding?

Mr Rennie—There was no appeal by the Commonwealth to that finding.

Senator MARK BISHOP—We are all agreed on the facts. What I am asking you, Mr Rennie, was whether the agency or the department did any independent assessment of analysis of that range of allegations?

Mr Gladman—Just one point of clarification just from reading the decision of the court in the Wood matter: I was just noting that one of the findings that the court made was that the authority did not come to the conclusion that the applicant had failed to comply with the regulations. The authority went on to consider some other matters that had been raised in correspondence it had received but it did not go as far as saying that Ms Wood had failed to meet those regulations 27, 28 and 30, I believe.

Senator MARK BISHOP—Mr Rennie, do you care to answer my question?

Mr Rennie—Senator, I thought I had answered your question.

Senator MARK BISHOP—You have affirmed what Mr Lee found. You have not yet told me whether ACPA or the department made any analysis or investigation of the series of complaints made about the existing pharmacy? That is really a yes or no answer.

Mr Rennie—Senator what I am saying is there was no appeal by the Commonwealth against the decision of Justice Lee—

Senator MARK BISHOP—No, prior to the decision of Mr Justice Lee on 19 December—that is, when the matter was under review at departmental level and a recommendation was made—did the department or ACPA at that time do any independent—

Ms Halton—Can I just correct you? When you say it was under review at departmental level, the department basically, as I understand it, does not have a jurisdiction to review this. It is a decision taken by an independent body, serviced by a secretariat. Effectively this is a

matter dealt with at arm's length from the department; it is not a matter for departmental review.

Senator MARK BISHOP—So the question really should be to ACPA—is that what you are telling me?

Ms Halton—Yes.

Senator MARK BISHOP—So, ACPA is the responsible agency.

Ms Halton—Yes, that is right.

Senator MARK BISHOP—It received allegations as to the way the existing pharmacy in Karratha was conducting its business. That correspondence was received and considered, we know that. I am asking you: did ACPA do any independent analysis or investigation as to the veracity of those complaints?

Mr Rennie—Could I take that on board, as I was not at the meetings? Certainly I have read the statement of reasons issued by the authority and that, from my recollection, was not raised in their statement of reasons, but I would like to take that on board and check, through the secretariat, to see whether in fact what you are saying is true or not.

Senator MARK BISHOP—I am not saying anything; I am asking.

Ms Halton—What Mr Rennie is saying is that we will similarly have to ask. This is not a departmental issue; we will have to go to them and put that question to them and see whether we can get an answer with which we can then come back to you.

Senator MARK BISHOP—I understand. Could I ask that you expedite that process and provide that answer as soon as possible?

Ms Halton—Yes, I am happy to. You will understand that, unlike officers of the department whom I can gently encourage to speed up, this is not necessarily within my gift. But we will go to them as a matter of urgency and see if we can get answers to those questions for you.

Senator MARK BISHOP—Subsequent to the decision of the Federal Court in this matter, has ACPA in any way reviewed its internal processes on these sorts of issues?

Mr Rennie—Once again, I would have to take that on board to check to see whether they have made any change as a result of this particular case. They have been reviewing their processes but whether it is the result of this case or some other circumstances I am not quite sure. Could I get back to you on that?

Senator MARK BISHOP—Yes. Do we not have officers from ACPA here?

Ms Halton—No.

Senator MARK BISHOP—Why is that?

Mr Rennie—The authority is an independent authority appointed by the minister. They are not departmental employees. There is one member who is a departmental employee, who is not here tonight—she is actually on recreation leave.

Senator MARK BISHOP—But I wrote to the secretary of the committee some time ago expressly requesting that relevant officers of ACPA be present at this estimates hearing so that questions could be asked of them.

Ms Halton—I think you will find—but we will come back to you with advice on this—that, a bit like tribunals and things of that sort, they would not normally be called. They are not called to estimates. Departmental officers can be called to estimates—but I will get some advice on that.

Senator MARK BISHOP—How is ACPA any different to, for example, the Australian Communications Authority or the Australian Broadcasting Authority? It is a regulatory agency that issues licences. A request was made for the officers to be in attendance so that they could be examined.

Ms Halton—I cannot comment about those agencies but, for example, we would not call the PBAC or any of those bodies.

Senator MARK BISHOP—But Ms Halton, with due respect, it is not a matter for you to call them. I requested in writing that they attend and I have received no response.

Ms Halton—My understanding is that you do not have a jurisdiction to call them to attend, but let me confirm that advice for you.

Senator MARK BISHOP—I am not suggesting that I did call them to attend. I wrote to the secretary of the committee and asked that the relevant officers be in attendance.

Ms Halton—I do not know that we were aware of that request—I am giving you my understanding. We will take some advice over the dinner break but, as I say, my understanding is that that committee never attends, as a number of other committees that are established do not attend, because they are not like officers of the department, if I can put it that way.

Senator MARK BISHOP—I understand they are not officers of the department; they are officers of a separate agency established under legislation.

Ms Halton—It is not an agency. It is not covered, one of my colleagues is pointing out, and it is not covered in the portfolio budget statements, which would be the agencies who would come—

Senator MARK BISHOP—But it is covered in the annual report.

Ms Halton—We are not examining the annual report.

Senator MARK BISHOP—I can raise questions out of the annual report at any time I like, if it is a matter of the business of the department.

CHAIR—We are going to go round and round in circles.

Senator MARK BISHOP—I am concerned, Madam Chair, that at first glance it appears that there has been a high degree of irregularity occurring in the issuing of licences by an agency. A request has been made for the relevant officers to be in attendance to take questions and it has been ignored.

Senator Patterson—They are not officers. Senator Bishop, I do not know when you wrote the letter to the committee secretary who that went to. Why don't we find out about that over the dinner break?

Ms Halton—I do not recall that you wrote to me asking for those officers.

Senator MARK BISHOP—I have not written to you, Ms Halton; I wrote to the secretary of the committee.

Ms Halton—Normally what happens is that, when officers are requested from various parts of the portfolio, we get notification in the portfolio proper. For example, we have discussed Dr Louise Tighe. There was a request that Dr Loy be available, and that came to the core part of the department. We have arranged that. I cannot answer your technical question as to whether you can technically call this group. I have a suspicion you cannot, but we will find the technical answer to that question. The reason we cannot answer that tonight is that we did not know you had put in this request. I apologise that you put in a request we did not know about, and we will endeavour to get you the technical answer to your question as soon as we can, but in the way the estimates process normally works we are told within the portfolio proper who the senators would like. So earlier we were told who was not required and we have therefore provided access to all the other agencies—

Senator MARK BISHOP—But the minister's office was told.

Senator Patterson—Senator Bishop, you said that you wrote to the committee secretary. Now you are telling me you told the minister's office.

Senator MARK BISHOP—I told your office on Friday.

CHAIR—We cannot proceed with this issue any further.

Senator Patterson—I do not know who you told in my office.

Senator MARK BISHOP—I will tell you who I told because I have a note—

Senator Patterson—You just said to me I told your office. You had not said that before.

CHAIR—Order !

Senator MARK BISHOP—A Ms Emma Handyside at 4.40 p.m. on 29 May.

CHAIR—You asked at 20 to five on a Friday afternoon for a Monday meeting. We cannot proceed with this any further. The offer has been made to examine it over the dinner break and that will happen. We can go around in circles all we like, but I propose to call a halt to proceedings after I have called the minister because she wants to make a brief statement.

Senator Patterson—I have an answer to a question Senator Allison asked about the states not signing up to the agreement and getting what they got last year plus WCI1. New South Wales would stand not to get $1,084,000,000; Victoria, $832 million; Queensland, $851 million; Western Australia, $404 million; South Australia, $260 million; Tasmania, $85 million; ACT, $58 million; and the Northern Territory, $89 million. These are estimated funding reductions over the five years. We are asking the states to tell us what they are going to spend—we are not telling them what to spend—in the next financial year and to match our growth.

I also wanted to make a comment about a press release that Mr Smith has released where he has implied that the government did not table an RIS—that it was conspicuously absent and that the office of the Department of Health and Ageing admitted that no RIS was produced because changes to Medicare were essentially voluntary in character. He outlines Treasury requirements to the RIS process. The way you would read that, if you had not been here at the estimates, is you would presume that on a whim the Department of Health and Ageing had decided not to have an RIS. Let me just reiterate very clearly—Mr Smith, when we are doing estimates, seems to half tell the story—that the Office of Regulation Review advised that a regulation impact statement was not needed on the Fairer Medicare package. While the Office of Regulation Review are the experts on this, the reason that there was not an RIS is fairly clear, as Mr Smith's press release notes, that the arrangements in the package are entirely voluntary. There is no red tape for practices that sign up to the package—and this is not an admission but a matter of public record. For Mr Smith to issue a press release implying that it was the department who, on a whim, made that decision, it actually went through the appropriate process and the Office of Regulation Review advised that it was not necessary.

He also claims that the government was unaware of the inflationary impact of the package. That is not true. As I have stated repeatedly, there is nothing in the package which should cause doctors to increase their fees. This issue was explicitly agreed with by the Department of Finance and Administration in formulating the estimates. Mr Smith then uses a comment from a practice manager. The quote that is used shows a lack of understanding of the package and it is an area that I will keep on addressing because there is no need—and I use the quotes—'to offset the cost of bulk-billing concessional patients' because there is no cost in doing so. The heart of the government's package is that doctors will be financially better off if they sign up—that is, financially better off because there is no cost to offset and no reason to raise fees. I would appreciate it if Mr Smith could issue press releases that were a fairer reflection of what goes on here in the estimates committees.

Senator MARK BISHOP—I wrote to the secretary of this committee on 13 May expressly requesting that officers from ACPA attend this Senate hearing. That request was formally forwarded to the department on 14 May, and there is a record of that. The department has—

CHAIR—Senator Bishop, the secretary to the department has, I think, by recollection, made the offer on no fewer than five occasions in the last 10 minutes to find the answers for you over the dinner break. By restating what you have already said on five, six, or seven occasions is not going to change anything.

Senator MARK BISHOP—The secretary to the department advised that they were unaware that a request had been made by me for ACPA to attend. The department has received a formal request in writing on 14 May to that effect.

CHAIR—Ms Halton has undertaken to investigate the matter.

Ms Halton—You said, Senator, that you wrote to ACPA itself.

Senator MARK BISHOP—No, I did not; I said I wrote to the secretary of the committee.

Ms Halton—Which—

Senator MARK BISHOP—This committee.

Ms Halton—This committee?

Senator MARK BISHOP—Yes, the estimates committee, who forwarded the correspondence to the department the following day.

Ms Halton—I apologise, Senator. That was not brought to my attention. As I have said to you, I was not aware that you had requested them. People are out now trying to ascertain whether there is a precedent for this kind of committee to be summoned to Senate estimates. I believe that that is not the case, but we will check with the Prime Minister and Cabinet over the dinner break and we will come back to you with an explicit answer after the dinner break.

Senator MARK BISHOP—Thank you.

Proceedings suspended from 6.32 p.m. to 7.35 p.m.

CHAIR—Ms Halton, I believe you have a response for Senator Bishop.

Ms Halton—I have looked into the history and it sounds to me as if there has been some confusion. Essentially, you sent a letter, as I understand it, to the secretariat. I think the words went to activities of the authority and policy processes relating to the rules drawn up. My understanding is that my officers received this from the secretariat and they had a conversation internally as to what was meant. They came back to the secretariat and said, 'Does this actually mean committee members, because that would be highly unusual.' They were told, 'No, officers.' Subsequently, we got a list of the agencies and/or others who were actually required. That does not give you a solution for this evening, but I think I can understand how the confusion has occurred.

In future, if you would like a committee member to be here, we can ask them to attend and we would be happy to do that. But, in terms of the specifics for this evening, as I indicated to you before the dinner break, if you would like to ask particular questions and if we cannot answer them tonight, I would be very happy to try and get them answered for you by the end of the week, for example. We would get back to you very quickly. In this particular area there has not been an experience of questions being asked, so there has just been some confusion all round. I am very sorry about that. But the officer did come back to the committee and ask the question.

Senator FAULKNER—I do not know that you should be offering a committee member—

Ms Halton—No, I am—

Senator FAULKNER—Except if that committee member also happens to be an officer of your department.

Ms Halton—There is one—

Senator FAULKNER—So that is an exception and I think that is reasonable.

Ms Halton—There is one, but, unfortunately, that officer is on four weeks recreation leave at the moment, so we could not have fielded that officer.

Senator FAULKNER—For this group—the Australian Community Pharmacy Authority—there is an appropriation that you can point to in the PBS?

Ms Halton—No, I do not think so. It is departmentally subvented, so it does not have a separate appropriation. It is a committee.

Senator FAULKNER—So what program or what output, to use the modern terminology, do we find it in?

Ms Halton—Output 2, which is where we were.

Senator FAULKNER—Can you take us to a page in the PBS which might mention this group?

Ms Halton—No, I do not think you will find them mentioned, because they are one of hundreds of committees, I have discovered, in my department.

Senator FAULKNER—Can we define it down from output 2 any further? Is there a—

Ms Halton—We can define it down to pharmaceutical benefits, recognising that program 2 has a number of elements. You would accept that it has, for example, health care agreements, medical benefits and pharmaceutical services. So I think we are able to define it down to that level.

Senator FAULKNER—So this is a committee that has a departmental representative—

Ms Halton—It has one departmental representative.

Senator FAULKNER—Can you say who that officer is and what level they are? It would be useful for the future.

Ms Halton—Yes, absolutely.

Mr Rennie—Catherine Farrell is the officer and she is an ELII, at the level of section head within the department.

Senator FAULKNER—Can you say to us whether the department is responsible for effectively administering the work of the committee?

Mr Rennie—The department is responsible for the secretariat to the committee, yes.

Senator FAULKNER—And the secretariat is effectively coordinated through the officer you mentioned?

Mr Rennie—That is right. The secretariat lies within the section headed by that officer that I mentioned.

Senator FAULKNER—The issue here, and the only reason I have a mild interest in it, is the extent to which there is an appropriate role for this committee to examine the authority's work.

Ms Halton—Yes, absolutely.

Senator FAULKNER—It seems to me that there is, so I certainly think that you should not be too generous in proposing committee members, apart from departmental officials.

Ms Halton—No, and as I said, had this been clearer we would have been able to bring the officer concerned, who is a committee member normally—and as I have said there has obviously been some confusion—but regrettably she is on four weeks leave.

Senator FAULKNER—I suspect—I do not know—that there does not seem to be a major dispute about the capacity of this committee to examine the work of the authority, the administration of the authority or any outcomes or decisions of the authority.

Ms Halton—There is no issue there. I think that the question we were being asked before went to why they had taken particular decisions and done particular things. Some of those issues are the subject of an AAT appeal and a number of them have been subject to court action. The point is that from the message we had we thought the questions were going to be in relation to procedural matters, the operation of the rules.

Senator FAULKNER—If there are no issues that could go to the question of sub judice—

Ms Halton—No.

Senator FAULKNER—there appears to be no reason why this committee cannot examine in detail the administration, the determinations, the secretariat that services the Australian Community Pharmacy Authority, and a range of other issues that go to the interface between the department and the authority itself. That is a position of principle that I suspect you are not arguing and no-one on this side of the table is going to argue. You then get to a set of issues, which are perhaps unique to the examination of this particular round of estimates, about whether certain questions can or cannot be answered—and I have not heard the evidence on this; I am in no position to make a judgment on whether it is appropriate to be answered—and of course the situation that the relevant officer is apparently not available.

Ms Halton—As I said to Senator Bishop before the dinner break, to the extent that we cannot answer his questions, given that there obviously has been confusion, we would be very happy to take those questions and provide a very speedy response to them.

Senator FAULKNER—I think the key thing, if it is flagged by committee members in the future—it may not be, but I think it is in the interest of the authority—is that we all have a reasonable understanding of where it sits. I do not have an understanding of its role or its responsibility, but I have an understanding at least that if I wanted to develop that I would know when and where to ask.

Ms Halton—Yes. As I said, I do not think we have any difference on that.

Senator MARK BISHOP—There has been some misunderstanding or confusion; I accept that, Ms Halton. I have some questions related to this which I wish to pursue with the ACPA or the department.

Ms Halton—Certainly.

Senator MARK BISHOP—The relevant officers are not available, so I will accept your offer to put the questions on notice. If you could get a written response back to me by the end of the week, if that is not too soon, that would be much appreciated.

Ms Halton—We will certainly endeavour to do that. If there are any issues which, given the absence of the officer we have talked about, we have trouble with, we will come back to you by the end of the week giving you a clear timetable. We will do as much as we can; hopefully that will be all of it. If there is any issue that we cannot resolve in that time frame we will tell you in what time frame we can.

Senator MARK BISHOP—Thank you.

Senator Patterson—Can I clarify something just to make sure there is not a misunderstanding of what happened between Senator Bishop and my office. He rang and spoke to my personal assistant. The person who deals with this is away on leave at the moment and one of the staff, Ms Handyside, rang back. Senator Bishop indicated that he wanted to make representation on this issue and that a decision should not be made before he made representation—that is, either before he saw me or raised it at estimates. But he did not indicate that he had asked for the ACPA. There was not a request for the ACPA through my office. I think that is important, because that was the implication.

Senator MARK BISHOP—No. I did not make any request to Minister Patterson's officers that the ACPA be in attendance. I had previously addressed that issue through correspondence to the secretary of this committee.

Senator FAULKNER—Which is normally what senators on this side of the table do.

Senator Patterson—I am just clarifying that, because sometimes things can be said here that imply that staff members have not passed something on to me in detail.

Senator FAULKNER—Yes. But then the secretariat raises it with the department and it goes from there, which appears to have happened in this circumstance. It strikes me as being reasonably unexceptional, I must say.

[7.46 p.m.]

CHAIR—We will now move to outcome 6, Hearing Services, and outcome 7, Aboriginal and Torres Strait Islander health.

Senator CROSSIN—Referring to page 185 of the PBS, can someone tell me the amount of money that has been provided for the Commonwealth Hearing Services for 2003-04?

Ms Feneley—Those figures on page 189, the resource allocation, indicate figures of $181,836,000 for administered expenses, which includes vouchers and CSOs—community service obligations. Have I answered your question?

Senator CROSSIN—My question relates to an answer you have given me previously, where it was $150 million for 2001-02 and $168 million for 2002-03. We are now looking at $181,836,000. Is that right?

Ms Feneley—That is correct. We are anticipating a growth of about 10,000 voucher clients this coming year. Those costs have been built into the program.

Senator CROSSIN—Of that, what amount is allocated to the Australian Hearing Services for the community service obligation?

Ms Feneley—In the current year, the Australian Hearing Services received $28.9 million, and that is going to be increased just slightly next year. That covers all the community service obligations for children under 21, complex clients, Aboriginal and Torres Strait Islanders, and those in remote communities.

Senator CROSSIN—How much of that $29.756 million will specifically be spent on Indigenous people?

Ms Feneley—Australian Hearing currently takes the decision about how that money will be split up across the different client groups.

Senator CROSSIN—There are no instructions from the Office of Hearing Services on priority needs for that money?

Ms Feneley—We meet regularly with Australian Hearing to discuss with them where we see the special needs areas to be but, fundamentally, they as a board take those decisions as to how they will spend that money. We are hoping that, with the feasibility study that was announced in the recent budget, that will give us an opportunity to look more closely at the actual costs for the different groups within CSOs. Because we will also be looking at the capability of others, apart from Australian Hearing, to provide services to Aboriginal and Torres Strait Islanders, we may well have a better targeted program out of that particular feasibility study.

Senator CROSSIN—At this stage, if Australian Hearing Services said that, of that $5.945 million, they intended to spend $5 million on eligible clients with complex rehabilitation needs and only $0.945 million on Aboriginal and Torres Strait Islander people, there is nothing your office could do about that?

Ms Feneley—We are certainly discussing with Australian Hearing ways that we might improve the targeting within that CSO group. As I mentioned, we think there is an opportunity for us to do that with the feasibility study.

Senator CROSSIN—Why is that money not provided to Australian Hearing Services with much more tied restrictions to it?

Ms Feneley—It has been an historical allocation, and I can only suggest again that through the feasibility study we are hoping to make those funds more targeted.

Senator CROSSIN—How do you evaluate at this point that you are getting value for the dollar in terms of those target groups?

Ms Feneley—Australian Hearing provide to us quarterly reports on the number of people that they are seeing under the community service obligations so that we see the money is being expended on that range of client groups. You are right; it is not specified that there be particular amounts spent against each of those target groups.

Senator CROSSIN—Can you provide this committee with those figures for the last two quarters?

Ms Feneley—Yes, I can do that, but not tonight.

Senator CROSSIN—Do you know how much of this $30 million, let us call it, will be spent on travel by Australian Hearing Services? How much of last year's allocation was spent on travel by Australian Hearing Services?

Ms Feneley—We do not have those exact figures, but we would expect that it would be a fairly high proportion of the cost of providing services to remote areas. In the Northern Territory, for example, due to a shortage of audiologists, sometimes Australian Hearing might fly somebody in from another state to provide that service. The benefit we see there is that they are getting a regular service even though there may be additional travel costs.

Senator CROSSIN—Ms Feneley, you are right. My understanding is that Australian Hearing Services—and you might want to take this on notice and get back to me about it—last year sent an audiologist from Sydney to the Pit lands, and audiologists were sent from Bendigo to service the Pitjantjatjara country, which is the corner of the Northern Territory, South Australia and Western Australia.

Ms Feneley—That is correct. I am aware of an audiologist going from Bendigo.

Senator CROSSIN—That actually gobbled up 80 per cent of the funds. So out of that money last year, only 20 per cent was actually spent on services; 80 per cent was spent on travel.

Ms Feneley—I am conscious of an article that was in *Audiology Now* that talked about hours spent in travel et cetera. On reading that article, Australian Hearing expressed concern to us that those costings were not accurate. We are currently looking at that with Australian Hearing with a view to responding to that article.

Senator CROSSIN—In formulating this year's budget provision, is anything being done to look at that percentage of travel? If there is not a possibility of basing two audiologists in Alice Springs, for example, rather than flying them from Bendigo or Sydney—which, at the end of the day, I think would save you thousands of dollars—why is something like travel not over and above the money that is provided for the actual service?

Ms Feneley—It certainly is a concern, but I think the reality is that there is a shortage of audiologists. It is important for Australian Hearing to be able to get audiologists in there to provide services, even though it is costly at this point. But I should say too that the Aboriginal congress in Alice Springs does have two audiologists, albeit one is part-time. I mentioned at an earlier hearing that we were negotiating for them to become an accredited provider with our program, We have had recent meetings with them and they are coming to Canberra in the next few weeks for us to try and finalise a service level agreement rather than the standard contract that we have with them. We are also working with the Aboriginal congress to establish a hearing aid bank in Alice Springs. We are in the process of sending them unused hearing aids that have been returned to the office. So I think we are going to be improving access to services through the congress in Alice Springs.

Senator CROSSIN—But at this point the majority of the allocation for the community service obligations for the coming year will still be spent on travel rather than actual services.

Ms Feneley—If there are ways we can get around that we will. We are currently in the process of a mid-term review of Australian Hearing's service level agreement, and that is one of the issues that we would hope to bring up with them in finetuning that agreement.

Senator CROSSIN—So was no review of that done prior to formulating this year's budget, so that additional moneys were allocated for travel?

Ms Feneley—No, there was not, but it was in anticipation of the mid-term review of the service level agreement, where it is expected that funding may be more targeted.

Senator CROSSIN—When is that review happening?

Ms Feneley—It is happening at this time. We met with Australian Hearing last week.

Senator CROSSIN—When is it expected to be finished?

Ms Feneley—We would hope that to be finished in the next month.

Senator CROSSIN—What is the time frame for the feasibility study? It is mentioned on page 186.

Ms Feneley—The report of the feasibility study will be completed by December this year.

Senator CROSSIN—What is involved in that?

Ms Feneley—The feasibility study is looking at the capacity and interest of the private sector to take on the provision of the community service obligations. So it is looking at the full range of community service obligations and whether, in fact, there might be groups who would be interested in perhaps taking on just some of those clients. There may be providers who would be interested in just providing services in remote areas and to Aboriginal and Torres Strait Islander clients. It will also examine the full impact of Australian Hearing entering the private market for all hearing services. At this stage, when clients of Australian Hearing turn 21 years of age, they move on to private service providers, so it would look at the possibility of Australian Hearing keeping those clients on a user pays basis.

Senator CROSSIN—What amount of money has been allocated against the feasibility study?

Ms Feneley—The amount is $300,000.

Senator CROSSIN—As well as extending the Australian Hearing Services area, is it also to increase, I suppose, the range of private providers in the market under the community service obligation? Is that right?

Ms Feneley—It has the potential to do that. The feasibility study will gauge the level of interest amongst private providers in providing those community service obligations.

Senator CROSSIN—When you say that do you include Aboriginal controlled health organisations—like congress—as private providers?

Ms Feneley—Yes, it would include them. We have been talking to the Aboriginal congress already about that. They were concerned that the feasibility study looked very closely at the capacity of Aboriginal controlled organisations to be accredited providers to take on the provision of community service obligations.

Senator CROSSIN—In question E02-030—you provided me with the answer last November—I asked for the number of adults who had accessed the Commonwealth Hearing Services Program. I understand that in 2000 it was 130,000 adults, of which only 100 were ATSI. Do you have figures for 2001 or 2002 with you?

Ms Feneley—Yes, I do. In 2001-02, 1,471 of the 40,840 clients who received hearing services were Aboriginal and Torres Strait Islander people, so it is only 3.6 per cent.

Senator CROSSIN—I have a figure that gives me 130,000 adults accessing that program in 2000. Why is it only 40,000 now?

Ms Feneley—That is community service obligation clients, not the total number of voucher clients.

Senator CROSSIN—What is the total number of clients then? Is that figure from 2000 accurate? Was the 130,000 adults figure the total number of clients?

Ms Feneley—There were 143,461 vouchers issued in 2001-02. The CSOs are on top of that.

Senator CROSSIN—I need to compare apples with apples. I do not know if you have my question No. E02 with you from last November, but certainly that 130,000 is not broken up into total clients or CSO clients; as far as I was aware, it is just a total figure.

Ms Feneley—We will try and get that question and answer it before the end of the evening.

Senator CROSSIN—When I got the response that, of 130 adults, only 100 were Aboriginal and Torres Strait Islanders, I thought that was particularly low.

Ms Feneley—The 100 sounds very low.

Senator CROSSIN—Those are your words, not mine. I would like an updated figure on those.

Ms Feneley—We will get that to you before the end of the evening.

Senator CROSSIN—That would be useful, because I need to compare the same sorts of figures. You probably will not have an update on the percentage of Indigenous Australians who have reported ear or hearing problems. This was 18 per cent, I understand, from the ABS statistics of 2001. I presume that there has been no new collation of data since last November.

Ms Feneley—Not that I am aware of.

Senator CROSSIN—I would not have thought so. If you could have a look at that question and provide me with those numbers, that would be useful. You also mentioned Indigenous Australians who are accessing the outreach program. Do you have a breakdown of those by urban, rural and remote locations?

Ms Evans—Senator, could you give me the question again? I thought it was being directed at the Hearing Services people.

Senator CROSSIN—I am not sure who has responsibility for collecting the data, or whether the data even exists, on adult Aboriginal and Torres Strait Islander people who are eligible under the Commonwealth Hearing Services program to access either the voucher system or an outreach program or, in some cases, both.

Ms Evans—That will be Ms Feneley's area.

Senator CROSSIN—Do you keep that data by urban, rural and remote locations?

Ms Feneley—No, we do not have that.

Senator CROSSIN—You do not keep that sort of breakdown?

Ms Feneley—Australian Hearing would have that information.

Senator CROSSIN—If they are adults?

Ms Feneley—Only if they come under their AHSPIA program.

Senator CROSSIN—That is not necessarily the voucher system, though; is that right?

Ms Feneley—That is correct.

Senator CROSSIN—It is my understanding that they are two separate programs.

Ms Feneley—They are.

Senator CROSSIN—So who keeps the figures? Who can tell me how many Indigenous people in urban centres, rural centres and remote centres access either of those programs?

Ms Feneley—Australian Hearing can provide information about those serviced under community service obligations. We will have to search our database for the other information.

Senator CROSSIN—In remote areas, which sites, and how many staff, can offer diagnosis, referral and post-referral supervision and care?

Ms Feneley—I can provide a list of sites that Australian Hearing's audiologists visit. We would need to do a cross-check to see where there are Aboriginal health workers as well. Australian Hearing usually goes only into communities where there is an Aboriginal health worker, so that there is ongoing care of the children they see. At our briefing I think I gave you a list of the services they provide.

Senator CROSSIN—That is right, but in each of those places, what guarantee do you have that there are staff who are able to diagnose, or who have the skills to refer or the skills for post-referral supervision? Do Australian Hearing Services go into places where those staff are not necessarily located?

Ms Feneley—No. Generally they would only go into communities where there are staff that can provide that follow-up service and provide appropriate referral. There is a fairly heavy reliance on the Aboriginal health workers, as well, to do some of that work.

Senator CROSSIN—What check does your office do to supervise or monitor Australian Hearing Services to see that that, in fact, is the case, so they are not going into places where there is that lack of staff, or they assume there is staff but there may not be at the end of the day?

Ms Feneley—When we have our regular quarterly meetings we talk to them about how they are making decisions about the communities they go to, and I think they have given us a very strong message. For instance, I recently visited Yalata and there is a need for an audiologist to visit Oak Valley, which is about 500 kilometres up the road—a dirt road, four-wheel drive only. There is no Aboriginal health worker at Oak Valley at this point in time, so Australian Hearing are trying to negotiate for something to happen in that area so that they can go in and ensure that there are follow-up services.

Senator CROSSIN—Would there be situations where they may need to go into communities where there are no trained staff as such, but they would go anyway? Is the demand being held up by the lack of trained Indigenous staff?

Ms Feneley—I would say, in some instances, yes, and it has been my experience that it has been. Australian Hearing are concerned about making sure that there is coordination between the various services. They often work with teachers of the deaf and certainly with schools and a range of health workers. Just using the Oak Valley example again, Australian Hearing are

really working now to try to make sure that they do have workers there that can provide the follow-up services for them.

Ms Evans—Can I just add to that. Through the Aboriginal and Torres Strait Islander health program, we contract with Australian Hearing Services to provide training via the Aboriginal community controlled health services to two health workers in each of the community controlled health services.

Senator CROSSIN—Except in the Northern Territory.

Ms Evans—Except in the Northern Territory, where there is a different arrangement—you are quite correct. I have a note here that tells me that a survey conducted in June 2002 found that the retention rate for Aboriginal health workers trained in hearing health was about 60 per cent for designating hearing health worker positions and that overall only 13 per cent of Aboriginal health workers trained in hearing health have left their respective services, but they may be using their skills in other positions. So one of the things we have attempted to do is to ensure that that training is there.

Senator CROSSIN—In the PBS, under 'Hearing Services', is there an allocation for training of Aboriginal health workers in Hearing Services?

Ms Feneley—No, there is not.

Senator CROSSIN—There is not a designated training budget item under your outcome?

Ms Feneley—No, there is not.

Senator CROSSIN—Where would I find training under outcome 7?

Ms Evans—We contract with Hearing Services to provide that training.

Senator CROSSIN—Where is that? I have not finished with outcome 6 yet, but I will just swap to this because it is related.

Ms Evans—It is under our health services allocation, but I can tell you the amount of money that we provide for training.

Senator CROSSIN—Yes.

Ms Evans—For 2002-03 it was approximately $380,000, but I could get the exact figures for you. That is excluding the NT training program, which, as you have pointed out, is a separate training program.

Senator CROSSIN—Do you have the figures for 2003-04?

Ms Evans—I do not have those figures.

Senator CROSSIN—They are not in this PBS?

Ms Evans—No, because they are under the health services money generally and part of our allocation. We are finalising those allocations at the moment, but when that figure becomes available I can let you have it.

Senator CROSSIN—So there is nowhere in outcome 7 where you can point me to an allocation for training moneys for this coming year?

Ms Evans—No, because it is under a broader budget.

Senator CROSSIN—What broader budget would that be?

Ms Evans—I might call on Ms McDonald to answer that.

Ms McDonald—The budget estimates for the administered item of Aboriginal and Torres Strait Islander health are provided at the top of page 203 of the portfolio budget statement. The amounts that Helen Evans was referring to are included in that allocation. If you are interested we can certainly give you a split-up by area. The hearing amounts that Ms Evans was referring to are a part of a budget of around $2.4 million which is provided for hearing, out of that total budget.

Senator CROSSIN—Are you telling me that out of around $2.4 million, excluding the Northern Territory, only around $380,000 to $400,000 is allocated to training for Hearing Services?

Ms Evans—Yes. I can take that on notice and provide you with a breakdown of that $2.2 million, if you like.

Senator CROSSIN—Are you anticipating an increase in the amount of money that will be allocated towards training for Hearing Services in the coming financial year?

Ms Evans—Not in an overall sense.

Senator CROSSIN—We have just heard that Australian Hearing Services cannot go into some communities because there is a lack of trained Indigenous people, but there does not seem to be a significant increase in the training moneys to alleviate that problem.

Ms Evans—As you would be aware, there has been a recent review of Hearing Services.

Senator CROSSIN—I know. I have read it many times now. We might get to chapter 7 of that review in a minute. That review still does not allocate the dollars though.

Ms Evans—No. The training issues are raised—

Senator CROSSIN—They are.

Ms Evans—but it is not my understanding at this stage that we are intending to increase that allocation.

Senator CROSSIN—I have raised with you in the past the eligibility criteria for those who can access Hearing Services' programs—in particular, Indigenous people in receipt of CDEP. Since our estimates in February, has the department done anything about reviewing that eligibility? I am looking at both of you because I am not sure who would pick up that ball and run with it.

Ms Feneley—We have discussed this internally and we are planning to meet with Centrelink to discuss issues around eligibility for CDEP clients. We are also planning to meet with CRS to discuss eligibility for Indigenous people who are wishing to return to the work force. But it is a work in progress, so I do not have anything more than that to report at this time.

Senator CROSSIN—Has there been any work done on the number of Indigenous people on CDEP who may be eligible to access this service if they came under the eligibility criteria?

Ms Feneley—Not yet.

Senator CROSSIN—You do not know what those figures are or what they possibly could be?

Ms Feneley—No.

Senator CROSSIN—Bearing in mind that 18 per cent of Indigenous Australians report hearing or ear problems, what percentage of your client base is Indigenous?

Ms Feneley—Of the CSO clients it was only 3.6 per cent.

Senator CROSSIN—In making approaches to Centrelink you have not looked at any research or figures that might prove your case that, if eligibility criteria were broadened, you might be able to pick up more Indigenous people accessing those services?

Ms Feneley—We may well be able to but, as I said, it is still work in progress and I do not have more to report beyond that.

Senator CROSSIN—Can I take you to the number of children accessing your program. This is also related to a question I asked last year, E02-031. I understand that five per cent of your programmed services delivered to children were delivered to Aboriginal children in 2000. What is the percentage of your program delivery to Indigenous people for 2001 or 2002?

Ms Feneley—I have the figures here for the CSOs, which is that figure of 3.6 per cent that I mentioned; that was the 1,471.

Senator CROSSIN—And that is not broken down into adults or children?

Ms Feneley—No, it is not.

Senator CROSSIN—I might get you to look at that question and perhaps provide me with a comparison of that data as well.

Ms Feneley—Okay.

Senator CROSSIN—So your answers to me just came in generic Commonwealth Hearing Services Program reportable figures, rather than a breakdown with the CSO, I think.

Ms Feneley—We can do that.

Senator CROSSIN—When you actually say that you are providing hearing services at a tertiary level, does this mean to people who might have to access a hearing aid?

Ms Feneley—Yes, it does.

Senator CROSSIN—Do the Commonwealth hearing services do any sort of audit on schools or classrooms that may be fitted out properly to assist with those children who have hearing problems?

Ms Feneley—When Australian Hearing visits different sites they provide a service regarding the sound field amplification systems. In fact, Australian Hearing produces a model of the amplification system. Our minister, Kevin Andrews, has written to Dr Brendan Nelson to get his assistance in raising the issue of provision and maintenance of sound field systems in schools in Indigenous communities with his ministerial advisory council. That council has a task force focusing on Indigenous issues. The intention is to raise awareness and promote

the use of sound field systems. But at this point in time schools are required to fund the sound field systems out of their individual budgets. It varies from state to state.

Senator CROSSIN—What is the cost of that, basically?

Ms Feneley—Approximately $3,000 per system.

Senator CROSSIN—Per classroom?

Ms Feneley—That is correct.

Senator Patterson—It would be nice if the states actually did something about it.

Senator CROSSIN—I have seen it in a few places in the Northern Territory. I just wondered if you kept an audit on where it was being rolled out and how effective it was.

Ms Feneley—No, we do not. We rely on Australian Hearing to provide us with that information. But with this process that has been initiated by Minister Andrews we are hoping to glean more information about where the sound field systems are located. One of the difficulties with the systems is that when teachers move on from the school there is not always a commitment to use them in the classroom. And because there might be some technical problem with the system as well, it might be some months before somebody can get out there to fix the system. So there are a range of issues around the successful use of the amplification system in schools. It is certainly something that we, along with Australian Hearing, are intending to promote. I also gather that Australian Hearing at the moment are having difficulty meeting demand for them, so clearly some schools are able to fund the provision of those systems.

Senator LEES—I have seen several new Indigenous schools where the design of the roof construction is to actually facilitate hearing and to help those kids. Is that standard now? Is that something you have been able to talk to the states about so it is mandated that, if there is a community where this is an issue and there are risks, any new construction follows that design principle?

Ms Feneley—I understand there are new building regulations that do take that into account. Australian Hearing in its work around the country has also been providing advice on acoustics to schools where, perhaps, there is a very modern looking building but in fact it has all the wrong shaped ceilings, or windows to get light in. I am not aware of the full detail but my understanding is that there are new building standards that consider acoustics in classrooms.

Senator LEES—Is that in all states and territories?

Ms Feneley—I could not be sure of that, but we can check for you.

Senator LEES—Yes, please, that would be very helpful.

Senator MOORE—Does Australian Hearing get paid for those consultancies?

Ms Feneley—I think it is probably fair to say that opportunities are often taken when they are out in various communities, and even in some of the urban areas, to provide some information that might assist a school.

Senator CROSSIN—Turning to this infamous report into the Commonwealth funded Hearing Services, which has made interesting reading on a number of nights, under key findings on ear health and hearing point 3 states:

The Aboriginal Health Worker training and audiometric equipment supply program provided by Australian Hearing Services on behalf of the Office for Aboriginal and Torres Strait Islander Health has made a particularly strong contribution to the achievement of National Hearing Strategy outcomes.

What are the indicators of this? On what is that statement based?

Ms Evans—I will have to take that one on notice.

Senator CROSSIN—I assume that there are some performance indicators, past and present, upon which statements such as that are evaluated. I do not seem to be able to find the evidence on which such statements can be based other than that it sounds like everything is working fairly effectively, but I do not have the evidence to prove that. It would be very useful if you would take that on notice and provide the details.

Ms McFarlane—There are performance indicators related to the hearing program; however, reporting is patchy. We do not have consistent information but we can certainly pull together what data we do have.

Senator CROSSIN—Leading on from that, on page 188 of the PBS, performance indicator No. 4 is headed 'The proportion of eligible Aboriginal and Torres Strait Islander clients receiving hearing assistance under the Program in relation to the total volume of program clients'. I assume that means you would be able to give me for, say, the last two years, the total number of clients and the proportion of them who are Aboriginal or Torres Strait Islander. You may want to take that on notice.

Ms Feneley—Yes, it will be from the quarterly. I will take that on notice.

Senator CROSSIN—That is right. You say that your indicators are going to be from quarterly databases from Hearing Services and Australian Hearing.

Ms Feneley—That is correct.

Senator CROSSIN—Perhaps if we have the last four quarters and then, by the time we get to November estimates, we will be able to look to see whether the indicators are being improved over the year. I assume that part of that data will give me information from Australian Hearing in relation to the number of eligible clients who participate in the voucher scheme? Do you have that?

Ms Feneley—Yes, it will.

Senator CROSSIN—Has there been a change in the number of communities in which the AHSPIA program is provided since we met just before Christmas last year?

Ms Feneley—Not significantly. We have not had a report from Australian Hearing to indicate new communities they are going to. We can certainly get that information from them.

Senator CROSSIN—Last year, I understand, the direct cost of that program was $649,000. Is that the amount that was spent as opposed to the amount that was allocated?

Ms Feneley—It was around $675,000.

Senator CROSSIN—That was allocated, was it?

Ms Feneley—No, that was not the allocated amount; that was part of the CSO funding that Australian Hearing received.

Senator CROSSIN—Can you find that for me?

Ms Feneley—Is that a more recent figure that you are looking for?

Senator CROSSIN—Yes. This figure is a November figure. I am assuming that is 2001-02.

Ms Feneley—It was the previous year, yes. We could get you a year-to-date figure from Australian Hearing.

Senator CROSSIN—That would be useful. In relation to training, you talked about around $370,000 being allocated in 2002-03. How much of that has been spent or has it all been expended?

Ms McFarlane—It is our understanding it will be fully expended this financial year. In addition to that, there is an allocation for the Northern Territory.

Senator CROSSIN—What is that allocation?

Ms McFarlane—We have allocated $60,000 for the Northern Territory training.

Senator CROSSIN—Is that for this financial year?

Ms McFarlane—It is for this current financial year.

Senator CROSSIN—And you are anticipating that will be expended as well—is that right?

Ms McFarlane—We are anticipating that the majority of that will be expended.

Senator CROSSIN—Why wouldn't all of it be expended?

Ms McFarlane—The negotiations for the provision of training in the Top End of the Northern Territory have taken longer than we had anticipated. While arrangements are in place for Central Australia, the Top End is still under negotiation.

Senator CROSSIN—So with Central Australia the Aboriginal congress will now be undertaking that training. Is that correct?

Ms McFarlane—That is correct.

Senator CROSSIN—Who are you negotiating with in the Top End?

Ms McFarlane—We are working with the Top End subcommittee of the Aboriginal Health Forum—TERIHPC. We are working through that group.

Senator CROSSIN—A subcommittee?

Ms McFarlane—It is a subcommittee to the Northern Territory Aboriginal Health Forum that is responsible for the Top End.

Senator CROSSIN—So you are negotiating with TERIHPC, who would provide that training.

Ms McFarlane—We are seeking agreement through that planning body and that particular body on an approach to training in the Top End.

Senator CROSSIN—There are not too many providers. Who at this stage is a preferred provider?

Ms McFarlane—I cannot answer that at this stage.

Senator CROSSIN—How long has it been since health workers or Indigenous people in the Top End have had access to training?

Ms McFarlane—I understand we have been working to put arrangements in place for this financial year—so it is since the beginning of the financial year.

Senator CROSSIN—So it has taken nearly a year.

Ms McFarlane—It has.

Senator CROSSIN—Has a review of the referral process to access Australian Hearing Services been done?

Ms Feneley—Yes, it has. We have looked at the referral process for the AHSPIA clients and there is no longer a requirement that they see a GP before they can be referred to audiology services. As long as they are seen under the AHSPIA program, that requirement does not exist.

Senator CROSSIN—When did that come into place?

Ms Feneley—In the last couple of months.

Senator CROSSIN—So you are not as inflexible as people say you are?

Ms Feneley—Not at all. We are actually looking at, on a broader level, the referral process for other clients as well, and where the role of the GP might best sit in the referral process.

Senator CROSSIN—Children can now be referred from primary and secondary help providers. Does that mean a referral can come through the health clinic on the community without a GP having been there?

Ms Feneley—Yes, it does. Australian Hearing have their own policy that, if a child requires a hearing aid to be fitted, they seek a GP's approval at that point.

Senator CROSSIN—Is Lajamanu in the Northern Territory still not an Australian Hearing Services site or has that been reviewed and changed?

Ms Feneley—That is currently being reviewed. I understand that Australian Hearing have visited but I am not aware of the services they are now providing, if any.

Senator CROSSIN—Can you take that on notice and get back to them, because I have not asked them to come to this estimates.

Ms Feneley—Yes.

Senator CROSSIN—In the 'Strategies for future action' review—I am looking at chapter 7 here—is there any way that you can give me an indication of where the implementation or even the consideration of some of the suggestions in the review is at? For example, for the policy directions they have suggested nine changes. What happens now that you have got this

review? Is there some sort of cross-working party looking at this to see what would be feasible to implement?

Ms Feneley—We have a draft work plan that should be finalised within the next few weeks and that will be given to the minister for her consideration, but in the meantime we have been working on a number of issues, such as the eligibility issue and some other initiatives that I mentioned earlier. But we do expect that within the next couple of weeks that work plan will be finalised.

Senator CROSSIN—Are you able to indicate to me which of the nine policy directions you have picked up, or is that part of the work plan?

Ms Feneley—The work plan is expecting to pick up all of the policy recommendations and work through them.

Senator CROSSIN—And the same with the models for service delivery? Again each of the subheadings in the chapters—

Ms Feneley—Yes, our plan is a comprehensive one. It is looking at reviewing all of the recommendations of the report and proposed directions, and implementing possible initiatives.

Senator MOORE—After the minister gives her approval or recommendation for future action, would we be able to get a copy of that?

Ms Feneley—That is for her to consider.

Ms McFarlane—I would anticipate that, yes, once it has been to the minister and the minister has approved it—

Senator MOORE—We waited with interest for the review and now it would be good if we could get the recommendations.

Senator CROSSIN—I have no more questions.

Ms Halton—Chair, before we continue, can I just indicate something to the committee. We had a series of questions earlier on today about the response of the Office of Regulation Review concerning the need for a RIS. You will recall that we said that parts of those bits of correspondence were possibly given in confidence, so we could not table them. We have gone away and looked at the correspondence. One of the bits of correspondence from the department actually attached a draft of the cabinet submission, so we have removed the draft of the cabinet submission, for obvious reasons. But in regard to the correspondence seeking the advice and then the correspondence back saying that, as we said earlier, we were excepted from the RIS requirements, I have got both those bits of correspondence that have been declassified for tabling.

CHAIR—Thank you.

Senator MOORE—Ms Feneley, at previous estimates we have talked about the state of the industry in terms of the profession. On a couple of occasions we have talked about the fact that there seems to be a bit of a crisis with regard to trained audiologists across the country. Has that situation improved?

Ms Feneley—We are working very closely with ASA and ACCORD, our two professional bodies, with regard to work force issues. The Hearing Services Advisory Committee is also looking at that issue. There is a working party that is looking at work force issues.

Senator MOORE—You referred to that working party being formed, I think, in the last round of estimates—or maybe it was the issue of looking at the industry. Is there any time frame, or is it an ongoing working party.

Ms Feneley—It is ongoing, but we would expect that we would be able to look at some of the outcomes of that working group very soon with a view to having further discussions with ASA and ACCORD about increasing work force participation in audiology.

Senator MOORE—Good.

Senator LEES—I am interested in the Indigenous health portfolio. Looking on page 198 of the portfolio budget statements, there is a discussion of the program in the Pit lands, specifically the detox and rehab centre for petrol sniffers. This one is looking forward—it is what the department is planning in 2003-04. I realise some of those programs that are already there are state related programs, but I was wondering what has been happening and whether you have a base from which you will be moving on. What is the department's estimate of where programs are already up to? What has been working and what has not been working in South Australia, in the Pit lands specifically?

Ms Evans—On page 198—can I just check—are you referring to the feasibility study? Establishing a detox—

Senator LEES—Yes. But there are already a number of groups, I understand, working up there.

Ms Evans—Yes, there are a number of services around there.

Senator LEES—I am looking at what has happened to date. Surely you are basing what you are now going to do and what you are now going to study on what has already been done. Do you have some material or some specific evidence on what is happening already?

Ms Evans—Yes. We did a review of three petrol sniffing services that we funded in the Central Australian area, not all on the AP lands, and we can let you have a copy of the summary of that review. I think it is true to say that we are still at fairly beginning stages about what is successful and not successful in petrol sniffing. There is a whole range—as I am sure you would appreciate—from supply side restriction, such as the Comgas Scheme, which we fund, which makes avgas available instead of petrol. There are prevention activities, such as youth activities—funding of youth workers—and then there is treatment of people who are already sniffers. There are programs such as the Yuendumu one, with an outstation.

Senator LEES—I have been up there and looked at that. Is that still running and still working well?

Ms Evans—The Yuendumu one?

Senator LEES—Yes.

Ms Evans—It is still working, yes, and it was one of the three services reviewed in the report that we can make available to you. I think that report revealed that there were issues

there. There were issues there in terms of staff training, occupational health and safety, monitoring et cetera, but we are working on the outcomes of that report.

Senator LEES—Have you looked specifically at issues at Docker River, where their problems have been exacerbated now that Western Australia has clamped down and people have actually moved across into the Northern Territory? That community has tried a number of strategies, including getting a camel project up and running to try and get some employment going, but it cannot find the funding it needs in order to get some of the strategies it believes will work off the ground.

Ms Evans—Yes.

Senator LEES—I want a short cut; I do not want to spend too much time. Are you looking specifically at things such as employment strategies as well as some as the outstation projects and other things that have worked?

Ms Evans—Yes, we are looking at a full range of activities in terms of recreation, employment and useful activities—the whole range.

Senator LEES—So would there be an opportunity in what you are doing in Anangu lands to look something like the camel project—which is partly done and needs a very little amount of seed funding—through health, as other sources I have tried have not worked for them. We could model that and look specifically at Docker River—at getting a model up that might actually work.

Ms Halton—Could I just make an observation? In fact there is some work going on that the Anangu themselves are undertaking in relation to, for example, camels. I know, as a matter of fact, that out at Fregon they are making money out of it. The point that you make more broadly, though, about having a variety of strategies is well made and we agree with you entirely.

Ms Evans—The whole of government approach that is being engaged under the COAG trials—and you probably know that the AP lands is a trial site and Ms Halton is the lead secretary for that—should allow us to pull—

Ms Halton—Sponsor.

Senator LEES—Docker seems to have missed out. When I visited last year—

Senator CROSSIN—Where is that COAG trial that you are sponsoring?

Senator LEES—Mutijulu seemed to be working.

Ms Halton—The South Australian part of the Pitjantjatjara lands.

Senator CROSSIN—It is not in Northern Territory.

Senator LEES—It is certainly not at Docker, because they were crying out for—

Ms Halton—No, we know that.

Senator CROSSIN—The only trial in the Northern Territory is at Wadeye.

Ms Halton—That is correct.

Senator Patterson—There is one in each state and territory.

Senator CROSSIN—This is more northern South Australia—is that right?—north-west.

Ms Halton—Yes. It is that part of the Pitjantjatjara lands which are within the South Australian state boundaries. That said, we are very conscious in this particular area that if you have increased policing in Pukutja, for example, the kids can end up at Mutijulu or places like that, so that is an issue that we are aware of. In this area, the need to work a little bit more flexibly across boundaries is something we are conscious of. Obviously, from a portfolio perspective, given our particular interest in sniffing, detox et cetera, we are very conscious of the need to be reasonably flexible in identifying projects and working with communities on things that they think will actually work.

Senator LEES—Perhaps I can talk to you later. I do not want to go into any more details, but there are a series of specific things that the community has been asking for in that area for quite some time and nothing—

Ms Halton—I am very happy to talk to you separately.

Senator LEES—Before passing to Senator Crossin, I refer to page 199 PBS, which states you will:

> ... continue to work with the Aboriginal and Torres Strait Islander Commission and stakeholder groups to develop closer links between the bringing them home counselling program and the Link Up program

I am just looking at total expenditure now—where we are at in terms of how much money has been spent to date on all that came out of the *Bringing them home* report and the Link Up program and everything like that.

Ms McFarlane—For the bringing them home program elements that we are responsible for in the health portfolio to 30 April this year, it is $43.3 million since the commencement of that program.

Senator LEES—That is all aspects of it.

Ms McFarlane—Those are the parts that we are responsible for, so that does not include the Link Up program. It is about the bringing them home counsellors.

Senator CROSSIN—So that is $43 million since 1996, is it?

Ms McFarlane—Since 1998.

Senator LEES—The bits of the program that you are not responsible for—where else do we go for the figures?

Ms McFarlane—ATSIC is responsible for the Link Up program and Family and Community Services have taken on the parenting element of that program.

Senator CROSSIN—Has there been any increase in that $43 million since 1998? Or is that the amount you have been working with since that time?

Ms Evans—The amount that was allocated from government was $38.9 million over a four-year period to June 2002 and then it was continued on an ongoing basis, so that has been confirmed.

Senator CROSSIN—What does 'continued' mean? You have been given another $39 million for another four years?

Ms Evans—No. As I understand it, it is a continuing allocation on an annual basis.

Senator CROSSIN—What is that?

Ms McFarlane—It is $9.3 million.

Ms Evans—Annually.

Senator CROSSIN—Since last year—is that right?

Ms McFarlane—That is the recurrent basis, yes.

Senator CROSSIN—In terms of the COAG trial, what is the key community that that is situated in?

Ms Halton—I think the heads of government agreed that there would be up to 10 trial sites but effectively, at the moment, we are working on one site per state or territory. Three sites have been announced to date: the Northern Territory, Queensland and South Australia. The South Australian site and the agreement of the Pitjantjatjara people to participate with the South Australian government and the federal government in that trial were announced just recently. Essentially the trial will work with all of the communities in that geographical area, so there are Commonwealth officers and state and territory officers talking to community members from Fregon to Pukutja and right through that whole region.

Senator CROSSIN—So it is not concentrated on one particular community as it is, for example, at Wadeye? It encompasses a number.

Ms Halton—No.

Senator CROSSIN—But it is none of the communities in that part of the Territory; is that correct?

Ms Halton—Essentially it is a collaboration between the community, the state government, the Territory government and obviously in some cases where relevant, a local government. The trial sites do look different across the states and territories. For example, in Queensland the total of the Cape has been identified as being the priority. You are right: Wadeye has been identified in the Northern Territory. There is a challenge for us, particularly given geographic mobility across that tri-state border area—which in our portfolio we have been very conscious of for a number years—and is something we have to think about. We are in the early stages of talking to the local community about what they want and what the issues are for them.

One of the reasons we volunteered to take on this particular region is that we have some considerable experience in working across that tri-state border area. I think we would all acknowledge the issues that are quite difficult in those particular communities. There are some advantages; there are some strengths in that region, one of which is the health service. It is early stages yet but I think the thing that I would reflect on here—and I have been to visit the community three times now—is that there is a great interest and willingness on the part of the local community to participate, to take ownership and to set some direction for the project. We are trying to work it the other way round, if I can describe it that way: rather than

government coming in and saying, 'Have we got a program for you,' we are trying to work with them.

Senator CROSSIN—So it is a bit of self-determination.

Ms Halton—A little self-direction and shared responsibility is the language being used, yes.

Senator CROSSIN—Ms Evans, I would like to go back to the evaluation report you were talking about to Senator Lees. The last time I saw that report I think you had provided a summary of it, but it was not fully available. Is it now fully available?

Ms Evans—There were negotiations, as I understand it, with the three services that were assessed, because their issues around confidentiality are very identifiable. There was an agreement that the summary report was what would be made available publicly, so there is no more detailed report available in the public domain.

Senator CROSSIN—It is only about half-a-dozen pages or so, isn't it?

Ms Evans—That is correct.

Senator CROSSIN—That has already been provided to this committee at previous estimates.

Ms Evans—Yes.

Senator CROSSIN—We do have an issue we want to raise in relation to page 203 of the PBS. Footnote No. 1 states:

Following a review of the administered items relating to Outcome 7, these administered items will not be used in 2003-04.

Can you explain that footnote to us, please?

Ms Evans—Senator, is this the first footnote on page 203?

Senator CROSSIN—Yes.

Ms Evans—I might refer to Ms McDonald to answer that one.

Ms McDonald—In previous PBSs the administrative appropriation was broken into two groupings. It was a fairly artificial divide: the first grouping was around service delivery. The second grouping, which was a very small grouping worth about $20 million or so out of the total $230 million appropriation, was about national infrastructure development—things like work force training and development of specific health strategies. It was for infrastructure that improves the quality of the health system, whereas the major item was in relation to delivery of services on the ground. Over time, as more experience was developed, there seemed to be a need to combine them into one. A lot of elements of the program crossed both areas and transitioned from one to the other. You might invest in training and development in the early stages of service delivery and then provide ongoing service delivery in the longer term. The infrastructure structure item was only a very small one.

Senator CROSSIN—So you do not actually break that $258 million or so into services and infrastructure now? It is just one big total.

Ms McDonald—No, we do not. It is one total amount. It was always utilised as one amount and then broken into smaller components. Those components were then basically grouped into those two broad groupings.

Senator CROSSIN—I want to ask you about vaccination levels and the Australian Childhood Immunisation Register. I understand that there was an evaluation of the coverage of childhood immunisation. What is the current status of that evaluation?

Ms McFarlane—The management of the register is undertaken under outcome 1, Population Health Division, and we would need to check that for you.

Senator CROSSIN—I have probably missed them. They were probably on at eight o'clock this morning or something, were they?

Ms Halton—No, they have not been on yet. It sounds counterintuitive, but we have not done outcome 1 yet.

Senator CROSSIN—So they are actually responsible for that immunisation register; is that correct?

Ms McFarlane—Yes.

Senator CROSSIN—Are you able to tell me how many Indigenous children are on that register? What is the link between their work and your department?

Ms Evans—The register is a total childhood immunisation register on which all providers of immunisation services are requested to register. They are also requested to register Indigenous identification of children—that is, of course, entirely voluntary. The data comes from that register; it is a single register for childhood immunisation.

Senator CROSSIN—Are you able to give me an indication of what the immunisation rates would be for the invasive pneumococcal disease?

Ms McFarlane—We have some data. For example, in the Northern Territory 96 per cent of eligible children had received their first dose of the pneumococcal conjugate vaccine at two months of age and 64 per cent of older children had completed the catch-up schedule for the vaccination. The program has only been under way since June 2001, when it commenced in Central Australia, so the data is really still coming in. The best data is really on a state by state basis.

Senator CROSSIN—Are you able to provide us with that or do you just have the Indigenous numbers?

Ms McFarlane—The program has a number of target groups. Those target groups are all Indigenous children under two years of age across Australia and, in high risk regions, non-Indigenous children as well.

Ms Halton—We will do the best we can to get you some more data on that. I would like to reinforce what we are hearing anecdotally. For example, I was told by a doctor from Pukutja in the Pit lands recently that over 95 per cent of the children there have been immunised. That is a consistent message we are getting across those clinics.

Senator CROSSIN—I want to turn now to Indigenous mental health. You would be aware that the Northern Territory government has established a select committee to look at the issue

of substance abuse in communities. One of the issues that that committee has highlighted is the lack of resources to adequately address the mental health needs in remote communities. What is the specific budgeted amount in this PBS for mental health for Indigenous people?

Ms McFarlane—We have a social and emotional wellbeing program in OATSIH, where we have allocated approximately $6 million for this financial year, but of course mental health services are also provided by state and territory governments and, to some extent, general practitioners.

Senator CROSSIN—So $6 million has been allocated to the social and emotional wellbeing program this financial year. Is that correct?

Ms McFarlane—Yes.

Senator CROSSIN—How is that divided between the states and territories?

Ms McFarlane—I would have to take that question on notice.

Senator CROSSIN—Is it done that way or is it done by project?

Ms Evans—It is largely done by a combination of ways; we can give you more detail on it. Some of it is through Aboriginal medical services; some of it is through regional mental health programs. It is done in a variety of ways, but the money we administer is almost totally for Indigenous specific services. We can give you more details on that.

Senator CROSSIN—Is it coordinated with substance abuse services?

Ms Evans—The comorbidity, as I am sure you are well aware, of mental health and substance use is really very strong, so progressively we are looking to bring together and fund social health units in Aboriginal medical services which cover both substance use and mental health issues. As you may also be aware, a process is under way under the auspices of the National Aboriginal and Torres Strait Islander Health Council—the ministers' advisory council—to develop a current social and emotional wellbeing plan, or an updated social and emotional wellbeing plan, which we are linking very closely with the development of the third mental health strategy, because there needs to be a close link between Indigenous specific mental health services and mainstream mental health services. Part of the emphasis, as I understand it, of the mental health strategy is to recognise those comorbidities.

Ms Halton—Can I add to that. You may also be aware of the announcement, as part of the budget, that one of the priorities in relation to the drug strategy is comorbidities—

Senator CROSSIN—Are you referring to the national comorbidity initiative?

Ms Halton—Yes, that is correct. In fact, we are in the process of arranging a joint meeting at some point next year between the Aboriginal and Torres Strait Islander Health Council, which I chair, and the Australian National Council on Drugs, so we can discuss the issues that we have in common. The ANCD have a particular interest in comorbidity, so there is a very strong intersection.

Senator CROSSIN—Is that next month, not next year?

Ms Halton—It will end up being next year.

Senator CROSSIN—That is seven months away.

Ms Halton—Probably only another couple of meetings of each of those bodies have already been scheduled, but we have already had at the health council one of the members of the ANCD come to talk about Indigenous issues in respect of substance abuse and some of those comorbidity issues, so a dialogue has already started. The point about having a joint meeting—so, basically, both councils will meet together—is precisely to look at ways to expand on those issues.

Senator CROSSIN—Of the $4.4 million allocated in this budget to look at the national comorbidity initiative, what percentage of that will actually be used for Indigenous communities or Indigenous issues?

Ms Halton—I do not think that has been determined yet. The budget announcement has only just been made and, certainly, the parliamentary secretary will be taking advice on those issues.

Senator CROSSIN—How will it be determined?

Ms Halton—Again, I do not think that has been determined yet. The point I am making to you is that the ANCD have an acute awareness of the issues facing Indigenous people, and it is our expectation that that will be explicitly considered and addressed as part of that strategy.

Senator CROSSIN—Can you take on notice to provide this committee with that advice when a decision has been made? I am sure it will occur before our estimates again in November.

Ms Halton—Certainly.

Senator CROSSIN—Has OATSIH done any analysis on the effect of the government's Medicare and PBS proposals contained in the budget, including access to health care, on Indigenous people?

Ms Evans—Are you referring to A Fairer Medicare?

Senator CROSSIN—Yes.

Senator Patterson—That does not have any PBS implications.

Senator CROSSIN—Setting aside the PBS proposals, has there been any assessment of that package, on access to health care by Indigenous people?

Senator Patterson—They are not PBS proposals.

Ms Evans—We have not done any detailed analysis of that—we would be advised by our colleagues who are managing that package. But undoubtedly we would be hopeful that there would be significant benefit to Aboriginal and Torres Strait Islander people with the changes in the bulk-billing arrangements and also through the incentive payments, particularly to remote service providers, and through some of the work force incentives. Beyond that, I think it is too early to say.

Senator CROSSIN—Has your department done any specific analysis or research on which you can base that conclusion?

Ms Evans—No, not any specific analysis.

Senator CROSSIN—Have you looked at the impact that the PBS proposal to increase the copayment to 30 per cent might have on Indigenous people?

Ms Halton—Which PBS proposal?

Senator CROSSIN—Has there been an analysis of the impact on Indigenous people of the increase of the copayment up to 30 per cent?

Ms Halton—Are you referring to the government's proposal in the last budget to increase the concessional fee by $1?

Senator CROSSIN—I am trying to ascertain whether or not your department has done any analysis of the impact of the initiatives—including that one, although I guess it is in the past—that have been announced under A Fairer Medicare.

Senator Patterson—As I said, there is nothing but the PBS in that package.

Senator CROSSIN—So there has been no specific analysis about the impact on Indigenous people in relation to any of the Medicare package?

Senator Patterson—If you look at the package, most of those health services are in rural and remote committees and in many cases they are bulk-billed. There are some cases where people do not have Medicare cards—we are trying to extend that. In the cases were they are bulk-billed they will stand to get significantly more than they do now, so they will benefit. There will be a net benefit in every instance where they bulk-bill, which is probably most of their clients, except the ones who have the problem of not having a Medicare card.

Senator CROSSIN—There are currently only two doctors in the Northern Territory who bulk-bill, and they are not taking on any more patients.

Senator Patterson—Aboriginal medical services, which will get this benefit as well, will benefit significantly.

Senator CROSSIN—For Indigenous people who do not necessarily access Aboriginal medical services, has the department done—

Senator Patterson—The Medicare package is designed to do exactly what you are concerned about. What I was concerned about, and you were not here earlier, is that just increasing the rebate will not achieve the outcome of increasing the likelihood that people on a health care card—and many of the people you are talking about have a health care card or concession card—will be bulk-billed. Getting the bulk-billing rate up to 75 per cent or 80 per cent, or whatever you want to do through your package, will still not guarantee that. Behind the bulk-billing rate of 75 per cent, which is the average that you are looking at—that is, 70 per cent in country areas, 75 per cent in outer metropolitan areas and 80 per cent in the city—you can still hide the fact that there are people on a pension who cannot get bulk-billed. I can go down to Camberwell and get bulk-billed, and I do not think that is fair. What we have tried to do, as best we can—we cannot make doctors charge a certain amount—will increase the likelihood that the people you are concerned about will have an increased likelihood of being bulk-billed.

Senator CROSSIN—So when you make that statement, is the department including Indigenous people who may have a health care card? You have done no particular research or analysis on the impact of A Fairer Medicare on Indigenous people, positive or negative.

Senator Patterson—Well, it should be more positive.

Senator CROSSIN—There is no particular piece of work OATSIH has done in relation to that package; is that right?

Senator Patterson—If your party agrees to it and it goes through, it will increase the likelihood that those people will be bulk-billed and it will increase the income for Aboriginal health services. That is the bottom line.

Senator CROSSIN—I will go back to my question. There is no particular work, research or analysis that OATSIH has done in relation to A Fairer Medicare package relating specifically to Indigenous people; is that correct?

Senator Patterson—They do not need to do that. It will improve the likelihood that the people that you are concerned about will be bulk-billed and it will improve the income of our Aboriginal health services, particularly in remote communities.

Senator CROSSIN—So the answer is no; is that right?

Senator Patterson—Because the package is designed to improve—

Senator McLUCAS—How can you say that? It is clear you have no evidence.

Senator CROSSIN—I am asking if OATSIH have done a particular body of research or analysis to prove either positively or negatively the impact of A Fairer Medicare package. Has that work been done? It is a yes or no answer, I would have thought.

Ms Evans—At this stage, no. I would have thought it was a bit premature to do that.

Senator Patterson—It is fairly obvious. There are other things they need to do rather than research the obvious.

Senator CROSSIN—In relation to the PBS, there is a Pharmacy Guild project in relation to assessing how the section 100 arrangements are working in remote communities. Are you aware of that work that is being undertaken by the Pharmacy Guild and NACCHO? I am wondering if that project, which was due to report by the end of 2002, has actually done that and whether that report is available.

Ms Evans—I am aware that there is a review being undertaken of section 100. I do not want to sound like a typical bureaucrat, but that is being carried out in another part of the department under the PBS branch. I am not sure that there is anybody here from that branch. But there is a formal review about to be under way on the section 100 arrangements and how effective they have been. We can get more details of the timing of that for you.

Senator CROSSIN—So you have not yet considered whether to extend the section 100 arrangements to other less remote areas? Or is that part of the second phase of this review?

Ms Halton—PBS and the extension of section 100 are actually issues for outcome 2. Ms Evans, the minister and I can all attest to having seen very fully stocked pharmacies in communities that, until section 100 arrangements came into place, used to have to send out to

a pharmacy some hundreds of kilometres away. In terms of improving access, I think there would be no doubt of that. When we come back to outcome 2, there should be somebody who can answer that question.

Senator CROSSIN—Under the improved monitoring of entitlements issue, an initiative introduced last year requires the provision of a Medicare card or number in order to obtain medicine subsidised through the PBS. Between 15 and 38 per cent of Indigenous people have no Medicare card or number. Has OATSIH done an analysis of the impact of this initiative on the access to PBS medicines by Indigenous Australians?

Ms Evans—To clarify, as Ms Halton said, pharmaceutical benefits are covered under outcome 2. One of the things that we have a very strong emphasis on across the department is that program areas take primary responsibility for their program areas. OATSIH manages Indigenous specific areas and development of an overall national strategy. We provide advice and support to mainstream programs. But the specifics of those mainstream programs are the core responsibility of those program areas. So the PBS access issues and the changes in the requirement to provide a Medicare card are things that that program would be in a better position to answer.

Senator CROSSIN—They are not things that you are working on jointly or cooperatively, given the impact it has on Indigenous people as they do not have Medicare cards.

Ms Halton—I think we should be clear: the department has a very clear policy that ensuring that Indigenous peoples get good health services is the job of the entire department. The fact that Ms Evans runs a particular component of that response does not mean that she has responsibility—and, to wit, others do not—for ensuring that all of the programs in the department respond appropriately to the needs of Aboriginal and Torres Strait Islander people. At the end of the day, we have gone to some considerable lengths to make sure that Aboriginal and Torres Strait Islander business is everyone's responsibility in the department. So it is not Ms Evans's business to be continually double-checking. The executive take responsibility for ensuring that the whole department takes those responsibilities seriously. The deputy secretary, Philip Davies, chairs the overarching committee in the department to ensure that that happens.

Senator CROSSIN—So you are saying that people who have responsibility for this outcome, outcome 2, would not be referring to OATSIH for advice or collaborative arrangements under this initiative?

Ms Evans—I do not think that is what Ms Halton was saying. In fact, that is a role that OATSIH plays. Across the department we absolutely provide advice. We work very collaboratively across the department. But the primary responsibility for those programs rest of those program managers, and they are in a better position to answer about the specifics. We do indeed provide advice right across the department.

Ms Halton—But we hold them accountable for whether or not their programs achieve good outcomes for Aboriginal and Torres Strait Islander people.

Senator CROSSIN—I will put those questions on notice for people associated with outcome 2. In the PBS and the budget, under the heading 'National Indigenous Chronic Disease Self Management Service Delivery Project'—

Ms McFarlane—Can you please clarify which page that is on in the PBS?

Senator CROSSIN—That is good question. I will have to find that. It also has the National Child Nutrition Program and the health program grants, GP services for remote and rural NT. Give me a minute and I will find it for you, unless you can find it before I can.

Ms McFarlane—Is it on the top of page 199?

Ms Halton—On the bottom of page 198, the top of page 199?

Senator CROSSIN—I was specifically looking for a table, actually. I do not think they are the pages. Let me just say that the National Child Nutrition Program had an estimated actual of around $1.6 million. The 2003-04 budget estimate was $725,000. Could you explain to me the funding decrease?

Ms McFarlane—The National Child Nutrition Program is run out of outcome 1, the Population Health Division.

Ms Halton—The officers for that program will be here after program 2.

Senator CROSSIN—Funding for the National Indigenous Chronic Disease Self Management Service Delivery Project has decreased from $409,000 to $282,000. Do you not manage that fund either?

Ms McFarlane—Is that the Sharing Health Care Initiative? I am not sure what you are referring to. We are undertaking some initiatives within OATSIH specifically around chronic disease and have undertaken a number of activities in the past, specifically looking at diabetes, but I am not clear what specifically you are referring to in terms of the dollar figures. The Sharing Health Care Initiative, again, is managed out of another outcome.

Senator CROSSIN—I will come back to you if I can. It might well be that it is under other outcomes. It is the same with the health program grants, GP services for rural and remote NT. In 2002-03 the estimated actual was $433,000, but there is nothing allocated against it for this budget estimate.

Ms Feneley—I think the point is that—

Senator CROSSIN—It is not under OATSIH?

Ms Feneley—No, it is not them. If you can give us the page number, we can tell you which program it is under, but it is not OATSIH.

Ms Evans—We can take that on notice and get you a comprehensive response. There are a range of initiatives, some of which are OATSIH specific and some of which are run out of outcome 1.

Senator CROSSIN—I have got a copy of page 6, but it is not from this year's PBS. It must be from one of the major portfolio agency budget books, but I cannot tell you whether it is book 1, 2, 3 or 4 because I do not have them with me. I just have page 6 photocopied.

Ms Evans—Perhaps if you could give us the question in writing, we will track it down.

Senator CROSSIN—It may well be from the 'Issues for Indigenous Australians' booklet.

Ms Halton—That would be the one produced by Minister Ruddock. It is not ours.

Senator CROSSIN—No, but it is still under the Health and Ageing portfolio.

Ms Halton—Yes, but the document you referred to is not one produced by our portfolio.

Senator CROSSIN—We will come back to it if we need to. I want to finish by looking at the Eye Health Program. What was the actual figure spent in 2001-02?

Ms Evans—On eye health?

Senator CROSSIN—Yes.

Ms Evans—It was $3.48 million.

Senator CROSSIN—I understand that, in a response to a question from Senator Crowley last year, Ms Norington suggested that the actual expenditure in 2000-01 was around $2.685 million. Can you describe why there is a difference in the figures?

Ms Evans—I would have to go back and check the response. There may be a difference between estimated and actuals, but that would just be speculation. I have in front of me the actuals, up to 2002-03, which are obviously only estimated figures. The actual figure that I have in front of me for 2001-02 is $3.48 million.

Senator CROSSIN—The actual planned expenditure for 2000-01, I understand, was around $3.9 million. Is that correct?

Ms Evans—For 2002-03?

Senator CROSSIN—No, for 2000-01.

Ms Evans—For 2000-01, the actual was $2.54 million.

Senator CROSSIN—But what was the budgeted amount for that year as opposed to what was actually spent?

Ms Evans—I would have to take that one on notice.

Senator CROSSIN—If you could do that, that would be good. What was the budgeted amount for 2001-02?

Ms McFarlane—The estimated amount was 3.9.

Senator CROSSIN—What is the explanation for the underspend from an estimated amount of 3.9 to an actual spend of 3.4?

Ms McFarlane—Clearly the 3.9 figure was given only as an estimate. During that particular financial year we had planned to complete the review of the implementation of the program and conduct an eye health coordinators workshop. They were two major activities which were delayed because of the necessity to go to tender twice to engage a suitable consultant to undertake the eye health review. There were some other planned activities that did not end up going ahead but have carried over into this financial year.

Senator CROSSIN—Have you been able to identify a consultant to conduct that review now?

Ms McFarlane—Yes. The review is currently under way.

Senator CROSSIN—Who is that consultant?

Ms McFarlane—The Centre for Remote Health in Alice Springs.

Senator CROSSIN—It is due to be completed by the end of June. Is that correct?

Ms McFarlane—Towards the middle of the year. We are not yet in receipt of a draft review report and that needs to go to a review reference group, which will be meeting towards the end of June. Dependent on the comments and feedback provided by the reference group, we would be anticipating getting the final report in early July.

Senator CROSSIN—The difference in the $600,000 has been moved into the 2002-03 budget. Is that correct?

Ms McFarlane—I do not make the difference quite $600,000. Certainly the activities that did not go ahead last financial year have been moved into this financial year.

Senator CROSSIN—What is the amount that has been allocated in the budget for eye health in this PBS then?

Ms McFarlane—For this financial year?

Senator CROSSIN—Yes.

Ms McFarlane—It is 3.27.

Senator CROSSIN—Are you able to give to me the amount that has been moved from the 2001-02 amount?

Ms McFarlane—I would need to take that question on notice.

Senator CROSSIN—For 2001-02 the allocated amount was 3.9. For 2002-03 what was the amount?

Ms McFarlane—It was 3.3.

Senator CROSSIN—And now it is 3.27. Is that correct?

Ms McFarlane—Rounded up to 3.3.

Ms Evans—The actual estimate is 3.27.

Senator CROSSIN—So we have actually had a decrease in the amount of money that has been allocated in the budget towards eye health. Is that what is happening?

Ms McFarlane—The difference reflects differences in activity at a national level. We have recurrent funding that goes to services for Aboriginal eye health coordinators that are funded through this program, and they are ongoing recurrent dollars. The fluctuations up and down are related to activities that we undertake at a national level in the program and estimates of maybe additional equipment needs or training needs. They change on a year-by-year basis.

Senator CROSSIN—Give me some more detail about that. How or what has changed from 2001-02 to now in relation to some of those areas?

Ms McFarlane—There are differences in training activities around the country. We were planning for the program to be rolled out in Tasmania and in fact what has been opted for is a staged approach in Tasmania rather than a complete roll-out of the program. They are currently undertaking a needs analysis for the program in Tasmania. They are a couple of examples.

Senator CROSSIN—You are going to take on notice the amount of unexpended funds that were carried forward into each year?

Ms Evans—What we can undertake to do is to look at what was estimated and then at actuals up until this year and provide you with some explanation about the differences.

Senator CROSSIN—That would be good—thank you. Are the 29 eye health coordinators still in the same geographic locations as they were last November?

Ms McFarlane—That is correct. Obviously, there is some fluctuation and turnover of the staff, but—

Senator CROSSIN—The positions still stay in the same places?

Ms McFarlane—That is right.

Senator CROSSIN—Have you been working with Vision 2020 in the World Health Organisation on the presentation of a resolution on the elimination of avoidable blindness to the World Health Assembly in May? Has that happened?

Ms McFarlane—The department has been in discussions with Vision 2020.

Senator CROSSIN—Has that presentation happened?

Mr Davies—Yes. I have just returned from the World Health Assembly in Geneva and we garnered support from more than 40 national delegations to support that resolution. It was submitted and passed.

Senator CROSSIN—Can we have a copy of that resolution?

Mr Davies—We can get that for you probably tomorrow morning.

Senator CROSSIN—So does that actually commit to, or urge member states to commit to, the global initiative for the elimination of avoidable blindness? Is that correct?

Mr Davies—I cannot recall off the top of my head whether it commits member states. It probably is framed in terms of urging member states and requiring the Director-General of the WHO to undertake certain activities. That depends on the precise form of wording. But, certainly, the spirit of it is very supportive of that program.

Senator CROSSIN—And you will be able to provide that to us?

Mr Davies—We can get that, yes.

Senator CROSSIN—Do we still know how many Indigenous people and particularly children under the age of five have trachoma in this country?

Dr Fagan—No, we haven't—we discussed this last time—

Senator CROSSIN—Yes, I know. The reason I ask is that I think I have probably been to about 26 Indigenous communities since then. I ask each health centre in each of those communities if they would be able to tell me how many children under the age of five in that community have trachoma. They keep very extensive records about those numbers and those children. So I am still trying to understand why there is a gap between what I see as extensive record-keeping out in communities and your inability to collate that nationally and tell me, in the year 2003, exactly how many Indigenous children under the age of five in this country

have trachoma. We have just come back from the World Health Organisation and passed a resolution that urges us to do something about it.

Dr Fagan—As you know, it is a very geographically defined condition. Some parts of Australia have far greater prevalence than others. It is really important to have that information at the local health centre level and at the local regional level. One would have to query how much value any data that we provided would have, especially because that information would change rapidly from one week to another as children get treated. They have to become reinfected to be recounted, if you like. So you would have to wonder about the investment in gathering that information on numbers at a national level because it would have only very limited value in terms of its accuracy over time, in contrast to it being kept a local level.

Senator CROSSIN—Do you have figures by state and territory? Do you have figures by region?

Dr Fagan—No, we do not have jurisdiction level information. As we have discussed before, this is a condition that needs to be dealt with in collaboration between the regional public health units, which are a state and territory concern, in collaboration with primary health care centres. We need to keep our eye on the information that becomes available, but it is a fluctuating situation which needs to be dealt with locally and at the local regional level.

Senator CROSSIN—Is the Commonwealth doing anything to encourage it? How are we ever going to know if the incidence of glaucoma is increasing? How will we know when that magical day will come around when we will be able to say that we do not have it in Australia any more, we have wiped it out?

Dr Fagan—There are some things that we can say. It appears that while the prevalence of infectious trachoma varies, fluctuates and is endemic in certain areas, the severity of the condition is reported to be decreasing. Some authorities will argue that you see less blinding trachoma, less trichiasis, which is one of the end results of glaucoma.

Ms McFarlane—I will add that this is one of the areas that we have asked the review to comment on and provide us with some specific information around trachoma.

Dr Fagan—And indeed to help us define a more consistent approach to our monitoring.

Senator CROSSIN—We will see what the review brings up and we will come back to it in November no doubt. I understand a 1997 report conducted by Professor Hugh Taylor actually recommended the establishment of a national information network to provide information and support to indigenous groups working on eye health. Has that recommendation been picked up or implemented?

Ms McFarlane—The recommendation has not been implemented per se exactly as it was conceived by Professor Taylor, but there have been a number of developments in that area.

Senator CROSSIN—Are you talking about the Indigenous health intranet, for example? Is that one of those?

Ms McFarlane—Indeed.

Senator CROSSIN—Have there been any further initiatives other than the three or four you provided me with last November?

Ms McFarlane—The area of performance measurement and data is an area that we are continually look at developing. This is something that the review is going to provide us some commentary on.

Senator CROSSIN—What amount of money in the previous budget has been put aside to support some of these initiatives? Does the intranet have a particular budgeted amount?

Ms McFarlane—It does. I would have to take that on notice.

Ms Evans—We did provide a grant to Edith Cowan University to assist them in the running of the intranet, not specifically for this aspect, but we provide a grant. Ms Cass may have a figure, but we may have to take it on notice.

Senator CROSSIN—You provided me with a number of initiatives. What amount of money do you provide either totally for or towards those initiatives?

Ms McFarlane—Against each of those?

Senator CROSSIN—Yes.

Ms Evans—Is that in response to the written answers we gave you after the last Senate estimates around eye health? You would like some figures?

Senator CROSSIN—Yes, in this budget—for the 2003-04 year.

Ms Evans—I just wanted to clarify what it was that we were committing ourselves to do.

Senator CROSSIN—I will now go to the Workforce Information Program. Are there funds in this PBS allocated against that program for 2003-04?

Ms Cass—There are funds allocated for work force programs.

Senator CROSSIN—What is the amount?

Ms Cass—In the current financial year, 2002-03, it is $9.2 million.

Senator CROSSIN—Is it right that the core funding for the Workforce Information Program ends in June 2004?

Ms Evans—Are you referring to the WIPOs specifically?

Senator CROSSIN—Yes.

Ms Evans—That is only one aspect of the program. Ms Cass can answer in terms of the WIPOs.

Ms Cass—Funding has been set aside and offered to the state affiliates of NACCHO for continued funding for WIPOs—work force information policy officers—until June 2004.

Senator CROSSIN—I was under the impression that there was already funding there until June 2004.

Ms Cass—There is. The offer stands.

Ms Evans—I think that is what we are saying. It has been committed. We have offered them the money till June 2004.

Senator CROSSIN—So there are no forward estimates of funding beyond June 2004 for those officers?

Ms Evans—There is no commitment with the affiliates at this particular point in time, no. That is something that we are reviewing.

Senator CROSSIN—So what is the amount in the PBS that has been allocated against those officers?

Ms Cass—A total of $694,000 per annum.

Senator CROSSIN—And what is the total amount of money under the Workforce Information Program?

Ms Cass—It is $9.2 million per annum in this financial year.

Senator CROSSIN—Does it go beyond 2004-05?

Ms Cass—It does. It is recurrent funding.

Ms Evans—Can I just clarify that? Putting it a bit simplistically, we have a big bucket of money. From that, we allocate across various areas and, at this stage, we are internally reviewing this year's allocation and looking at next year's allocation.

Senator CROSSIN—But next year's allocation is $9.2 million. Is that correct?

Ms Evans—We are still working on that at the moment. There is every reason to believe that there will be at least that much money allocated, but I would not want you to think that that is the absolute figure because, internally, we are still going through a negotiating process across the various components of that program.

Senator CROSSIN—I see. Is there an estimated amount beyond 2004-05?

Ms Cass—For the WIP program?

Ms Evans—For the WIPOs in particular?

Senator CROSSIN—No, just for the work force funding.

Ms Evans—The work force funding is ongoing in our budget at the moment.

Senator CROSSIN—It is ongoing. So what is the proposed allocated amount for 2004-05? Or don't you know that either?

Ms Evans—We are still deciding on 2003-04. I think we can work on the assumption that we would not be reducing the amount, as work force is a very high priority. There may be some growth, but I could not give you a figure at this stage for 2004-05.

Senator CROSSIN—I just cannot find a line item for it in here. Can you direct me to it?

Ms Evans—No, there is no specific line item. It is part of the large appropriation.

Senator CROSSIN—It is part of this huge $258 million total?

Ms Evans—Yes.

Senator CROSSIN—Perhaps when you have worked out how that is going to be broken down you might get the information to us.

Ms Evans—We can do that, absolutely.

Senator CROSSIN—There was an issue about the WIP funding being provided on a six-monthly basis for the purposes of community controlled health organisations. Will they still be getting their funding on a six-monthly basis, or will it be a much longer term than that?

Ms Evans—It has been committed through till June 2004. The six-monthly arrangement was very temporary. We had arrangements for them to provide an evaluation and data as to how they were performing, and there was some delay in getting that in. There were also negotiations around the role they would play within the overall work force strategic framework. Having resolved those issues, we gave them a commitment in the second half of last year—

Ms Halton—That is right.

Ms Evans—that the funding would go through to the end of June 2004. So they have had that certainty.

Senator CROSSIN—So it is not every six months, but on a much longer term basis?

Ms Evans—Yes.

Senator CROSSIN—Last year you provided me with the figures of Aboriginal health workers employed on CDEP. You only had 2001 census figures. Is there any way you can get more recent figures than that? Can ATSIC actually provide you with the number of health workers employed on CDEP for 2002?

Ms Cass—We will take that on notice.

Senator CROSSIN—Does the department do anything about providing health workers who are on CDEP but have completed vocational education, like VET certificates or even diplomas, with additional money so that they can actually get a salary for the qualifications they have?

Ms Evans—That is a decision of the service. We provide services with global budgets and then it is their decision as to what salary they pay their workers.

Senator CROSSIN—You do not provide that salary so that they can do that?

Ms Evans—We provide them with a global budget and then they decide within that the composition of the work force and the salaries they will be providing.

Senator CROSSIN—You do not make any stipulation about where you provide top-up funds for, say, CDEP? Although, come to think of it, you would not be providing money for CDEP because that comes out of the FACS—

Ms Evans—No, we do not; that is from ATSIC.

Senator CROSSIN—But do you not make any stipulation about those health workers who have TAFE qualifications or diplomas being employed on particular wages?

Ms Evans—No, we do not go into the internal workings of organisations to that degree.

Senator CROSSIN—So particular Aboriginal health organisations could be employing trained health workers who have a diploma on CDEP, and OATSIH make no comment about that, have no policy about that and have no influence over that?

Ms Evans—I am sure you would appreciate that the internal HR policies of organisations are really their responsibility and they do not take kindly to interference. It is appropriate that they have their own employment policies.

Senator CROSSIN—Even though they might be totally funded by Commonwealth funds?

Ms Evans—Yes.

Senator CROSSIN—Once you hand over the money it is all care and no responsibility, is that it?

Ms Evans—I would not say that at all. I would say that the staff they employ and the salaries they pay them are internal decisions for that organisation.

Senator CROSSIN—Is it something that is reviewed when an organisation seeks further funds? Is it something your department would look at when an organisation seeks further funds?

Ms Evans—We would look at the outcomes that the service provides but we would not look at the specific employment policies—

Senator CROSSIN—You do not look at whether they underpay their Indigenous staff?

Ms Evans—No.

Senator CROSSIN—My time is running out very fast, and I want to spend a few minutes on PHCAP.

Ms Halton—We have had the officers from outcome 2 here since nine o'clock, as we agreed, and the officers from outcome 1 are streaming in now. While there is a natural pause, I would like to ask whether we are likely to need the officers from outcome 1. If we think we might then they can stay, but it would seem a little silly to have them sit here for 1¼ hours if they are not needed. If you want them here they will stay.

Senator McLUCAS—I cannot answer the question totally, but I probably have half an hour more work left on outcome 2 after Senator Crossin has finished.

Senator CROSSIN—I think I will be about 10 minutes.

Senator McLUCAS—That would take us to 25 past 10. I feel very sorry for the people from outcome 1 who may have waited for 25 minutes at the very end of the session, but—

Ms Halton—If you think you will need them we will keep them. I just thought it was worth asking the question.

Senator McLUCAS—The other option is that we shut down at that time and then start off in the morning, but I am very concerned that we have a lot to do tomorrow.

CHAIR—I would prefer to carry on.

Ms Halton—That is fine, I just thought it was worth asking.

Senator McLUCAS—Sorry, I cannot manage the time.

Ms Halton—That is okay.

Senator CROSSIN—Going to the Primary Health Care Access Program, at the last estimates you provided me with the year to date 2002-03 expenditures on PHCAP by specific

site. It was in response to question on notice E03-114. Can you update that table for me, please?

Ms Evans—I do not have an update with me, but we could provide that.

Senator CROSSIN—In relation to a particular community controlled health organisation in the Northern Territory—Miwatj Health Aboriginal Corporation—when was the last time OATSIH or the department received any audited accounts from this organisation?

Ms Evans—I will ask Ms McDonald. She manages this. I am not sure whether they are on quarterly or six-monthly reporting.

Ms McDonald—I would have to get the information from our Northern Territory office.

Ms Evans—They will be either on six-monthly or quarterly reporting. That is a standard.

Senator CROSSIN—They might be on either of those. What I want to know from you is exactly when was the last time they reported to you and when was the last time financial audited reports were presented to you. I would like to know what consultants were employed by Miwatj in the last 18 months, who they were and the amounts that were paid to each of those consultants in the last 18 months. I would also like to know if each of those consultants has to acquit those funds and, if they do have to, who has and who has not. I would also like to know how OATSIH assesses the performance of that Aboriginal health organisation.

Ms Evans—We will take those questions on notice.

Senator CROSSIN—Has OATSIH played a role in trying to resolve some of the difficulties at Miwatj in the last three to four months?

Ms Evans—We have. We have played a very active role. In fact, I would say we have played an almost day-to-day role during some periods. I imagine you are well aware that the issue in relation to staff went before the Industrial Relations Commission on 19 March. At that point we organised for an independent review to attend Miwatj, and we received a report on 10 April.

Senator CROSSIN—Who conducted that review?

Ms Evans—Mr Stephen Heydt conducted that review. On 11 April we put all their funds on hold until there could be a better resolution of the staff situation. We made it very clear that we did not find the situation satisfactory and that we would be working with them and the Industrial Relations Commission et cetera to try and resolve it.

Senator CROSSIN—Have funds been released to that organisation since April?

Ms Evans—I asked most recently this afternoon. My understanding is that there was an Industrial Relations Commission hearing on Friday, that all parties felt that progress had been made and that all parties are working towards early return of staff. I was advised about five o'clock this afternoon. My understanding is that they are hopeful that all staff will be back by Wednesday and, yes, now some partial funds have been released.

Senator CROSSIN—There is an issue with the funding that OATSIH provides to Aboriginal community controlled health organisations that will become, I think, an issue in the roll-out of the PHCAP funding. It is the issue of whether you stipulate anywhere that boards must contain people who have expertise in either medical provision services or

accounting. Is that a requirement of part of the make-up of those community controlled boards?

Ms Evans—There are not specific requirements and many of the organisations, as you may be aware, are incorporated under the Aboriginal corporations act, which outlines membership of the board and requirements for that. Obviously the incorporation act or provisions are what guide the members of the board.

Senator CROSSIN—But there would be some organisations that are not incorporated.

Ms Evans—They are all incorporated. We do not fund unincorporated organisations.

Senator CROSSIN—Has OATSIH looked at making a condition of funding that is given to these organisations, requiring certain people with certain expertise to be on the board?

Ms Evans—No, we have not. We expect them absolutely to abide by the incorporations regulations and act that they are incorporated under but beyond that we do not make specific requirements as to who should be on the board.

Senator CROSSIN—Not necessarily who should be, in terms of particular people or names, but is there any consideration being given to suggesting that boards would require, for example, people with financial expertise or people with medical expertise as being at least, say, two out of the number of people who make up the board?

Ms Evans—We have not given that consideration as something we would have as a requirement. You would expect that a board would want to have the mix of skills that enable it to sufficiently overview the service it is running.

Ms Murnane—Our staff in the Northern Territory office have undertaken a structured program on budget management for boards and for Indigenous salaried staff. There is a lot to be done, undoubtedly, but we are aware that there is an issue there. I might say the issue about boards is not specific to Indigenous services. We are going through a change—a growing sophistication—in the way services are run, in the accountability required, and right through the service structure there is a need to assist boards to upgrade their capability. Undoubtedly we could always do more, but we are trying to do some things with that—short of regulating, or making mandatory requirements or qualifications for being on boards.

Ms Evans—Could I just add that we do indeed. We have a specific fund of money for management support and we are working closely with the Office of the Registrar of Aboriginal Corporations, which is putting a strong focus on training and skills of board members. As Ms Murnane said, we are putting a strong focus—and realise that many boards do need assistance and support. However, we would not want to duplicate the requirements under the Aboriginal corporations act; that is for them to cover.

Senator CROSSIN—On page 196 of your PBS, where you talk about a major focus for 2003-04 being the implementation of PHCAP, what is the amount of money for 2002-03 and 2003-04 that has been allocated against PHCAP?

Ms McDonald—Sorry, could you repeat those years?

Senator CROSSIN—The current financial year we are in now and the coming year that the PBS covers.

Ms McDonald—This financial year is $33.5 million and next financial year is $54.7 million.

Senator CROSSIN—What amount out of those two allocations is specifically targeted at training—and training board members in particular?

Ms McDonald—I only have the combined figures for national infrastructure. I would need to get those figures separately for you. We could certainly give you some figures for this year. As to next year, some of the requirements may not yet be identified because planning is still under way and in particular communities the requirements for training would depend on what is required in a particular site.

Senator CROSSIN—Could you provide to me figures showing how much of the $33.5 million for this financial year has been dedicated to training, and how much you intend to provide out of the $54.7 million towards training? I have to say it is becoming fairly evident to me that one of the major planks of PHCAP is that you move the control of the funding for health services from a central agency to a self-determined community controlled board. I will be interested to see how much of that is actually aimed at training these people, who have probably never administered health in their lives, to now administer a substantial amount of it.

Ms McDonald—In relation to the services, in some instances there will be new boards made up of people who have not administered or managed services before. There are likely to be very long development periods in those particular areas such as the central Australian area in the Northern Territory. There are other areas where PHCAP is established where there have already been significant investments put into establishments of boards. In some areas you are likely to have community advisory committees which will provide advice and input to an external service provider who may provide on behalf of the community. So you will have a range of different models. At the moment under the program there are services in different stages of development along that continuum.

Senator CROSSIN—I am still interested in a breakdown of the amount of money that was provided for training in this financial year and next financial year, and perhaps, if you can, where that training dollar is being targeted in each state and territory.

Ms Evans—I think that we are well aware of the very variable capacity across community controlled services. It is a very clear commitment on our part, and on the part of state governments, that we will not be handing funds over to organisations or services who do not have the capacity to cope. I do not think anybody is doing Aboriginal people a service if in fact you are setting up services that do not have the capacity to deliver. Often the lead times are very significant. In the Katherine West coordinated care trial there was a two-year lead time. It was five years in the making until it became sustainable. Where communities do not have the capacity or do not want to provide these services, there is not going to be any intention to force them across into community control. I think that is a really important point. There are a lot of myths and misinformation around.

Senator CROSSIN—I understand that. I am curious to know what percentage of money is being set aside to give these people the skills to do this.

Ms Evans—That is a reasonable question, Senator.

Ms Halton—We will look into that.

CHAIR—We will now go back to outcome 2.

Senator McLUCAS—I have some questions about practice incentive programs that I think I will have to put on notice, but I just want some advice as to whether or not it is possible to answer them. Is it possible for us to get a breakdown by state and territory and by quarter of the number of practices enrolled in the various PIP programs since the inception of the first program?

Mr Stuart—Yes, we have overall numbers with us here, but we would have to take on notice numbers by program.

Senator McLUCAS—I just want to make sure that these can be answered. Can you provide a breakdown of the funding provided within each of the various incentive programs?

Mr Stuart—Would that be take-up by practices and funding by program over time within the PIP?

Senator McLUCAS—Yes.

Mr Stuart—Yes, we can do that.

Senator McLUCAS—Finally, can you provide the average amount that each practice that is enrolled receives for each of the practice incentive payments that they are enrolled for?

Mr Stuart—Yes, I think so. We would need to check that, but we believe so.

Senator McLUCAS—Thank you. I want to go now to the announcement last week that the government would make payments to GPs, apparently to assist them in improving the electronic management of patient records. I understand that the payments were made at the end of May—in fact, last week. How were payments for each practice determined?

Ms L. Smith—Those initial payments went out to all practices that were enrolled in the PIP program—in the IMIT initiatives under PIP.

Senator McLUCAS—So, to be eligible, a practice had to be enrolled in PIP?

Ms L. Smith—That is right.

Senator McLUCAS—In the IMIT program?

Ms L. Smith—I might have to clarify that. It is possibly all practices, but I will check on that for you.

Senator McLUCAS—Could you do that now, please? Is that possible?

Ms L. Smith—I think I let the PIP person go home, but I will just check.

Mr Stuart—My belief is that it is for all practices participating in the Practice Incentive Program—that is my strong understanding—rather than those engaged in the existing IMIT program. The rationale for that, from a policy sense, would be that we want as much participation in this program as possible. It is not a limited participation.

Ms L. Smith—I can confirm that it is all practices. That means 4,593 practices are eligible for that payment.

Senator McLUCAS—Out of how many practices altogether?

Ms L. Smith—That is all of them. That is the 4,593 enrolled in the PIP.

Senator McLUCAS—So all practices that are enrolled in PIP in any shape or form will receive a payment?

Ms L. Smith—That is correct.

Senator McLUCAS—But that is not all practices; you have to be enrolled in PIP in some way?

Ms L. Smith—That is right.

Senator McLUCAS—What proportion of practices is that?

Mr Stuart—The easiest way to answer that question is that 80 per cent of services in Australia are provided by practices that participate in the Practice Incentive Program. We do not have a great deal of information about practices that are not enrolled in the Practice Incentive Program. There can be doctors working together in a practice or single-handed doctors working in common rooms. So we do not have a definition of a practice where doctors do not practise together under the Practice Incentive Program.

Senator McLUCAS—So you are essentially saying that it is about 80 per cent?

Mr Stuart—About 80 per cent coverage of patients under the PIP.

Senator McLUCAS—Regarding the payment that was made last week, how did you work out how much to pay each practice?

Ms L. Smith—The payment is based on the number of patients that practices see. An average payment based on that was made to each practice.

Senator McLUCAS—Was that per full-time equivalent patient, or whatever the terminology is?

Mr Stuart—That is correct.

Senator McLUCAS—I asked an 'or' question and you said, 'That is right.'

Mr Stuart—It is in respect of full-time equivalent patients, in effect.

Senator McLUCAS—So that varied according to the practice?

Mr Stuart—Yes, the payments vary according to the practice. On average, it is $6,800 per practice, but it depends on the number of total equivalent patients that the practice sees.

Senator McLUCAS—Was it $2.40 per standard whole patient equivalent?

Ms L. Smith—It was $3.15 per standard whole patient equivalent.

Senator McLUCAS—How did you come to the figure of $3.15?

Mr Stuart—By backward derivation. The program had $31.6 million available to spend, and that is the amount that has been spent—essentially, by spreading it out using the methodology, under the PIP, of the standardised whole patient equivalent.

Senator McLUCAS—From what program did that $31.6 million come?

Mr Stuart—It comes from within the Practice Incentive Program.

Senator McLUCAS—Was it money that was not spent? Had it been apportioned to a particular PIP and not expended?

Mr Stuart—Yes, it was a general underspend from within the Practice Incentive Program.

Senator McLUCAS—From a range of the programs?

Mr Stuart—Yes, from a range.

Senator McLUCAS—On notice, can you try to identify which of the range of programs that money would have come from? Is that possible?

Mr Stuart—I am not sure. Possibly. The issue with the Practice Incentive Program is that, unlike the MBS, it is a budget limited appropriation. So it is necessary for the department to be a little conservative in its estimation of likely take-up in particular programs. As a result, there is a greater risk of undershoot than of overshoot in relation to the budget for that program. For example, with some of the chronic disease initiatives, we might allow a certain funding with the high-side expectation that will there will be a certain level of take-up and when that level of take-up does not quite eventuate we end up with some funds left over, and it is those sorts of funds that have been applied to this expenditure.

Senator McLUCAS—What would have happened to that money had it not been spent before 30 June?

Mr Stuart—It would most probably have been returned to consolidated revenue.

Senator McLUCAS—In what cases would it not have been returned?

Mr Stuart—Where the department had made a case for the carryover of those funds into the next financial year.

Senator McLUCAS—Was it essentially a case of: we are going to lose it, so we have to spend it?

Mr Stuart—Yes, essentially.

Senator McLUCAS—So there was $31.6 million left in the bucket, you had to get rid of it and you decided to use it to assist the doctors in improving the electronic management of patient records. Why was that priority identified?

Mr Stuart—The priority is identified for a couple of reasons. One is that there are a number of bodies of an advisory nature in general practice who have identified this as an important next step—for example, in relation to chronic disease management. They include the General Practice Partnership Advisory Council, which is a policy advisory body to the minister.

Senator McLUCAS—Which council was that?

Mr Stuart—The General Practice Partnership Advisory Council, known as GPPAC, which advises the minister on policy. Also, this kind of direction would be welcomed by the General Practice Computing Group, which advises on general practice computing issues. The final part of that is that, in the context of the minister's desire to do something very active on the red-tape front, electronic records are a very important and essential platform for being able to

reduce transaction costs in general practice so we can stop doctors having to write out things longhand on forms and directly import data on pieces of information that really are required.

Senator McLUCAS—So everyone who opted into PIP got a payment of $3.15 per standard whole patient equivalent?

Ms L. Smith—That is correct.

Senator McLUCAS—Irrespective of whether or not they were computerised?

Mr Stuart—Yes, that is correct.

Senator McLUCAS—So, if they had a completely computerised practice, like the one I attend, they got $3.15 per patient?

Mr Stuart—Yes.

Senator McLUCAS—And a completely uncomputerised practice, still working on a card, got $15 per patient?

Mr Stuart—Yes, that is correct.

Senator McLUCAS—So there was no discrimination between those two practices about how the money was applied?

Mr Stuart—At this stage, that is true.

Senator McLUCAS—Why not?

Mr Stuart—There are two issues in that. One is that general experience is that paying incentives only to those who lag behind on a given issue tends to be not well received by those who have already invested from their own means to be in a better position.

Senator McLUCAS—We have been involved in IMIT and PIP since I was a member of the Cairns Division of General Practice, to be frank, and we have been offering incentives for that period for those people who participate. Now we are offering an incentive to those people who have participated for that period of time and those people who possibly do not intend to participate in the computerisation of their records. Is there no contract that you have signed with those GPs or those practices which says that you must attempt, start or do something? Is there any contract associated with that average of $6,800?

Mr Stuart—That would involve a considerable amount of red tape for what is essentially a simple program.

Senator McLUCAS—A simple program that has no outcome, potentially, for the health department.

Mr Stuart—The structure of this program is that in 18 months time there will be another payment of a similar size consequent on GPs reaching milestones which are to be set.

Senator McLUCAS—At that point of the second payment, if there has been no compliance, no change or no computerisation of patient records, do they pay back the first one?

Mr Stuart—No. The second amount will not flow.

Senator McLUCAS—But they still get their average $6,800, with no conditions basically.

Mr Stuart—That is correct. The background to this is that the Practice Incentive Program is carving out from doctor income. It is a child spawned out of the MBS, if I can put it that way. It is a part of doctor remuneration. Given that it is a part of doctor remuneration, it would not sit well if that funding were returned to consolidated revenue. The position was that it would be better if it were paid to GPs, given the origins of the funds, but paid for something which was potentially beneficial. The department did not have the time at the end of the financial year to consult with GPs about the precise requirements for that funding or to frame those requirements. The opportunity was not there for the amount of consultation which we would prefer to undertake. So what we have done is to design a two-step payment process: an initial payment with relatively few strings attached and a further payment upon reaching of milestones, which allows us to do the consultation on the detail of it after the payment rather than before the payment.

Senator McLUCAS—I come back to the point: they do not actually have to comply with anything to get the first payment.

Mr Stuart—No, they do not. But there is an incentive in respect of reaching the milestones for the second payment: to apply those funds to a positive purpose.

Senator McLUCAS—Is the second payment in the same form—that is, $3.15 per full-time equivalent patient or whatever the words are?

Mr Stuart—We expect that the second payment will be of a similar order to the first.

Senator McLUCAS—Will it have a condition attached, though?

Mr Stuart—It will have the condition attached of having reached certain milestones.

Ms Halton—Senator, can I just make a point about IT. You obviously have familiarity given your experience in Cairns, and we have had some considerable coverage of this in relation to Fairer Medicare. The reality is that medical practices are increasingly going to rely on information technology. I think the point being made here is that there are a number of initiatives that are relevant to the computerisation of practices, some of which go to how they manage the interactions they have with the Health Insurance Commission and the other of which is how they manage their patient flows. I think Mr Stuart told you earlier on in estimates today about some of our experiences with overseas information about how practices can better manage their own business, the whole capacity issue.

Senator McLUCAS—Yes, Ms Halton, I am aware of that.

Ms Halton—The essential point here, and what Mr Stuart is trying to say, is that as a contribution to meeting the increasing requirements on these practices this amount has been paid. There is a clear expectation they will respond to those broad requirements in relation to general practice by becoming more IT literate and by responding to the many programs we have already talked about today. As Mr Stuart has indicated, there is a clear statement to them that there will be another tranche of this money that will come with it. In other words, they have to have responded to those requirements or the next tranche will not flow.

Senator McLUCAS—Thank you, Ms Halton, but the point needs to be made that all PIP payments have some condition attached to them, that this is a very unusual one and that it is made unconditionally in the first instance. To further that point, we all accept that

computerising practices is very good, but why was it not given to all practices rather than just to those that were registered with PIP? If that argument held true, you would provide it to all practices across Australia, not just to those who have made some attempt to become associated with PIP.

Mr Stuart—The funds were out of the PIP and so have been provided to PIP practices. They are a part of that quality program.

Senator McLUCAS—I understand that. I suppose I was questioning Ms Halton's policy framework. You did make mention earlier about the GP computing group people who would be welcoming of this proposal. In last week's *Medical Observer* Dr Ron Tomlin said:

> However, to facilitate effective implementation of appropriate systems, more needs to be done beyond offering financial incentives.

Also in that article, Dr David Rivett said doctors were 'mystified' because:

> Patient records are not and have never been a red tape issue in general practice.

It seems to me that a portion of money was there, there was a period of time to use it and that those payments have been made with very limited consultation.

Ms Halton—I would like to make one comment. You quoted a remark by David Rivett. I have to say that when the minister met with the GPRG under a week ago we discussed the question of patient records and an ability to electronically extract from patient records the information required by—but not limited to—Centrelink as an example of where increased computerisation could actually respond to a red tape concern. This was one of the issues raised, including by Dr Rivett. I cannot comment on that particular quote, but I can say that we were left—and I think it was universal—with a very clear impression from the GPRG, including Dr Rivett, that computerising patient records was actually a way of responding to red tape.

Senator McLUCAS—It does not seem to be the priority though given that you have got two senior peak body people involved in both general practice and IT basically saying that they were surprised, and one suggested that the grant was money for jam. I think it was meant to be money for IT. We might come back to that later, especially in terms of the conditions that will be attached to the second payment.

There is one other issue that I want to go to, and that is a question which I placed on notice in the Senate on 27 March this year. The answer to this question is now overdue. It goes to work force issues to do with North Queensland. I might just place that question on notice here and see if I can get an answer that way.

Senator Patterson—I think that is the one we have written to you about. I am not sure, but there is one someone told me about this morning as I ran out. They said that we had written to you about the fact that it had not been responded to in the 30 days and given a reason why. If this is the one, there is a complication about how much time it is going to take. We are going to give you an estimate of the cost and then you can make a decision about whether you want the information. It is quite a difficult one—but I am not sure that is the one.

Senator McLUCAS—I look forward to getting that letter. Could the department supply a list of all the areas which have applied to be considered an unmet area of need over the past three years? Is that a list that is available?

Mr Stuart—I will let Bob Wells know of your interest in this area and you can ask him under outcome 9.

Senator McLUCAS—Finally, I want to turn to the bulk-billing questions that I ask every estimates. Do you have the March quarter electorate by electorate data available here?

Mr McRae—Yes. We have the December quarter data here too; we were unable to provide that last time because it had not been released.

Senator McLUCAS—Thank you. I will put the rest of my questions on notice. There is one slight amendment to the normal process that we ask for each time: we have actually asked for a quarter back into 1996 as well. I will leave those questions on notice.

Senator NETTLE—I have two more questions on the PBS. One is asking you to explain something to me in the portfolio budget statements. On page 98 it says:

The Government has decided to enhance the capacity of the Health Insurance Commission to validate on line the eligibility of Centrelink concessional card holders to receive benefits under the Pharmaceutical Benefits Scheme at concessional rates. This is expected to generate savings of $30.7 million over four years.

I am just wondering whether someone can explain that to me.

Mr Rennie—I will run through the measure to help clarify what is in the budget papers. It involves the development of an improved and more accurate process to establish a person's concessional status. It builds on the IME or the Improved Monitoring of Entitlements measure that was implemented from 1 May last year, the recording of the Medicare numbers. The improved validation process will assist pharmacy in ensuring that concessional pharmaceutical benefits are only provided to those who are eligible to receive them at the concessional rates. Pharmacists are legally obliged under the National Health Act to only supply concessional pharmaceutical benefits to a person if they are satisfied that that person is entitled to receive the concessional benefit level of entitlement.

The new measure will be phased in from 1 July 2004. It will enable the pharmacists to immediately verify a person's concessional status electronically through a function of PBS, the Health Insurance Commission's PBS online, and the person's Medicare number. The implementation will result in the establishment of a formal feedback loop between the Health Insurance Commission and Centrelink. The improvements of data matching between the HIC and Centrelink will improve the accuracy of the concessional status validation process. The department and the Health Insurance Commission will be consulting extensively with the Pharmacy Guild and other key stakeholders during the implementation of the measure. This will involve a comprehensive education campaign to be conducted to inform pharmacy and community about the implementation of this new measure. That is a bit of an overview.

Senator NETTLE—Thank you. Is this an at pharmacy process that we are talking about?

Mr Rennie—That is right.

Senator NETTLE—Does the government believe that some people have been claiming concessions which they are not entitled to? Is that the basis for bringing in the measure?

Mr Rennie—That is right. The savings have been achieved through the improvement of being able to check the concessional status of people as they receive the pharmaceutical benefits at the concessional level.

Senator NETTLE—What is the evidence on which the assumption has been made that people have been claiming the concessional rates where not eligible?

Mr Hancock—The measure has two elements. One of the major elements is the improvement of data quality and timeliness between the concessional data to the HIC. The HIC receives in its current process overnight a batch of concessional entitlement updates to its file. The process is very cumbersome. It has been in place for a number of years. The process requires us to match against our Medicare enrolment file. The data quality issues around that are that we only get an 80 per cent match rate and a 20 per cent mismatch rate. What this budget measure is about is putting an additional capability within HIC to improve that entitlement checking data and an online link between HIC and Centrelink to make it more timely. So funding has been set aside in this measure for both Centrelink to improve its systems and for HIC to modernise its systems.

Senator NETTLE—What is the cost for HIC to improve the capacity to carry out these checks?

Mr Hancock—The administrative costs for HIC over four years is $14.8 million. Included in that is funding for payment of software incentive to software vendors. The other element of this is the PBS online check in place in pharmacies' desktop software. To put that capability in requires software vendors to be able to put that functionality into pharmacy desktop software.

Senator NETTLE—I could not understand how you were going to make the saving, but you have explained that you think it is because people have been incorrectly using concessional cards.

Mr Hancock—The discussion with Centrelink to date has been that when a person goes into a pharmacy right now they are obliged to show their concession card. People fall in and out of concession from time to time. There is no ability for pharmacy at this stage to actually check online whether that person is entitled or not.

Senator NETTLE—My next question relates to page 124 of the PBS and the issue of new listings on the Pharmaceutical Benefits Scheme. Page 124 states that there were 87 new items and 181 new brands for 2002-03. I am wondering if this ratio of new items to new brands is consistent with the ratio that we have come to expect in previous years between new items and new brands being listed on the PBS.

Ms Corbett—I am not aware of any significant trend shifting that pattern. Overall there are about 1,500 different medicines in different doses on the PBS. When you take into account the brands that expands to 2,500 different branded items. So this would be of the same scale. I do not think there is any trend there of an increasing number of brands—if that was the purpose of your question.

Senator NETTLE—I am looking at this year's statement where the ratio is 87 to 181. My question concerns whether we are seeing an increase in brands rather than an increase in drugs, and what the implications of that are for innovative research being done in the production of pharmaceuticals. You might have seen in the report by the Australia Institute reference to the PBS discussion around the concept of 'me-too-ism' in creating new brands—with new branding of generic drugs becoming a focus rather than research and creation of new products. That is why I am asking the question—to understand whether that pattern and that ratio of new items to new brands is consistent with the patterns we have seen over the last few years and whether there is any trend there.

Ms Corbett—To be honest, we have not really analysed that carefully. I see the point of your question, and it is something that quite possibly we should look at a little more closely. Certainly, since the expansion in generic medicines coming onto the market, there may be an influence from that. I would not think you could read into those small numbers, in comparison to the total numbers on the PBS list, any particular trend. You would have to look at things over a longer period. As far as I am aware, we have not done that work.

Mr Davies—I think the point that is significant here is reference pricing. The government only subsidises at the price of the lowest price brand, so a profusion of brands is not in itself necessarily a cause for concern.

Senator NETTLE—No. I am just trying to get an understanding of whether that is indeed the trend—a profusion of brands.

Mr Davies—If a profusion of brands is actually showing that there is active competition between manufacturers, then one would expect that that would put downward pressure on prices.

Senator NETTLE—I understand; I was just asking whether the research is happening for new drugs—whether we are going in that direction.

Senator ALLISON—There was an announcement by Senator Coonan about a week ago on medical indemnity insurance, particularly for post retirement, with the suggestion that this would be revenue neutral. I do not think it is included in the budget papers. Is that entirely under Treasury?

Mr Maskell-Knight—The Treasury portfolio is responsible for the legislation under which the regulations are going to be made. The reasons for that not being shown in the budget papers are twofold: firstly, it has only just been decided, so it would not have been decided in time to have been included; and, secondly, there is no direct Commonwealth fiscal impact.

Senator ALLISON—Do you understand how this can be revenue neutral when—as I understand it, at least from the interview I heard—it offers to relieve doctors of their post-retirement obligation under medical indemnity?

Mr Maskell-Knight—I feel somewhat exposed in trespassing on Treasury's territory, but I think there are several elements to what Senator Coonan said. One was that the government will be recommending that the Executive Council make regulations about retirement cover for the 2003-04 financial year. That will be paid for by doctors—no fiscal impact. The next thing Senator Coonan said was that the government is committed to ensuring there is affordable

retirement cover for doctors after the 2003-04 financial year. The government is working with the MDOs and the Australian Medical Association on exploring options for how that might work.

Another element of what Senator Coonan and the Prime Minister announced was that the government will fund what has become known as the 'blue sky' issue—that is, claims beyond the limit of a doctor's cover. The Prime Minister announced that we will fund those claims from the budget but we will then recover the amount by a levy on the insurer. So, again, it will be cost neutral as far as the budget is concerned.

Senator ALLISON—And the load, presumably, will be spread over working doctors through their premiums?

Mr Maskell-Knight—I imagine that would be so, yes.

Senator ALLISON—My only other question was about drought assistance. I wonder why Health is contributing $3.4 million to drought assistance. How does that get to be in the health budget?

Ms Halton—Can you say which page that is on? It is most likely to be entitlement to a card. It will be PBS entitlements as part of the drought package.

Senator ALLISON—For whom?

Ms Corbett—Farmers who are eligible for drought relief do get concessional rates of support, so they are entitled to PBS concession rates.

Senator ALLISON—What are those concessional rates?

Ms Corbett—Virtually, they are holding a health care card. So they could get every script at $3.70 currently.

Ms Halton—It says on page 114 of the PBS, 'Eligible recipients are provided with a health care concession card under the Health and Ageing component'. So it is pharmaceutical benefits.

Senator Patterson—And they would be more likely to be bulk-billed if we had the A Fairer Medicare package through the Senate.

Senator WEBBER—I would like to go to page 97 of the PBS, which talks about the new diagnostic imaging agreements expected to be finalised by 30 June this year. I was wondering if you could advise me whether the monitoring and evaluation group has reported on its recommendations for next allocation of MRI Medicare licences.

Mr Sheedy—The monitoring and evaluation group has provided advice to the government over recent times. Those recommendations have been considered as part of our negotiations with the diagnostic imaging professions for new agreements to take effect from 1 July of this year. We are well advanced with our negotiations, and we hope those agreements will be signed before the end of June. When they have been signed, we will be in a position to work with the diagnostic imaging profession—in particular, the radiologists—to consider those recommendations. In our negotiations to date, the profession have indicated some dissatisfaction with the processes that have occurred in the past, feeling that they have not being sufficiently transparent or open to their involvement or influence. As part of our

negotiations, we are considering involving the radiology profession to a greater extent than has been the case in the past. When those new agreements are signed, we will be embarking on that process as a matter of priority.

Senator WEBBER—How are you going to increase their involvement in the process and make a decision by 30 June, bearing in mind that we are already in June?

Mr Sheedy—We hope to have the agreements signed by the end of June.

Senator WEBBER—Right.

Mr Sheedy—Once they are signed, we then have to undergo a process of working with them to build on the work that has already been done by the monitoring and evaluation group to come up with some recommendations for increasing access to MRI.

Senator WEBBER—Will the recommendations of the MEG be made public?

Mr Sheedy—They will be when we have gone through that process, yes.

Senator WEBBER—And you expect that to be fairly soon.

Mr Sheedy—It is a matter of very great priority for us. This is something that has been sitting around—

Senator WEBBER—Indeed.

Mr Sheedy—for some considerable time.

Senator WEBBER—I am from WA, where it certainly has.

Mr Sheedy—The issue has been in coming to some agreement with the profession about a sustainable way of funding this element of diagnostic imaging. We hope we are about to sign off with the profession on that front, and then we will have to do a little bit more work with them to consider the ways in which a monitoring and evaluation group might proceed. But it is a very high priority.

Senator WEBBER—So the work with the professional group is the only hold-up to announcing the recommendations and making decisions about new licences?

Mr Sheedy—Yes. There is probably a limit to the extent to which I can talk about exactly how we might proceed, because we have not concluded those negotiations yet. But, in short, it is reasonable to say that we need to build on the work that the monitoring and evaluation group has done to date but work more closely with the radiology profession so we get a result which is more a result of a consultative process and, therefore, more likely to be well accepted by the full range of the radiology profession.

Senator WEBBER—So there is an acceptance of identifying areas of need, and it is just a matter of working with the professional body?

Mr Sheedy—Yes, that is right.

Senator WEBBER—So there is no doubt about that. Can you tell me where the areas of need are for the new licences?

Mr Sheedy—As I have just explained to you, we will need to go through some additional work with the radiologists under a slightly new regime. We hope, as I said, to build very much

on the work that the monitoring and evaluation group has done. The profession has indicated to us in our negotiations with them thus far that they have not felt comfortable about that arrangement. They have felt, in fact, that the work has been a little bit too distant from them and has been rather like a black box. We would like to be more transparent in our processes and work more effectively with the profession to get a result which is more acceptable to all. We aim to do it as quickly as humanly possible. We do have to sign these agreements first before we can continue.

Senator WEBBER—I accept that, but your relationship with the professional group does not necessarily impact upon accepting the areas of need for new licences, does it?

Mr Sheedy—Yes, it does.

Senator WEBBER—Your relationship with the professional group impacts on need?

Mr Sheedy—No.

Senator WEBBER—Surely we can identify need. All I am asking is whether you have identified the areas of need and agreed on them, so that it is just a matter of managing the relationship with the professional body before we can move forward.

Mr Sheedy—There has been a process to identify need. That has taken place, thus far, without the sort of involvement with the profession that I have outlined. In order for us to gain the agreement of the profession to work under a new regime—and, I think, as a matter of reasonable conduct—we have said that we will work with them in a different way. I do not think it is a matter of saying that we will fully accept, immediately, a process that has already occurred. We need to go through some steps with the profession, building on the work that has already been done, in order to either confirm or modify the work that has already been done to identify areas of need. It does not mean that the interests of the profession will somehow influence the scientific objectivity with which the process proceeds. We just need to work with them carefully so they understand it and do not feel as though it has been done behind their backs, without their involvement, and is therefore something to be suspicious of.

Senator WEBBER—That is an admirable aim. What you mean by developing a different relationship? How is it going to be different from what you had before?

Mr Sheedy—Again, I need to think fairly carefully about what I say as we have not signed the agreement yet and I would hate to do anything that might compromise that or our ability to sign the agreements. But, in short, the groups involved in the professions with whom we wish to sign a new radiology agreement, in this case, have not played a part in developing the methodology of the monitoring and evaluation group and have not been given a chance to nominate members of that group. It is a likely outcome that both groups that will be signatories to the agreement will nominate members to that group and then will feel more confident about its processes.

Ms Halton—It is about transparency to the profession.

Senator WEBBER—I accept that it is about transparency to the profession, but at the moment we do not seem to be able to reveal, therefore, where we might be in need of placing of services. I accept that; that is fine.

CHAIR—Per capita of population in Western Australia, it is still far ahead of any other state, isn't it?

Ms Halton—In services, yes.

Senator WEBBER—In the private sector, yes.

CHAIR—It does not prevent the state government from putting anything into the public sector that they want to. They can do it any time they like.

Senator NETTLE—These are my last questions on outcome 2 and they relate to the health care agreements. On page 107 of the statements there is a comment about more services being provided in private hospitals. The question is whether the department has undertaken any research into the impact on the demand for public hospital services and whether this has changed as a result of increased usage of private hospital services.

Dr Morauta—We have a considerable amount of material on trends in public and private hospital utilisation. We are just turning up some key figures.

Mr Eccles—As Dr Morauta outlined earlier in the hearing, we are looking at more services being provided in private hospitals—is that what you are striking at?

Senator NETTLE—Yes.

Mr Eccles—Private hospitals accounted for over 82 per cent of the overall increase in the number of patients treated in hospitals between 1997-98 and 2000-01. So 82 per cent of the increase in patients treated in hospitals was in the private sector.

Senator NETTLE—What is the nature of the services being provided in private hospitals that are accounting for this increase?

Mr Eccles—I do not think I have that information with me.

Dr Morauta—Broadly speaking, as private health insurance uptake has increased, there has been a broadening of the range of services provided in private hospitals. A considerable proportion of quite advanced surgery, such as breast surgery and cardiac surgery and so on, now occurs in private hospitals. I do not know whether we have that material with us, but we could take on notice a profile of the types of services provided in private hospitals versus public hospitals. I am sorry we do not have that here.

Senator NETTLE—I would appreciate that. Perhaps, in a general sense, would it be accurate to say that a majority of those increased services were elective surgery?

Dr Morauta—No. There has been a change in profile in private hospital admissions. There is now a substantial amount of non-elective surgery in the private hospital sector, too. They have been diversifying what they are doing.

Senator Patterson—Over 50 per cent of cardiac valve replacements are done in private hospitals, as are over 50 per cent of breast cancer operations, over 50 per cent of major joint surgery and over 50 per cent of radiation therapy—and none of those would be elective. There is also over 50 per cent of cataract operations, although some people might say that is elective. But those other ones are not. Some of them are up around 60 per cent, but they are all over 50 per cent.

Senator NETTLE—I look forward to the answers to the questions on notice.

CHAIR—As there are no further questions on outcome 2, I thank all the officers for outcome 2. You can get an early mark now.

Ms Halton—That would be a nine-minute early mark, would it!

Senator Patterson—The TGA have stayed here to answer about eight minutes of questions when they have had most probably the most difficult year. I find that really unacceptable. They came back from home to do eight minutes.

CHAIR—Do you want to strike or would you like to leave it until tomorrow morning?

Senator FORSHAW—I have some questions for the TGA and I will start now.

CHAIR—For eight minutes?

Senator FORSHAW—Yes. I understand we have eight or nine minutes left.

Senator Patterson—Eight.

Senator FORSHAW—I do not want to waste our time between now and 11 o'clock debating what time Senate estimates finishes, but I do recall sitting here some years ago when we were in government until two, three and four in the morning, courtesy of Senator Patterson's questions when she was in opposition.

Senator Patterson—Very good questions they were too.

CHAIR—Senator Forshaw, do you have any questions of the TGA?

Senator FORSHAW—Yes, I do. I would like to start off—and I realise we do not have much time, so I think we can just deal with this at the moment—with the review by Brian Corcoran into the auditing and licensing of good manufacturing practice. Would you be able to provide the committee with a copy of Mr Corcoran's report?

Mr Slater—It is an internal report. It is not a document that we make public, because it gives the TGA advice about efficiency gains and other improvements that it can make to its processes.

Senator FORSHAW—Whose decision is it that the report be not made public or provided to this committee?

Mr Slater—I would need to consult the minister about it.

Senator FORSHAW—You have just told me that you cannot make the report available to the committee. You must know why you have just made that statement that you cannot make it available to the committee, which in turn makes it public.

Mr Slater—I thought I said that it is not usual for us to make those documents public.

Senator FORSHAW—I ask you in these circumstances, without necessarily conceding for the moment the reason you have given: will you provide that report to the committee?

Mr Slater—May I take that on notice?

Senator FORSHAW—I would like you to take it on notice and I ask you to respond tomorrow morning when you come back as to whether or not you or the department—the administration—intend to make that available to the committee. Minister, would you advise

us as to whether or not you would be prepared to arrange for that report to be made available to the committee?

Senator Patterson—I have a fairly good grip on what is happening across the department. My parliamentary secretary is basically responsible for TGA, although in the end I am responsible. I am not aware of the detail of what is in the Corcoran report. I am not prepared to make that judgment until I know what it is about.

Senator FORSHAW—You are not familiar with what is in the Corcoran report?

Senator Patterson—As I said to you, it is a very large portfolio. I have my mind around most areas of it, and I may need to have my mind jogged as to whether I know anything about the Corcoran report, but at the moment there is nothing that comes immediately to my consciousness.

Senator FORSHAW—You are not aware of this report by Mr Corcoran?

Senator Patterson—I don't remember it. I do not know whether I have seen it. I get numerous reports given to me. But, as I said to you, this area, the TGA, is basically the responsibility of the parliamentary secretary, who receives all the minutes, and I do not recall seeing the Corcoran report. That is not to say that at some stage it has not passed across my desk in a copy of a minute to the secretary, but I do not recall it.

Ms Halton—The minister has not been provided with a copy of that.

Senator Patterson—Thank you for helping me, because I thought my memory was reasonably good.

Ms Halton—That is my understanding.

Senator FORSHAW—Would you just repeat that, Ms Halton.

Ms Halton—It is my understanding that a copy of that report has not been provided to the minister. It is an internal-to-the-TGA report. We will come back to you first thing tomorrow when we recommence on the TGA.

Senator FORSHAW—So it has not been provided to the minister. Has it been provided to the parliamentary secretary?

Mr Slater—No, not to my knowledge, but we will check that.

Senator FORSHAW—When was the report first commissioned?

Mr Slater—We think it was about December 2001.

Senator FORSHAW—What was the purpose behind seeking the report?

Mr Slater—We thought it was timely to have a look at our processes. The TGA has a reputation throughout the regulatory world of having one of the finest good manufacturing process records. We are the only country in the world that has an agreement with the USFDA for exchange of reports on GMP. We also hold the chair of the convention in Europe that looks after the development of good manufacturing practice codes and we are well known in the region for our expertise in good manufacturing practice auditing. But it was timely for us to have a look at our processes to see if they were state of the art.

Senator FORSHAW—So it was in the normal course of events, as it were, that it was decided it was timely to do this report; there was nothing particular that prompted it. Is that what you are saying?

Mr Slater—It was timely for us to do that. There were also a couple of issues that had been raised in relation to CSL and the auditing of CSL by the Auditor-General which gave rise to us to make certain that we had our processes up to date; so we had an external reviewer come and have a look at us.

Senator FORSHAW—Is there any reason why you would not have provided a copy of a review or report like this to the parliamentary secretary or the minister?

Mr Slater—We would provide those reports to the parliamentary secretary or minister if there were significant findings in them.

Senator FORSHAW—Who would determine whether there were significant findings?

Mr Slater—I would, as National Manager of the Therapeutic Goods Administration, and if necessary in consultation with the departmental secretary.

Senator FORSHAW—So did you report on this activity at all in the annual report of the Department of Health and Ageing?

Mr Slater—No.

Senator FORSHAW—Why not?

Mr Slater—Because, as I said, this was an activity where we were looking at our own internal performance. We had a reviewer come in to check whether there were recommendations that could be made about improving the activities of the TGA. We have a number of those sorts of reviews.

Senator FORSHAW—I think they are trying to tell you to wind up, Mr Slater, because it is 11 o'clock. But you finish your answer, and that will be my last question.

Mr Slater—The consultancy itself would have been reported in the annual report as a consultancy, if not the findings of the report.

Senator FORSHAW—The consultancy would have been reported in the annual report, would it?

Ms Halton—We will confirm that overnight, but it would be usual. That would be my expectation.

Senator FORSHAW—We might leave it there and we will certainly come back to it tomorrow. You will advise me tomorrow as to whether or not you—and I am sure the minister will advise us as well—are prepared to make that report available.

Mr Slater—Certainly.

Committee adjourned at 11.01 p.m.