COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Consideration of Budget Estimates

TUESDAY, 29 MAY 2001

CANBERRA

BY AUTHORITY OF THE SENATE

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Tuesday, 29 May 2001

Members: Senator Knowles *(Chair)*, Senator Allison *(Deputy Chair)*, Senators Brandis, Denman, Evans and Tchen

Senators in attendance: Senators Calvert, Coonan, Crowley, Denman, Evans, Gibbs, Harradine, Lundy, Knowles, Tchen and West

Committee met at 9.10 a.m.

HEALTH AND AGED CARE PORTFOLIO

Consideration resumed from 28 May 2001.

In Attendance

Senator Vanstone, Minister for Family and Community Services and Minister Assisting the Prime Minister for the Status of Women

Whole of Portfolio

Executive

Mr Andrew Podger, Secretary
Mr David Borthwick, Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Prof Richard Smallwood, Chief Medical Officer

Corporate Services Division

Mr Neville Tomkins, First Assistant Secretary, Corporate Services Division
Ms Wynne Hannon, Head, Legal Services
Mr Peter Moran, Assistant Secretary, Contestability Branch

Portfolio Strategy Division

Dr Robert Wooding, First Assistant Secretary, Portfolio Strategy Division
Ms Virginia Hart, Assistant Secretary, Budget Branch
Mr Robyn Foster, Senior Manager, Budget Branch
Mr Bill Ross, Director, Budget Management Section, Budget Branch
Mr Paul Fitzgerald, Assistant Secretary, Health Information Policy and Projects Branch
Mr Lyle Dunne, Director, Consumer Surveys & Projects, Policy and International Branch

Outcome 1—Population Health and Safety

Population Health Division

Mr Brian Corcoran, First Assistant Secretary, Population Health Division
Ms Judy Blazow, Assistant Secretary, Primary Prevention & Early Detection Branch
Ms Lorraine Breust, Director, HIV/AIDS & Hepatitis C Section, Communicable Diseases & Environmental Health Branch
Ms Marion Dunlop, Assistant Secretary, National Population Health Planning Branch
Ms Sue Kerr, Assistant Secretary, Drug Strategy & Population Health Social Marketing Branch

Mr Paul Lehmann, Director, HIV/AIDS & Hepatitis C Section, Communicable Diseases & Environmental Health Branch
Mr Steve Lowes, Director, Financial Management Unit Section, National Population Health Planning Branch
Prof. John Mathews, Head, National Centre for Disease Control
Mr Greg Sam, Director, Surveillance & Management Section, Communicable Diseases & Environmental Health Branch
Mr Rod Schreiber, Policy & Budget Strategies, National Population Health Planning Branch
Ms Caroline M. Smith, Director, Food Policy Section, Communicable Diseases & Environmental Health Branch
Ms Georgia Tarjan, Director, Primary Prevention Section, Primary Prevention & Early Detection Branch
Dr Bernie Towler, Director, Primary Prevention Section, Primary Prevention & Early Detection Branch
Ms Laurie Van Veen, Director, Population Health Social Marketing Unit, Drug Strategy & Population Health Social Marketing Branch

Therapeutic Goods Administration
Mr Terry Slater, National Manager, Therapeutic Goods Administration
Ms Rita Maclachlan, Director, Conformity Assessment Branch
Mr Pio Cesarin, Acting Director, Chemicals & Non Prescription Medicines Branch
Dr Leonie Hunt, Director, Drug Safety Evaluation Branch
Dr Joe Smith, Director, TGA Laboratories Branch
Dr Albert Farrugia, Manager, Blood & Tissue Services
Dr Susan Alder, Principal Medical Adviser,
Dr Brian Priestly, Scientific Director, Chemicals & Non Prescription Medicines Branch
Dr Fiona Cumming, Director, Office Complementary Medicines
Ms Elizabeth Cain, Acting Gene Technology Regulator, Interim Office of Gene Technology Regulator
Ms Elizabeth Flynn, Acting Assistant Secretary, Interim Office of Gene Technology Regulator
Ms Laurayne Bowler, Assistant Secretary, Interim Office of Gene Technology Regulator
Dr John McEwen, Director, Adverse Drug Reaction Unit
Mr Graham Peachey, Head, Regulatory Review Taskforce

Australia New Zealand Food Authority
Mr Ian Lindenmayer, Manager Director, Australia New Zealand Food Authority
Dr Marion Healy, Chief Scientist, Australia New Zealand Food Authority
Ms Claire Pontin, General Manager, Strategy & Operations
Mr Peter Liehne, General Manager, Standards
Mr Greg Roche, General Manager, Safety, Legal & Evaluation

Health Insurance Commission
Dr Jeff Harmer, Managing Director, Health Insurance Commission
Mr James Kelaher, Deputy Managing Director, Health Insurance Commission
Mr Geoff Leeper, Executive General Manager, Business Improvement

Mr Lou Nulley, General Manager, Business Improvement
Ms Ellen Dunne, General Manager, Program Management
Mr John Lee, General Manager, Finance & Planning Division
Dr Janet Mould, Acting General Manager, Professional Review
Mr Bob Thomas, General Manager, Information Technology Services

Outcome 2—Access to Medicare

Health Access & Financing Division
Mr Charles Maskell-Knight, Acting First Assistant Secretary, Health Access & Financing Division
Mr Brett Lennon, Assistant Secretary, Pharmaceutical Benefits Branch
Mr Terry Barnes, Acting Assistant Secretary, Financing & Analysis Branch
Dr Jane Cook, Medical Officer, Medicare Benefits Branch
Ms Jennifer Badham, Acting Assistant Secretary, BMMS Taskforce
Mr Stan Piperoglou, Acting Assistant Secretary, Pharmaceutical Access & Quality Branch
Dr John Primrose, Medical Officer, Diagnostics & Technology Branch
Mr Alan Keith, Assistant Secretary, Diagnostics & Technology Branch
Mr Ian McRae, Assistant Secretary, Medicare Benefits Branch
Dr Graeme Harris, Medical Adviser, Pharmaceutical Benefits Branch
Mr Alan Stevens, Director, Pharmaceutical Benefits Branch

Health Insurance Commission
See outcome 1

Outcome 3—Enhanced Quality of Life for Older Australians

Aged & Community Care Division
Dr David Graham, First Assistant Secretary, Aged & Community Care Division
Mr Marcus James, Assistant Secretary, Residential Program Management Branch
Ms Jane Bailey, Director, Complaints & Compliance Taskforce
Mr Stephen Taylor, Legal Officer, Complaints & Compliance Taskforce
Mr Andrew Stuart, Assistant Secretary, Policy & Evaluation Branch
Mr Raino Perring, Acting Assistant Secretary, Accountability & Quality Assurance Branch
Mr Warwick Bruen, Assistant Secretary, Community Care Branch
Ms Lana Racic, Acting Assistant Secretary, Office for Older Australians

Aged Care Standards & Accreditation Agency
Mr Tim Burns, General Manager, Aged Care Standards & Accreditation Agency
Ms Kristina Vesk, Communications Manager, Aged Care Standards & Accreditation Agency

Outcome 4—Quality Health Care

Health Services Division
Ms Lynelle Briggs, First Assistant Secretary, Health Services Division
Mr Peter Broadhead, Assistant Secretary, Acute and Coordinated Care Branch
Mr Dermot Casey, Assistant Secretary, Mental Health and Special Programs Branch
Mr Andrew Tongue, Assistant Secretary, General Practice Branch
Dr Rob Pegram, Snr Medical Officer, General Practices Strategic Development Unit
Mr Jonathan Benyei, Acting Assistant Secretary, Blood and Organ Donation Taskforce
Ms Joanna Davidson, National Manager, Office of Rural Health

Mr Richard Eccles, Director, Regional Health Services Section, Office of Rural Health

Outcome 5—Rural Health Care

Health Services Division

See outcome 4

Outcome 6—Hearing Services

Aged & Community Care (Office of Hearing Services)

Mr Peter DeGraaff, Assistant Secretary, Office for Hearing Services

Outcome 7—Aboriginal & Torres Strait Islander Health

Aboriginal and Torres Strait Island Division

Ms Helen Evans, First Assistant Secretary, Aboriginal & Torres Strait Islander Health

Mr Yael Cass, Assistant Secretary, Aboriginal & Torres Strait Islander Health

Ms Mary McDonald, Assistant Secretary, Aboriginal & Torres Strait Islander Health

Ms Margaret Norington, Assistant Secretary, Aboriginal & Torres Strait Islander Health

Outcome 8—Choice through Private Health Insurance

Health Industry and Investment Division

Mr Robert Wells, First Assistant Secretary, Health Industry and Investment Division

Ms Perry Sperling, Acting Assistant Secretary, Private Health Industry Branch

Dr Vin McLoughlin, Assistant Secretary, Priorities and Quality Branch

Ms Christianna Cobbold, Assistant Secretary, Health Capacity Development Branch

Ms Virginia Dove, Director, Public Affairs

Health Insurance Commission

See outcome 1

Private Health Insurance Ombudsman

Ms Samantha Gavel, Director, Policy & Customer Service

Outcome 9—Health Investment

Portfolio Strategies Division

See whole of portfolio

Health Industry and Investment Division

See outcome 8

Office of the National Health & Medical Research Council

Prof. Alan Pettigrew, Chief Executive Office, NHMRC

Prof. Elspeth McLachlan, Head, Centre for Research Management

Dr Clive Morris, Acting Assistant Secretary, Centre for Health Advice Policy & Ethics

CHAIR—I declare open this public hearing of the Senate Community Affairs Legislation Committee considering the budget estimates. The committee will now continue examination of the Health and Aged Care portfolio. I welcome back the Minister representing the Minister for Health and Aged Care, Senator Hon. Amanda Vanstone, and of course the officers of the Department of Health and Aged Care. The committee has completed outcomes 1 and 3. We will now commence with outcome 2, followed by outcomes 6, 4, 5, 7, 8 and 9 and then any questions on corporate matters which are spread across all outcomes. The opposition has just said that probably it would be safe to say that outcome 2 will go until close on lunchtime, if not till lunchtime. In fact, we could make that decision that it will go till lunchtime so that everyone could go to their respective desks, if they want to.

Senator Vanstone—And just call officers back if we happen to get a little bit more efficient and finish a bit earlier?

CHAIR—Yes.

Senator CHRIS EVANS—There is at least a couple of hours, I think, in outcome 2; that is all.

Senator Vanstone—I think that is very helpful. I turned around yesterday and I saw 70 to 80 people behind me, about 10 of whom would have been required at the table. If we all get to the end of our tether with estimates, people who are sitting here quietly must nearly go mental.

Senator CHRIS EVANS—They come for the sport, Minister!

Senator Vanstone—I do not think so. I think they are like battery hens: they are just wanting to get out of here. The more we can accommodate that, the better.

CHAIR—That is what worries me: having so many people effectively unproductive. Could I suggest that Hearing Services look at the possibility of coming back around 11.30, but we will advise Hearing Services if that is going to be the case, and then we will go on with the further program. We will make a decision now that lunch will be at 12.45 till 1.45.

Senator Vanstone—Could we do that a little earlier? That might assist in a number of ways. The last reason is that it would be an incentive to finish outcome 2 earlier. But if you have lunch at, say, 12 or 12.15 or 12.30, you can then say to these officers, 'Come back at 12.30.' So even if you are running a little late, they will not be held waiting here for very long, whereas if you have lunch at 1.00 p.m. but you get them back here at 11.30 a.m. and you have not finished the outcome, then they will be here while you finish, while you have lunch and then when you come back. If you adjust your lunch a little, then you can get them to come after lunch and then they might only have to wait a little if you are running a bit late.

CHAIR—It might be better just to advise as we go, so that we can monitor that and we will remain flexible.

Senator Vanstone—Can we have a 12.30 lunch or 12.15?

CHAIR—Do you want to set lunch now?

Senator CHRIS EVANS—I do not care. Usually it is best to say, 'We've got 10 minutes left. Let's finish the outcome,' but I am relaxed.

Senator Vanstone—Will you excuse me if I go at 12.30?

CHAIR—Certainly. We can remain a little bit flexible so that we can fit in what we can around the timetable. But, by all means, Minister, if you need to go at 12.30 that is fine. Be that as it may, we will be in touch with Hearing Services later in the morning and let you know how we are proceeding and, any other officers who are here, we will see you this afternoon.

[9.14 a.m.]

Department of Health and Aged Care

CHAIR—We will begin with outcome 2—Access to Medicare. Any questions? Senator West.

Senator WEST—I want to pursue the issue of practice nurses in some detail, if I may.

Mr Maskell-Knight—Practice nurses goes across both outcome 2 and outcome 4. As you would appreciate, we are from outcome 2 and we can answer quite a few of the questions. Some of them we may need to defer until outcome 4.

Senator WEST—Are outcome 4 able to answer everything or not? No, because you are here.

Mr Maskell-Knight—Yes.

Senator CHRIS EVANS—Just as a general proposition, Senator West, the way things seem to be spread across two or three outcomes seems to be much more pronounced in this budget. Could someone perhaps explain that to us? I meant to ask it at the start. It just seems more confusing than last time.

Mr Borthwick—That is certainly the case, Senator. You would have seen from the PBS that there are quite a number of measures that go across two, and sometimes three, outcomes. That is reflecting a few things. The payments mechanism is often in outcome 2—Charles Maskell-Knight's division. Often the policy development issues are in another division—in this case outcome 4. It also reflects the fact that we are trying to break down the silos within the department and get related areas of the department working in teams across divisions; so increasingly we have measures that span two or three divisions in the department. I think in terms of practice nurses it would be best to defer the questions until outcome 4, but we will make sure that the outcome 2 people are here at the time.

Senator WEST—A message is being sent up there. Does that message relate to this?

Senator Vanstone—Senator, please! It might be a very personal message.

Mr Borthwick—We can get the people across in half an hour or so; so maybe if you go on with the rest of outcome 2 and we can pick it up when relevant people arrive.

Senator WEST—If you are going to keep running the PBSs like this, it is going to continue to be a problem because there is no discrete area where a question can be asked. I am concerned about trying to get appropriate accountability with this. If the two groups are not here together, I could well ask questions to outcome 2 and be told it is a question for outcome 4 and outcome 2 will go away—not necessarily on this particular issue—and we will get to outcome 4 and be told, 'Oh, no, sorry, that should be dealt with by outcome 2.' It is essential, when issues go across two or three areas, that we have them all here together, because they are going to get questions. If we are going to have this ping-pong game between outcomes 2 and 4—

Mr Borthwick—We can understand the difficulty because it spans across numbers of outcomes. We had intended that the practice nurses questions would be answered under outcome 4 but that we would have outcome 2 people here as well at the time.

Senator CHRIS EVANS—I will take this up with the chair later. But, Mr Borthwick, I suggest that before the next round of estimates the department might like to provide some guidance about when they would like to handle some of the major issues.

Mr Borthwick—I think that is a very good idea.

Senator CHRIS EVANS—It allows senators who want to come in for a particular item to know when they should turn up—although sometimes on this committee we try and trick them so that they do not turn up. We take long enough as it is! That might be useful. If you would indicate, for instance, for a major initiative that clearly is over three programs that you

would prefer to handle it under outcome 4, then at least we could factor that in and it might be helpful.

Mr Borthwick—We will do that next time for sure.

Senator CHRIS EVANS—Maybe I can start on something else, and we can come back to that. I want to ask about PBS expenditure for 2001, provided someone tells me I am not in the wrong area.

Mr Borthwick—No, you are in the right area.

Senator CHRIS EVANS—Could somebody help me here? I am looking at the figures. It seems to me that there has been quite a change in the expenditure for the year 2000-01 over what was forecast. Could someone give me an overview of what has happened with expenditure on the PBS?

Mr Lennon—I assume, Senator, when you are talking about the year 2001, you are talking about the financial year 2000-01. Is that correct?

Senator CHRIS EVANS—Yes.

Mr Lennon—The PBS expenditure has, for the second half of the 1990s, averaged around 10 per cent per annum.

Senator CHRIS EVANS—You mean the increase?

Mr Lennon—The increase in PBS expenditure has averaged around 10 per cent per annum. In 1999-2000 there was a lift in expenditure, such that the expenditure growth in that year was about 13 per cent. That has been continued and indeed accelerated in 2000-01, where the expenditure increase is likely to be closer to 20 per cent.

Senator CHRIS EVANS—I got 21.5 per cent. Is that right?

Mr Lennon—That would be right. That would be correct, Senator.

Senator CHRIS EVANS—So the increase last year over 1999-2000 was 21.5 per cent in expenditure on the PBS.

Mr Lennon—That is the estimated increase in expenditure to 30 June 2001 over the previous year, 1999-2000.

Senator CHRIS EVANS—Expenditure in 1999-2000 was $3.481 billion. Is that right?

Mr Lennon—That is correct, Senator.

Senator CHRIS EVANS—And then in last year's budget I think the original estimate was that we would spend $3.795 billion. Is that right?

Mr Lennon—I do not have that figure before me, Senator, but it sounds of the right order.

Senator CHRIS EVANS—Perhaps you could check that for me, but that is the figure that I got out of last year's budget—$3.795 billion, which represented, I think, a projected increase of about eight per cent for the financial year 2000-2001. Then I think in the six-month review or in the revised version of the budget that was revised upwards. The actual expenditure then was $4.255 billion?

Mr Lennon—That is the estimated expenditure for 2000-01. The actual expenditure for 1999-2000 is $3.498 billion. You are correct in saying that for 1999-2000 the estimate that was originally given was significantly exceeded in terms of the outcome, and it is also correct to say that for the year 2000-01 the original estimate, which I think was of the order of nine per cent, is going to be substantially exceeded. It will be closer to 21 per cent.

Senator CHRIS EVANS—What was the figure budgeted for 2000-01 in last year's budget?

Mr Lennon—For 2000-01, it was growth of around nine per cent.

Senator CHRIS EVANS—No, what was your budget figure? What was the figure you expected to expend in dollars in 2000-01 in the budget?

Mr Lennon—$3.8 billion.

Senator CHRIS EVANS—$3.8 billion. And did you revised that in the midyear review?

Mr Lennon—Yes, we have revised that number several times during the course of the year.

Senator CHRIS EVANS—What did you revise it to in the midyear review?

Mr Lennon—I do not have that number handy. It was a significant increase, of the order of some hundreds of millions. It was at the time of the January estimates update this year that we did that revision.

Senator CHRIS EVANS—Could you get that figure for me, please, just so we can check?

Mr Lennon—Yes, Senator.

Senator CHRIS EVANS—The figure we spent, the actual expenditure, was $4.255 billion. Is that right?

Mr Lennon—We have not quite finished the financial year yet, Senator, but the estimate for the year ending 30 June 2001 is $4.255 billion; that is correct.

Senator CHRIS EVANS—And are you relatively confident about that estimate or do you think there is still some movement in that?

Mr Lennon—I am confident that that estimate will be fairly close to the mark, Senator.

Senator CHRIS EVANS—It looks to me in the out years you have gone back to estimates of seven per cent, 10 per cent and nine per cent—back to the order that it was running at in earlier years—but last year we had an increase of 17 per cent and this year it looks like an increase of about 21 per cent. Is that a fair summary?

Mr Lennon—It is correct to say that the trend growth that we had in the latter half of the nineties was around 10 per cent. For the last two years there has been a significant lift—in 1999-2000 of the order of 13 per cent; it looks more like 20 per cent this year; and we are projecting something closer to the order of nine per cent on average for the forward estimates years.

Senator CHRIS EVANS—The forward estimates are back to more like has been the historical trend in terms of your estimates, but we had a blow-out last year and a huge increase this year of 21 per cent. Can you tell me why we have had that increase over the budget estimates?

Mr Lennon—There are a couple of specific reasons why this year the estimate has increased substantially over the previous year. There has been the listing of a couple of high profile drugs on the Pharmaceutical Benefits Scheme—Celebrex, which is a drug for the treatment of arthritis, and Zyban, which is a drug for the treatment of smoking addiction. Both resulted in very substantial increases to the Pharmaceutical Benefits Scheme this year that will not be reflected in compounding growth as we go out in the forward years.

Senator CHRIS EVANS—When you say they will not be reflected in compounding growth, are you thinking that the expenditure on those has plateaued or that it will drop off?

Mr Lennon—There may be some adjustments, but our belief is that the bulk of the impact of Celebrex and Zyban will be reflected in this current financial year.

Senator CHRIS EVANS—Are you saying that the level they have reached will be built into future budgets and there will not be continued growth or that in fact their uses will begin to subside? I will come to some specific questions about them later. But, more generally, is expenditure on those items expected to continue to grow or do you think it has plateaued?

Mr Lennon—We are not expecting significant continued growth in either of those areas. Most of the growth has been reflected in the current year; so that has set a base that we will obviously move forward on, and that is already contained in the estimates for this year.

Senator CHRIS EVANS—I will come back and test your confidence on that in a minute. Can you then detail for me what contribution Celebrex and Zyban have made to this growth? What have you spent on Celebrex and Zyban compared to what you thought you were going to spend?

Mr Lennon—Celebrex was listed on the Pharmaceutical Benefits Scheme on 1 August last year and, up until 30 April, which is nine months collections, the cost of Celebrex to government has been approximately $140 million. There have been approximately 2.8 million prescriptions for Celebrex during that time.

Senator CHRIS EVANS—And what was your original projections on Celebrex?

Mr Lennon—The original projections on Celebrex at the time it was listed was that it would cost of the order of $40 million in the first year.

Senator CHRIS EVANS—The projections were $40 million and it has cost $140 million?

Mr Lennon—To this point, yes.

Senator CHRIS EVANS—We have another two months of the financial year left.

Mr Lennon—That is correct, Senator.

Senator CHRIS EVANS—And Zyban?

Mr Lennon—Zyban was listed on 1 February of this year. To the end of April, there have been 164,000 prescriptions written, and the cost to government is of the order of $40 million.

Senator CHRIS EVANS—$40 million?

Mr Lennon—Yes. Zyban can only be prescribed once a year, and there was a big, pent-up demand there at the point that we listed it on the scheme; so what you saw was a very strong uptake during the first couple of months. That is already subsiding.

Senator CHRIS EVANS—I will come back to that. What did we actually estimate for the cost of Zyban, or didn't you? It did not come on until February. Was the cost of Zyban part of the forward estimates or not?

Mr Lennon—At the time that Zyban was listed it was costed, yes. My memory is that it was costed at less than $10 million per annum.

Senator CHRIS EVANS—All right, it was costed at $10 million per annum and it has cost $40 million in three months. Is that right?

Mr Lennon—That is correct, Senator.

Senator CHRIS EVANS—But you are saying to me that the demand or the number of prescriptions written is already starting to fall off. Is that right?

Mr Lennon—Yes, it has fallen off considerably, but we still have a reasonable number of prescriptions written each week.

Senator CHRIS EVANS—I will come to the detail of that in a minute. What have you put in the forward estimates for each of these drugs?

Mr Lennon—The forward estimates assume that there will continue to be significant expenditure on both of those drugs, Senator, but not significant growth over and above what occurs this financial year.

Senator CHRIS EVANS—For the next financial year what have you budgeted for Celebrex?

Mr Lennon—The PBS is a global estimate, Senator. We do not do a drug by drug estimate, but it would be fair to say that we are not expecting any reduction in the use of Celebrex next year, so we have continued to budget big numbers for the use of Celebrex.

Senator CHRIS EVANS—I know you do not budget them as separate items, but you have been able to give me the estimates for the previous years; so clearly you have estimates for this year.

Mr Lennon—Senator, what I gave you was the estimate that we made at the time that Celebrex was actually listed on the Pharmaceutical Benefits Scheme and the actual usage up to 30 April this financial year.

Senator CHRIS EVANS—A budgeted expenditure on that drug for the year—that is what I am asking you for next year.

Mr Borthwick—We do a global estimate for the PBS as a whole. When it comes to listing a new drug, we do a specific estimate for that drug at that time, but we do not subsequently do specific drug by drug estimates. They are then rolled into the global estimates. Mr Lennon is able to tell you what we thought the cost would be at the time of listing, but we do not break that down subsequently.

Senator CHRIS EVANS—Perhaps we will approach it another way. You spent $140 million on Celebrex in about nine months. Do you estimate you will spend $140 million or so in the next nine months, Mr Lennon?

Mr Lennon—That would not be an unreasonable assumption, Senator.

Senator CHRIS EVANS—So we are looking at at least the same level of expenditure on Celebrex. You are not saying to me that you think demand for Celebrex is going to drop off at all at this stage?

Mr Lennon—No, I am not saying that, Senator.

Senator CHRIS EVANS—Is there some potential for growth in the number of prescriptions there as well?

Mr Lennon—As I indicated previously, Senator, while there is some potential for growth in prescriptions, we believe that the use of the drug has been taken up very quickly by the clinical community. The effect of Celebrex in terms of its usage and potential usage will be substantially felt during this current financial year. While there will be growth in the forward years, we are not expecting anything like the kind of growth we are experiencing at this point in time.

Senator CHRIS EVANS—And in terms of Zyban you say you think prescriptions are already starting to drop off. That is because of this once a year only rule. Is that one of the drivers there?

Mr Lennon—That is an important driver, Senator.

Senator CHRIS EVANS—What do you say about the sort of expenditure you expect to make on Zyban, given you have spent $40 million in three months?

Mr Lennon—We would expect that number to increase for the rest of this financial year but not at the same rate that we have experienced to this point. We had an issue where we had a huge pent-up demand. People got in, got their prescription and basically cannot get another prescription written, if they so desire, for another 12 months.

Senator CHRIS EVANS—That is 12 calendar months from when they got it last prescribed, is it?

Mr Lennon—Correct.

Senator CHRIS EVANS—You think there is a potential for another peak next February when some people want to have it again, but otherwise it will be new entrants to the market, as it were, new clients being prescribed the drug throughout the year.

Mr Lennon—That would be correct, Senator. Obviously there was a big pent-up demand at the point that Zyban was listed. There will be a group of people who tried Zyban and it assisted them to cease smoking. There will be a group who tried it and it was unsuccessful, for whatever reason. Some of that unsuccessful group may come back next year, some may not. We would expect a number would not, but some would. There will be some new entrants, but one would expect that the bulk of the population who could potentially be in a position to try it would have tried it in the first few months that it was listed.

Senator CHRIS EVANS—What can you tell us about prescription behaviour then in relation to Zyban that makes you think it is going to drop off? You are saying that you have already had evidence that it is starting to subside a bit, have you?

Mr Lennon—Yes. The number of prescriptions being written on a weekly basis now is substantially below—

Senator CHRIS EVANS—Do you have some figures for me on that, Mr Lennon?

Mr Lennon—I do not have them handy at the moment, Senator, but I am quite happy to get them for you.

Senator CHRIS EVANS—All right. I would be interested in looking at the month by month figures on the prescriptions of Zyban. If you could take that on notice, that would be helpful. You identified Celebrex and Zyban as two of the drivers of this 21-odd per cent increase in the PBS costs. You talked about some other issues as well that contributed to that. Do you want to detail those for me?

Mr Lennon—Another significant issue would be growth in the statin group of cholesterol lowering drugs. That is one of the biggest drug groups we have on the Pharmaceutical Benefits Scheme. Any strong growth there really shifts growth into another gear as far as the PBS is concerned. Growth in the statin group over the last couple of years has exceeded 25 per cent per annum in terms of expenditure.

Senator CHRIS EVANS—You say the statin group has been growing at 25 per cent per annum. Have you got figures on what they contribute to the PBS in terms of dollar amounts?

Mr Lennon—Yes.

Senator CHRIS EVANS—Not individual but—

Mr Lennon—The statin group as a whole currently costs in the order of $500 million in terms of cost to government.

Senator CHRIS EVANS—Is that $500 million in this financial year, 2000-01?

Mr Lennon—Off the top of my head, it is about $520 million this financial year.

Senator CHRIS EVANS—That is a 25 per cent increase in costs over the previous year.

Mr Lennon—Of that order, Senator, yes.

Senator CHRIS EVANS—Do you have those figures available now or not?

Mr Lennon—I do not have them available now, but I am happy to get them for you.

Senator CHRIS EVANS—Yes, if you would not mind.

Mr Lennon—If you give me a moment, I might be able to find them in some papers.

Senator CHRIS EVANS—It might be useful. Clearly, compared with Celebrex, they are a much bigger item.

Mr Lennon—Yes, that is correct. In the calendar year 2000 the cost to government of the statin group in terms of the expenditure on the Pharmaceutical Benefits Scheme—that is, the lipid lowering group or cholesterol lowering group of drugs—was $521 million, which was an increase of 24 per cent from calendar year 1999.

Senator CHRIS EVANS—Those were calendar years?

Mr Lennon—Yes, they are calendar year figures that I am quoting. I am quite happy to get you financial year figures if that would be helpful.

Senator CHRIS EVANS—It helps me understand it. Just as I think I have got something we change the system. So $521 million was a 25 per cent increase over the previous year.

Mr Lennon—That is correct.

Senator CHRIS EVANS—What have you budgeted for next year for that group?

Mr Lennon—As we said, Senator, we do not do a drug by drug breakdown.

Senator CHRIS EVANS—We have the budget measure about restricting statins, so we will come to that in a second as part of the general discussion. At a rough calculation—25 per cent increase up to $520 million—you have over $100 million worth of growth in those areas per annum.

Mr Lennon—That is correct, Senator.

Senator CHRIS EVANS—I am just trying to get a feel for it. I think we have a growth of $774 million in PBS spending from last year to this year. I am trying to work out in my own mind what is driving that. We have $140 million for Celebrex; we will probably have $50 million for Zyban by the end of the year. That is $200 million. There is, say, $125 million or so for statins. It still leaves us well short of the $774 million. Obviously a part of that is just CPI cost driven. Is there anything else that is a major driver of that growth?

Mr Lennon—In broad terms, Senator, there are two major drivers of growth in the PBS. One is the increase in the average cost to government of prescriptions which it subsidises on the Pharmaceutical Benefits Scheme. The other one is growth in the volume of prescriptions. The area which has traditionally contributed most to growth is the increase in the average cost

to government of prescriptions. The major reason for that increase is the practice of doctors transfer prescribing, by which I mean they tend to prescribe the newer and more expensive drugs more and more under the Pharmaceutical Benefits Scheme. Volume growth has also been a significant contributor in the last couple of years.

Senator CHRIS EVANS—I appreciate that advice, Mr Lennon. Can you break down for me, not in a scientific way but in a broad sense, what the value of those measures is in terms of driving this massive growth. I am just trying to get a picture of the 21 per cent increase in growth. Clearly, Celebrex, Zyban and statins are big drivers of that, but they are not the whole story. You have now explained to me about the cost of prescriptions and volume growth, which makes sense. But I am just trying to get a sense of who is contributing what, in broad terms, to that big growth.

Mr Lennon—Obviously there were some factors during the last year that were one-off factors. Celebrex and Zyban were the two that we discussed. In terms of the other factors—increases in average costs to government of prescriptions and volume growth—the increase in the average cost to government of prescriptions would be the more important factor. I am quite happy to provide a more detailed breakdown for you, if that would be helpful.

Senator CHRIS EVANS—Yes, that would be helpful for us to understand. Obviously, it is a huge budget item, and it is probably important that the parliament understands what is driving it before we inadvertently make decisions that add to that. So you think it is the average cost of prescriptions that is a stronger driver than the volume growth. Do you have figures on the volume growth for the last year or so?

Mr Lennon—I do not have them handy, Senator.

Senator CHRIS EVANS—Perhaps you could take that on notice as well. Would it be fair to say, then, that the average 10 per cent in growth that has been occurring is a result of that average cost of prescriptions growth and the volume growth and that the other 10 per cent is the new drugs that have come on the market? Is that fair? Or has there been a change in the underlying trend with an increase in the average cost of prescriptions?

Mr Lennon—It is fair to say that there have been some one-off factors this year that we have talked about that have been significant contributors to the jump in growth. It is also fair to say that we are now expecting to return to a more traditional growth path. Part of the reason, which I did not mention, is that we have had a reduction in growth in 2001-02, compared with this year, because of the budget measures, of course. We are expecting that we will return to a more traditional growth path once we are rid of the one-off factors that occurred this year. That is always a moot issue, of course.

Senator CHRIS EVANS—Yes. I was not being critical before; I just wanted to test your confidence on those propositions. That is what we are here for. I think Senator Gibbs wanted to talk about a couple of these specific ones.

Senator GIBBS—Yes. I would like to talk about the cholesterol drugs.

CHAIR—Senator Tchen was actually wanting the call, Senator.

Senator TCHEN—Thank you, Chair. Mr Lennon, following up the cholesterol lowering drugs, which Senator Evans already asked some questions about, I have a message from one of my constituents who is saying that he will never vote for me again because of this budget measure on the cholesterol drug. Can you explain to the committee what exactly are the measures in the budget?

Mr Lennon—Yes, we can do that, Senator. I am going to ask Graeme Harris, who is a medical officer working in the Pharmaceutical Benefits Branch, to do that for you.

Dr Harris—Senator, the measure is meant to educate doctors and consumers about the place of cholesterol lowering drugs in the overall management of hyperlipidaemia or high cholesterol. The measure has three elements. Firstly, there will be a clarification of the instructions to prescribers of cholesterol lowering drugs in the schedule of pharmaceutical benefits. With these changes, there will be an emphasis on using plain English and a better format for presentation of information, with the intention of making it clear to patients and prescribers that patients should receive dietary therapy and be shown to have cholesterol levels unresponsive to diet and lifestyle modification prior to the commencement of lipid lowering drugs. Importantly, there will be no change to the clinical criteria—that is, the patient risk categories and the corresponding cholesterol levels—for patient eligibility.

Secondly, there will be an educational program for doctors and consumers by the National Prescribing Service about the place of cholesterol lowering medicines in the overall management of hyperlipidaemia. Thirdly, the Health Insurance Commission will undertake targeted feedback activities to raise prescriber awareness of the PBS subsidy requirements. I should also point out that the measure does not affect the range of cholesterol lowering drugs on the Pharmaceutical Benefits Scheme. All existing drugs will remain on the PBS. In summary, the criteria for the subsidy of drugs has not changed and the PBS subsidy will continue for patients who meet the clinical criteria, which are also unchanged.

Mr Lennon—If I could perhaps emphasise those points, there has been no changes in the eligibility criteria for cholesterol lowering drugs. No existing cholesterol lowering drugs will be taken off the Pharmaceutical Benefits Scheme. This is an educational measure.

Senator TCHEN—I am sure this gentleman will be pleased to hear that, too. Mr Lennon has already told the committee that one of the justifications for this measure is the high and increasing cost of the PBS. Are there other factors involved, other justifications?

Dr Harris—I think there is some international comparative data that indicates that the level of usage in Australia is quite high. The other point to make is that estimates of the use of cholesterol lowering medicines on the PBS are very close to the level that one would expect from the known prevalence of risk factors within the community, and these expected figures basically come from the Australian Institute of Health and Welfare projections of the National Heart Foundation risk factor prevalence study which was conducted in patients aged between 20 and 69 years of age.

Perhaps the most compelling evidence is a study conducted by the Drug Utilisation Subcommittee of the PBAC. This study found that, in a cohort of approximately 30,000 patients newly prescribed with cholesterol lowering agents, when they were followed for a period of six months, approximately 30 per cent of patients actually discontinued therapy and a further nine per cent actually stopped the drug that they were initially prescribed and commenced with a second cholesterol lowering agent. In the context of drugs which have been shown to be clearly clinically efficacious and relatively safe, this would suggest that there is a misunderstanding of the place or the use of cholesterol lowering agents in the overall management of high cholesterol.

Mr Lennon—So we have a situation where we have a big, high cost item on the Pharmaceutical Benefits Scheme, being the cholesterol lowering drugs, the use of which has been growing very rapidly. We know there is some looseness in the way that the restrictions, as far as cholesterol lowering drugs are concerned, are worded. We know from the evidence

Dr Harris just provided that there are problems out there in terms of a suboptimal usage pattern. So this measure is all about clarifying the wording—not changing it—in a way which makes it crystal clear for prescribers, and backing that up with an educational campaign run by the National Prescribing Service, which is the government's quality assurer as far as best practice prescribing protocols go. In addition to that, the Health Insurance Commission will undertake targeted feedback activities, also in an educational vein, to ensure that we can satisfy ourselves that we have best practice use of these drugs out there.

Senator TCHEN—Mr Lennon, when you say 'clarifying the meaning', I take you to mean that the first element of the measure that Dr Harris talked about—clarifying the instruction to the prescribers. That is what you mean, is it?

Mr Lennon—I am going to ask Dr Harris to go through in some detail exactly what we mean by clarifying so that you can be absolutely clear about what is involved.

Dr Harris—It might help if I first explain how the criteria are set out for cholesterol lowering drugs. Within the pharmaceutical benefits schedule there is a general statement that sits at the front of the section that deals with the cholesterol lowering agents. This is followed by entries for the individual drugs, and they actually cross-reference back to the general statement. Within the general statement there are three sorts of information. Firstly, there is a list of drugs to which the statement applies, and there is also general information to assist the prescriber with the choice of the drug.

Secondly, there is a table that actually sets out explicit clinical criteria that must be met in order for a patient to be eligible for subsidy under the PBS. The clinical criteria are presented according to patient risk categories, and are presented as a table. There is a qualifying cholesterol level corresponding to each risk group. These have been referred to as clinical groups as well. The cholesterol level at which patients are eligible for subsidy is highest for a person with no other risk factors for cardiovascular disease, other than their elevated cholesterol level, and the qualifying cholesterol level would be lowest for patients with existing heart disease as they are at greatest risk of further cardiac events. In between, there is a range of patient risk categories and qualifying levels that vary according to those risk factors. As the risk to the patient for cardiovascular disease increases, the corresponding cholesterol level for eligibility falls. These criteria are basically unchanged.

Thirdly, just ahead of the table there is information about the use of dietary therapy and advice regarding lifestyle changes to modify risk factors. These would include factors such as smoking, physical inactivity and excessive alcohol consumption. It is in relation to that third area that the changes will occur. As I mentioned before, there is really an emphasis on using plain English and better presentation of that information to make it clear that patients should receive diet and lifestyle modification and be shown to have cholesterol levels unresponsive to those measures prior to commencing the use of cholesterol lowering agents.

Senator TCHEN—Who will be responsible for making these changes: the department or an expert panel?

Dr Harris—Essentially, the responsibility for carriage will lie with the department. Because of the fact that there are no changes to the substance or content of the statement, and only presentation and communication aspects will be affected, and because of the overall educational focus of the measure, the department will be working in conjunction with the National Prescribing Service and the Health Insurance Commission. I would also mention that the revised wording would be assessed by the Pharmaceutical Benefits Advisory Committee,

which is of course an independent advisory committee comprising clinicians and health and consumer services experts, prior to any implementation.

Senator TCHEN—I probably should have asked you this earlier, but what are the existing rules?

Dr Harris—As I have briefly explained in relation to what would be required for clarification of wording, the existing rules are basically set out in the schedule of pharmaceutical benefits, and there are explicit clinical criteria contained within a table within that general statement. As I mentioned before, the cholesterol level varies according to the patient risk group. It would be highest for patients with no risk factors for cardiovascular disease other than an elevated cholesterol level, and then it would fall with increasing risk in successive patient groups such that it would be lowest in patients with existing cardiac disease.

Senator TCHEN—So the minister was right in his comment?

Dr Harris—In regard to?

Senator TCHEN—When he referred to the risk level. That was when he was roundly criticised, you might recall.

Dr Harris—I believe the minister was referring to the baseline entry level for patients with no risk factors other than elevated cholesterol, and that level would be nine, as indicated by him. As I have explained before, obviously the cholesterol level required for patient eligibility then falls with increasing risk group.

Senator TCHEN—I will not ask you to comment on Dr Phelps's comment, just in case anyone knows. What is FCA?

Dr Harris—Sorry?

Senator TCHEN—What is FCPA? FCA? FAICD? These are all titles. No?

Dr Harris—No.

Senator TCHEN—It is a fellow of some institute or something. Never mind.

Senator CHRIS EVANS—I am glad I am a Luddite, Madam Chair! I could not be bothered.

Senator GIBBS—Thank you, that was very interesting. You say that the guidelines have changed to plain English so that the doctors who are prescribing this medication to patients understand it better, and they say, 'You should have this education program and lifestyle'. Doctors actually do that now. When a doctor finds out that a person has high cholesterol, it is my understanding that the doctor actually starts you on a particular diet, and there are certain foods you can eat and certain foods you cannot eat. They advise you to drink red wine each day—

Senator CHRIS EVANS—You remembered that bit.

Senator GIBBS—They do because red wine lowers cholesterol. So you have a glass of red wine each day and you exercise. It is my understanding that doctors actually do this now, or most doctors do; the doctors that I have been told about certainly do this. When this fails, then they put them on the appropriate medication. Of course, not all medications suit the same people. There are side effects to all of these things. As far as I understand, this is actually happening now. But, of course, you think that this is going to improve it. You did say that the review was done by the drug utilisation subcommittee; is that right?

Dr Harris—Yes.

Senator GIBBS—When was the review conducted?

Dr Harris—It was conducted in the last 12 months. The findings were published in the *British Medical Journal* in October last year.

Senator GIBBS—Who instigated this review?

Mr Lennon—It was the Drug Utilisation Subcommittee of the Pharmaceutical Benefits Advisory Committee. The Drug Utilisation Subcommittee is a standing subcommittee of the Pharmaceutical Benefits Advisory Committee, which is charged with having a look at drug usage patterns and reporting its findings back to the main committee to assist the committee in ensuring that drugs that are subsidised on the Pharmaceutical Benefits Scheme are clinically effective, safe and cost effective. It has a look at usage patterns out there as opposed to the assumptions that were made at the time particular drugs were listed for certain indications, and that assists the Pharmaceutical Benefits Advisory Committee in terms of satisfying itself whether particular drugs are being used in the optimum way or not.

Senator GIBBS—Thank you. Are the recommendations of this review itself available to the public?

Dr Harris—They are published in the *British Medical Journal*. It is not a formal review. It was basically a letter to the editor in the *British Medical Journal* outlining the research that had been undertaken by the Drug Utilisation Subcommittee.

Senator GIBBS—Could the committee have a copy of this? Not all of us read the *British Medical Journal*.

Mr Lennon—Yes, of course, Senator.

Senator WEST—Is it a refereed article or not?

Dr Harris—It is my understanding that it is not.

Senator WEST—So it does not have the same status in the BMJ as an article or a piece of research that is a refereed?

Mr Lennon—Senator, if it is in the *British Medical Journal* I think it is pretty safe to assume that it is.

Senator CHRIS EVANS—That is why we want it clear. Dr Harris described it almost as a letter to the editor.

Dr Harris—It is a letter describing the findings of the study.

Senator WEST—One study?

Dr Harris—Yes.

Senator CHRIS EVANS—In terms of a published copy of the review, its findings and what have you, that is not available? It is just a letter describing their conclusions. Is that a fair way of describing it?

Mr Lennon—Senator, we are happy to provide whatever detail we can on that matter.

Senator CHRIS EVANS—I think it is important to clarify it because we want to be clear in our own minds. Dr Harris has described it as a letter from the Drug Utilisation Subcommittee. Earlier it was described almost as if it were an article, which I assume in a medical journal is a refereed scientific article. Could you describe for me what it is?

Mr Lennon—My understanding is it is a piece of work carried out by the Drug Utilisation Subcommittee of the Pharmaceutical Benefits Advisory Committee, and the results of that work in part were reflected in a letter which was sent to the *British Medical Journal*.

Senator CHRIS EVANS—And you are offering to provide us with the letter but not the complete work?

Mr Lennon—No, Senator. What I said was that we would see what we could dig up in addition to the letter.

Senator CHRIS EVANS—What we would like is a copy of their report, I suppose, simply put. Did they provide a copy of the report to the PBAC?

Mr Lennon—I believe that they would have made their report available to the PBAC as a matter of course. There are a number of members of the PBAC who are on the Drug Utilisation Subcommittee, so they will be well aware of the conclusions of that committee; but I will check that out for you.

Senator CHRIS EVANS—For your sake and mine, I think to say you think as a matter of course it would have happened is probably not safe for either of us.

Mr Lennon—I appreciate that, Senator.

Senator CHRIS EVANS—So I would not mind definitive answers. Did they or did they not? Will you or will you not provide a copy of the report?

Mr Lennon—Yes, I understand, Senator.

Senator WEST—Where did the report go when it went from the advisory committee? Did it go to PBAC? What did PBAC do with it? Where did they send it? Who has copies of it? Who was given copies of it? That would be very helpful too, please.

Senator GIBBS—Could I just get back to this actual program that you are insisting happens? I know it happens now. Do doctors have to prove to somebody that the patient has actually changed their lifestyle, that they have really high cholesterol and that their life is in danger if they do not take these medications? Or is it totally left up to the doctor?

Dr Harris—The decision is taken by the doctor, as always, in consultation with the patient. As part of good medical practice, the doctor would document the patient history, examination, any investigations and any treatments in the medical record.

Senator GIBBS—This happens now, so with the saving that is going to be made according to the budget, how is that going to happen? Are you suggesting that a person with high cholesterol, after they have been taking statins for a while and their cholesterol has lowered, should stop using them?

Dr Harris—No, not at all.

Mr Lennon—In terms of where the savings are coming from, I think you are quite correct in saying that the bulk of the use of statins out there is in accordance with the Pharmaceutical Benefits Scheme and in accordance with good practice, and that is the assumption that is being made in terms of this measure. This measure is simply retaining current eligibility provisions but doing three other things that we believe will assist in getting some further improvement in the prescribing of what is a high cost drug group. It is accepted that prescribing out there, by and large, is in accordance with PBS restrictions and is no doubt in accordance with good practice, but we know that this is a very high cost drug group, the use of which is growing very rapidly. We also know that there is some looseness in the way that

the current PBS restrictions are worded. We also have some evidence that says that in some cases perhaps best practice is not always being followed. As a result of the three initiatives that are being put together as part of this budget, none of which changes eligibility conditions, those three initiatives being clarifying the wording to make sure that it is very clear for people—and that is being done by the—

Senator CHRIS EVANS—Are you going to save $103 million without changing the eligibility conditions? That is a very courageous call.

Mr Lennon—Senator, we estimate that we will save over that order of money over four years.

Senator GIBBS—I do not understand how you will.

Mr Lennon—The annual saving is of the order of $25 million in a budget that is of the order of $500 million and growing at 20 per cent per annum.

Senator CHRIS EVANS—I accept that it is a big budget and it is growing, but it is also a very big budget saving to be taken for what you describe as an education measure, not a measure that reduces eligibility. I am just trying to tease out with you how sound that is. That is a big budget saving.

Mr Lennon—These are always estimates, Senator, but in my experience that is not an unreasonable estimate at all in a situation where wording is being clarified and there is a looseness of wording at the moment, and there are educational programs backing up those changes, involving both the National Prescribing Service and the Health Insurance Commission. To get savings of the order of five per cent on a program that is $500 million plus and growing at 20 per cent per annum is quite a reasonable assumption.

Senator GIBBS—I hate to labour this but I do not understand. You are saying that for people who are now on medications, Lipitor or whatever they take, for their high cholesterol—it has cost $21.80, whatever the PBS is—it is going to stay the same.

Mr Lennon—That is correct, Senator.

Senator GIBBS—And because of your education program in plain English, doctors advising their patients that they should eat certain foods is going to make this enormous saving. I cannot see that unless you are saying that doctors irresponsibly, willy-nilly, write out prescriptions for these medications. I cannot quite believe that doctors would do that.

Mr Lennon—As I indicated, Senator, the savings are not enormous in the scheme of the statins program as a whole. The statins are currently costing $500 million plus, with their use growing at 20 per cent per annum. The savings on a per annum basis are somewhere of the order of five per cent. While that in absolute terms might look like a fairly big number, in terms of the overall program it is a small number.

Senator GIBBS—If the same people are going to have this medication I really cannot see that the savings are going to be there, unless you are going to make patients pay a higher cost for their medication.

Mr Lennon—For example, Senator, bearing in mind that we have strong annual growth in terms of new patients coming on, there will be a group of people who under the existing provisions may have gone straight onto cholesterol lowering drugs, who may spend a longer period of time with dietary therapy and lifestyle changes, and indeed who may never go onto the scheme.

Senator GIBBS—Thank you very much. I know you are going to change the wording, but has this occurred or is this a future thing?

Mr Lennon—Senator, it is intended that the changes would apply from 1 August 2001. There is a process which we are going through at the moment to ensure that we clarify the wording in a way which is optimal. That consultation process involves the department, the National Prescribing Service and the Health Insurance Commission, and will then involve the Pharmaceutical Benefits Advisory Committee. Following all those processes, with government tick-off we would envisage that the pharmaceutical benefits schedule will be changed from 1 August of this year and that the new and better worded provisions would be in place in the schedule from that time.

Senator GIBBS—Were international guidelines considered for this process?

Mr Lennon—In terms of the listing of statins on the Pharmaceutical Benefits Scheme generally, it is an evidence based process that takes into account best practice and clinical studies. Each statin or cholesterol lowering drug that is listed on the Pharmaceutical Benefits Scheme has to demonstrate that it is safe, clinically effective and cost effective. That is a precursor for any of these drugs getting onto the Pharmaceutical Benefits Scheme; all of that has had to have happened. This measure is simply about taking the current eligibility provisions, clarifying some looseness of wording that we know is there in the current PBS restrictions and backing that up with an educational measure.

Senator WEST—Earlier you said, 'I think there is international comparative data.' First, are you sure there is international comparative data; and second, what is it? Where is it from?

Mr Lennon—We do have, Senator, some international comparative data that indicates use of cholesterol lowering drugs in Australia is high by international standards.

Senator WEST—Who is that from?

Mr Lennon—In 1999 the Australian usage, using the World Health Organisation defined daily dose measurement, was 61 DDDs per thousand population per day, compared with Norway, for example, 41; Sweden, 27; England, 18.4, Italy, 14.5 and Finland, 23.

Senator WEST—Who did this work?

Mr Lennon—The World Health Organisation.

Senator WEST—Were they measuring apples with apples? It is the only research that indicates this, is it?

Mr Lennon—The World Health Organisation would have been measuring apples with apples, yes, Senator.

Senator WEST—Is this the only international data comparison work or international studies that have been done which indicate this?

Mr Lennon—No, Senator. I was merely pointing to one piece of international work that I am aware of. There may be others.

Senator WEST—Is there international work that looks at the effectiveness of statins and their use, correlating that to the incidence of heart disease and cerebrovascular problems?

Mr Lennon—That is correct, Senator.

Senator WEST—So there is international work that links in the reverse, in positive terms, a positive correlation between use of statins and reduction in cardiovascular episodes and coronary artery episodes?

Mr Lennon—It is entirely agreed, Senator, that statins, when used clinically appropriately, can reduce the risk and do reduce the risk of cardiovascular disease. That is accepted and is reflected in the fact that a number of statin cholesterol lowering drugs are prescribed on the Pharmaceutical Benefits Scheme. It is costing the scheme half a billion dollars a year. That point is fully accepted, Senator.

Senator WEST—Is there international work to look at the incidence of cardiovascular incidents and cerebrovascular incidents, to link those with the use of statins?

Mr Lennon—As I indicated, Senator, the Pharmaceutical Benefits Advisory Committee looks at the evidence each and every time it looks at statin drugs. It does take into account all of the latest clinical studies and work regarding the clinical efficaciousness of these drugs in terms of coming to decisions about listing, and changing particular indications for listing.

Senator WEST—But you do not have the evidence or you are unable to give us the names of the research beyond a letter that reports part of the advisory committee's findings into a PBAC report.

Mr Lennon—I was simply referring to some usage data that we have in Australia. In terms of that particular issue, what we were talking about was evidence more generally by way of clinical trials, et cetera. That is part of the standard procedure that the Pharmaceutical Benefits Advisory Committee uses when it is assessing drugs for listing on the Pharmaceutical Benefits Scheme.

Senator GIBBS—Is the department aware of the argument that it would be a greater long-term benefit in terms of health savings if statins were increased rather than decreased?

Mr Lennon—Senator, the use of statins is increasing substantially. That is on the basis of the current eligibility conditions. In terms of listing on the Pharmaceutical Benefits Scheme, the Pharmaceutical Benefits Advisory Committee takes an evidence based decision. That evidence based decision takes into account three factors: the safety of the drugs compared to other drugs on the scheme; their clinical or medical effectiveness compared to other drugs on the scheme; and also the cost of the drugs in terms of getting to a measure of cost effectiveness. As a result of all of that consideration process it has decided to list quite a large number of cholesterol lowering drugs on the scheme and their usage in clinical practice has expanded considerably. This current measure does not change this at all.

Senator GIBBS—I understand what you are saying. You are basically telling me the same thing all the time. Your prime concern here seems to be cost. My prime concern is there are an awful lot of people out there who, through no fault of their own, come from a family with heart disease. They are candidates for a heart attack, no matter what they do. They are taking this medication. It keeps them alive and it stops them from having heart attacks. When they inherit those sorts of genes through no fault of their own, because we cannot pick our parents, and they do all the right things, they do stay alive.

If the cost of this was changed and they could not obtain the drugs, if they did not stay on them for quite a long time and they ended up having heart attacks, it would cost the government an awful lot more with their health expenses. They would be in hospital having bypass surgery, triple bypass surgery, and it goes on and on. Of course that costs the government an awful lot of money, whereas prevention is better than the cure, surely. This is what I am concerned about, and I must say that a lot of very concerned constituents have been ringing my office, worried that something is going to happen and they are not going to be able to afford the drug if it is taken off the PBS.

Mr Maskell-Knight—Senator, no-one is talking about taking it off the PBS.

Senator GIBBS—No, not at the moment, but what I am saying is that these people need this and I cannot see how there is going to be this enormous saving without people actually being taken off the drugs.

Mr Maskell-Knight—Senator, as my colleagues have said, it is not an enormous saving. It is five per cent of half a billion dollars. It is big money in absolute terms, and I wish I were getting the saving rather than consolidated revenue, but it is a very marginal saving in terms of the overall budget. What we are saying is that we are not changing the criteria. As long as your constituents are being appropriately prescribed the drugs at the moment, they will continue to be appropriately prescribed them. What we have said, what the evidence suggests, is that there was some churning going on; people are on the drugs for two or three months and then drop off them again; there were clearly lots of new entrants. What we are trying to make sure of is that the new entrants into this therapy undergo diet modification and all those other things beforehand. No-one is disputing the fact that the lipid lowering drugs work and no-one is disputing the fact that they are being widely prescribed. The fact that growth is increasing by 20 to 30 per cent a year suggests that their take-up among people who need them is very significant.

Mr Lennon—I want to add one other thing, Senator. I can assure you that for any person who has significant risk factors in relation to cardiovascular disease—and I am happy for Dr Harris to go through these risk factors with you if that would be helpful—

Senator GIBBS—Sorry?

Mr Lennon—In terms of any individual who has any significant risk factor in relation to cardiovascular disease, they are currently eligible for PBS subsidy on the Pharmaceutical Benefits Scheme for cholesterol lowering drugs and will continue to be so.

Senator GIBBS—And that is just on the say-so of their doctor? If their doctor says, 'My patient is in this category,' that is fine?

Dr Harris—Yes.

CHAIR—Can we move on a little bit.

Senator GIBBS—Sure.

CHAIR—We seem to be going over and over the same ground.

Senator GIBBS—That is all right. I just like to get it clear in my mind.

CHAIR—There is a lot to go, Senator. That is the only problem. Can we move on.

Senator GIBBS—There are concerned constituents out there, Senator.

CHAIR—I know there are, but we have gone over the same answers time and time again. There are concerned people out there because this whole thing has been misrepresented by certain people. We now have the answers. If we could move on, it would be very helpful.

Senator GIBBS—Is the department aware of correspondence sent by the APMA to the minister in response to this budget measure?

Mr Lennon—Yes, Senator.

Senator GIBBS—Is a copy of the letter available?

Mr Lennon—That letter was provided to the minister. We would have to ask the minister whether he is happy to make that available.

Senator GIBBS—You do not have a copy of the letter at all?

Senator Vanstone—That is not the question, is it? If a bureaucrat has a copy of a letter from someone else to the minister, it is not the bureaucrat's to dish out. The proper answer has been given to you: 'I will seek advice from the minister.' Otherwise, go back to the writer of the letter and see if they want to give you a copy.

Senator WEST—Can I follow up a couple of things here. You indicated that you are going to clarify the detail in the preamble or the beginning of the schedule. Who wrote the words for the beginning of the schedule in the first place?

Mr Lennon—The Pharmaceutical Benefits Advisory Committee would have written the current words back in the early 1990s when the lipid lowering drugs were first put on the Pharmaceutical Benefits Scheme.

Senator WEST—And they did not think that their wording then was unclear?

Mr Lennon—Senator, we are now eight to nine years on from that point. A lot of water has flowed under the bridge and it is timely that we have a look at the wording as it was written back in 1992.

Senator WEST—You would not think that just an educational campaign, through the use of such as the divisions of general practice and stuff, would in fact be one way of undertaking the educational program without causing this concern within the general public?

Mr Lennon—We certainly must engage the medical community in terms of its educational campaign. They are absolutely central to it, and I am sure that the National Prescribing Service, for example, will be working closely with divisions of general practice, amongst others.

Senator WEST—What consultations have taken place with cardiologists and neurologists, vascular physicians, in relation to the working up of this particular change? Have they been consulted in any way?

Mr Lennon—We will be taking the proposed changes past the Pharmaceutical Benefits Advisory Committee, who have individuals with particular expertise in cardiovascular disease.

Senator WEST—But the colleges have not been approached at this stage. The decision has been made. Now you are going to go and talk to the experts in the treatment and prevention of cardiac episodes and cerebrovascular episodes.

Mr Lennon—As I indicated, yes, we are going to talk to a number of experts, including our expert medical group, the Pharmaceutical Benefits Advisory Committee, that does contain particular and specific expertise in the cardiovascular area.

Senator WEST—But this consultation is going to take place after the decision has been made. Can you advise me. You were telling me that the protocol for the treatment of hyperlipidaemia these days should be an evaluation of the risk factors within that individual patient, then treatment with dietary therapy and lifestyle changes, then consideration of the prescription of statins. What length of time do you think a patient should be on dietary and lifestyle therapy for the various categories that you have obviously undertaken to put these patients into? Has that work been done?

Dr Harris—In general terms, patients would be given general lifestyle advice. The treating doctor would then consider other risk factors that might be present and assess the sort of risk for cardiovascular disease. Then an approach would be made to treating any modifiable non-

lipid risk factors—for example, treatment of coexisting high blood pressure—and it would also require checking for secondary causes of dyslipidaemia or abnormal lipids. This might include assessing other drug therapies that are being used because it is known that some antihypertensive agents can adversely affect lipid profiles. It is an overall management of the patient. Generally, the diet and lifestyle approaches should continue for at least six weeks, and that is as set out in the current PBS guidelines. More generally, one would expect a trial of at least three months of therapy.

Senator WEST—What is the cost of these antihypertensives that have a tendency to elevate lipids? Are they the cheaper groups of the drugs?

Dr Harris—No. It is based on pharmacological actions, so it would be things like beta blockers and thiazide diuretics.

Senator WEST—Are they the cheaper methods of treating hypertension? What you might be in fact doing, with other changes you have made, is forcing somebody onto a cheaper brand of an antihypertensive or a cheaper form of treatment which in fact has the effect of elevating their lipids.

Dr Harris—No, I am only saying that the doctor, when approaching a patient coming in for the first time with elevated cholesterol, would look at that as part of the overall management strategy with hyperlipidaemia.

Senator WEST—I am just raising it with you because you raised the issue of antihypertensives and antihypertension treatment as one possible cause of elevated lipid levels. I am wanting to know what is the cost of that antihypertensive treatment that is most likely to cause an elevation—albeit it may be only minor—in the lipid levels. In fact, if it is the cheaper antihypertensive treatment which you are forcing people on to, then it might be a false saving.

Dr Harris—I am not forcing anybody on to any cheaper—

Senator WEST—The department or the government, with the changes—

Dr Harris—No, it is a decision taken by the treating medical practitioner in the overall management of the patient's condition. If they see the patient is receiving an antihypertensive treatment that might be contributing to this problem, they might consider changing to another form of antihypertensive therapy.

Senator WEST—Is that more likely to be a more expensive antihypertensive therapy?

Dr Harris—I would have to check that.

Senator WEST—Because there have been changes and there is pressure on medical practitioners out there to prescribe the cheaper drugs for hypertension.

Dr Harris—I cannot answer with certainty in terms of costs, but my general impression would be that the thiazide diuretics and beta blockers are in fact some of the cheaper forms of antihypertensive therapy.

Senator WEST—So we may well now be seeing an increase in the use of statins because people have been not forced but had pressure on for the use of the cheaper antihypertensive medications. I will leave my questions at that, thanks.

Senator DENMAN—How many Celebrex prescriptions have been written since the PBS listing and at what cost to the government? Have you been through that? We did not get the prescription numbers.

Mr Lennon—Off the top of my head the number is of the order of 2.7 million prescriptions.

Senator DENMAN—How many prescriptions do you expect will be written this financial year and next financial year?

Mr Lennon—I do not have that information at hand, Senator. As I indicated in answer to a previous question, we do not actually do drug by drug estimates in terms of looking at future years, but we would expect at least something of the order of the number of prescriptions that have been written this year would be written next year.

Senator DENMAN—So you are not really expecting any increase.

Mr Lennon—We may get some increase but, as I indicated in answer to an earlier question, we are not expecting growth rates of the sort we had this year. We basically had a situation where Celebrex was listed in August of last year and there was a very high take up. Basically we believe we are in a situation where usage of the drug, in its place in clinical practices, is going to be fairly well set by the end of this financial year so we are not expecting major increases from here on in, no.

Senator DENMAN—How do you monitor the reasons for the prescriptions of Celebrex as listed and that that is exactly what the prescriptions have been used for? I have heard of a couple of cases where Celebrex has been prescribed for conditions other than arthritic conditions. How do you monitor that?

Mr Lennon—Senator, the Pharmaceutical Benefits Advisory Committee, at the time it listed Celebrex on the scheme, indicated it would come back and have a look 12 months after the listing of the drug. It, indeed, is having a look at actual usage of the drug at its next meeting which is in mid-June.

Senator DENMAN—Right.

Senator CHRIS EVANS—What information do they get before them for that, Mr Lennon?

Mr Stevens—The PBAC will have information provided to them on usage by the PBS. They have also had data provided to them by the sponsor company, in this case Pharmacia, that have prepared a fairly detailed submission to present to the PBAC.

Senator CHRIS EVANS—In terms of Senator Denman's question, though, in terms of monitoring whether or not it has been prescribed for the purposes that you have authorised the PBAC for, how do you monitor that? What you described for me sounded like just data that says so many prescriptions written. Are you able to answer the question?

Mr Stevens—No, Senator. Part of the information available is data from various sources, such as the IMS or BEACH, which actually do surveys of prescribers.

Senator CHRIS EVANS—Do you want to tell me who IMS and BEACH are?

Mr Stevens—Sorry. IMS is International Medical Statistics. It is an independent organisation that provides data to mainly pharmaceutical companies on usage of the drug as a whole. They do surveys of medical practitioners about particular prescribing habits. They will pick up, from the medical prescriber surveys, information such as what condition the drug was prescribed for, what dosage the drug was prescribed for, et cetera. That kind of data would be made available to enable the PBAC to assess the various reasons why the drug was prescribed.

Senator DENMAN—With the onset of Celebrex and the prescriptions has there been a reduction in prescriptions of other medications for arthritic conditions?

Mr Stevens—There has been a reduction in the use of other nonsteroidal anti-inflammatory drugs. Celebrex is one of that class of drugs; it is in the same class. It has a better safety profile in the gastrointestinal safety profile. There has been an increase in Celebrex, but there has been a decrease in the use of nonsteroidal drugs. A lot of those drugs are relatively low priced and would not be subsidied through the Pharmaceutical Benefits Scheme because, if prescribed for general patients, they are priced below the general patient contribution currently of $21.90. The PBS, for example, would not pick up any data on that.

Senator CHRIS EVANS—So that you are not saving any money if they are replacing existing drugs?

Mr Stevens—They are replacing existing drugs used for pensioners, but also we are saying that they are replacing drugs used for general patients as well.

Mr Lennon—There is some offset, Senator, but the net effect is still a substantial net increase.

Senator CHRIS EVANS—Are you able to give an estimate of what the offset is?

Mr Lennon—We believe the offset on nonsteroidal anti-inflammatory drugs in terms of the Pharmaceutical Benefits Scheme would be of the order of $10 million.

Senator DENMAN—Thank you. What measures have been taken to control the blow-out of the PBS on Celebrex?

Mr Stevens—There has been a change in the listing of Celebrex with effect from 1 May this year.

Senator DENMAN—What sort of change?

Mr Stevens—The major change there was that the pack of the larger strength—that is, the 200-milligram pack—was reduced from a pack size of 60 to 30. The main reason for that was to emphasise the fact that most patients would only require one 200-milligram tablet per day. The product information for Celebrex indicates that in the majority of cases for osteoarthritis the usage should be 200 milligrams a day in either one or a divided dose. They can take two 100-milligram capsules, or one 200-milligram capsule. There is certainly some usage of two by 200-milligram capsules per day, but it is in very much the minority. Patients would still be able to obtain 60 capsules on one prescription if the doctor decided they needed that. They would not have to be paying for two prescriptions. If a doctor thought they needed 60 capsules of the 200-milligram strength for one month's supply, they would be able to get that under the normal arrangements through the authority. In addition, Senator, as previously indicated, the Pharmaceutical Benefits Advisory Committee is having a look at the experience with Celebrex to this point at its June meeting.

Senator DENMAN—Who instigated that change, then, to the prescription for 30 rather than 60—the government or the company?

Mr Stevens—That was as a result of discussions between the government and the company. The company themselves had been reinforcing the dosage regime for this particular drug well before the change came about on 1 May. Their reps are advising prescribers that the correct dosage for most occasions is 200 milligrams per day.

Senator DENMAN—What sort of cost effectiveness will this have? How much money do you think it will save the government?

Mr Stevens—We have estimated that that change, on an annual basis, would represent a decrease in government expenditure of around $20 million.

Senator DENMAN—How many Australians do you think will be affected by this measure?

Senator CHRIS EVANS—Did you say that just changing that was going to save us $20 million? You said it in a very low key way which made it sound like a minor, technical sort of change, and now we have found $20 million?

Mr Stevens—The $20 million is the savings that we estimate from the changes that occurred on 1 May. What I described there—the change in the pack size—is one change.

Senator CHRIS EVANS—I see.

Mr Stevens—There is also a price reduction accompanying the May amendment. Also the company themselves have introduced a further pack, a pack of 10 by 200 milligrams, which is being sold as a private prescription, which may well take a bit of pressure off the PBS. With those three measures combined we expect to make the $20 million savings per annum.

Senator CHRIS EVANS—Can you describe the price reduction for me?

Mr Stevens—Four per cent.

Senator CHRIS EVANS—Four per cent? So how does that work? Is it on price?

Mr Stevens—Yes, the price that we agreed with the manufacturer, Pharmacia. They reduced their price that they sell to pharmacists by four per cent.

Senator CHRIS EVANS—Why did they do that—because of volume of sales?

Mr Stevens—Basically.

Senator CHRIS EVANS—Yes, so because they are selling more they can afford to market it at a lower price. Is that it?

Mr Stevens—That is right.

Senator CHRIS EVANS—Do you have the two prices there?

Mr Stevens—From the top of my head, the price for an equivalent pack would have reduced, at the price to pharmacy level, from $26 down to $24.97.

Senator CHRIS EVANS—I know you have explained all this to me before, and I confess that I would need to reread the *Hansard*, but does all of that then flow on to the government as savings?

Mr Stevens—Yes, because the cost of the drug is over both patient contributions, the concessional patient contribution and the general patient contribution; all the savings would flow to the government.

Senator CHRIS EVANS—So 100 per cent of the four per cent flows on to the government.

Mr Stevens—Yes.

Senator DENMAN—How many Australians do you expect to be affected by the new prescribing measure?

Mr Stevens—I cannot really answer that, Senator. I do not expect that any patient would be adversely affected by it. It is only a clarifying issue and, as I stated before, if the prescriber

believes a patient requires a higher dosage of Celebrex, or any particular product under the Pharmaceutical Benefits Scheme, they can prescribe that through the authority system.

Senator DENMAN—Thank you.

Senator CHRIS EVANS—I have a couple of questions on Zyban to round out this section. I think you took on notice for me the number of prescriptions written for Zyban, Mr Lennon. Or do you have that information?

Mr Lennon—I have the information, Senator. The number of prescriptions that have been written for Zyban since the time that it was actually listed on the Pharmaceutical Benefits Scheme, which was 1 February of this year, to 30 April is approximately 165,000.

Senator CHRIS EVANS—Yes, that is right, you did tell me that. And you do not estimate numbers for the next financial year, you told me.

Mr Lennon—Not on a drug by drug basis, Senator, no.

Senator CHRIS EVANS—Last time we talked about this you said Zyban was to be used as part of a comprehensive treatment program, and you described that process for us at the estimates. I do not want to go through that again, but I was interested in how you are monitoring the level of compliance with that broader treatment condition. As you said, there has been an explosion in the number of prescriptions written. Have we had an explosion in the broader treatment, or just an explosion in prescriptions?

Mr Stevens—We have had an explosion in the number of prescriptions written. I cannot answer the other.

Senator CHRIS EVANS—But that is the real question, isn't it?

Mr Lennon—We only have three months of data at the moment.

Senator CHRIS EVANS—Yes.

Mr Lennon—We really need a better data set. We would be confident that this will have a significant impact out there, but we would really need a longer data set to be able to get it together.

Senator CHRIS EVANS—How do you measure that? How do you check the compliance with that broader condition?

Mr Stevens—This would be one of the issues that the Drug Utilisation Subcommittee of the PBAC could take up. As Mr Lennon explained, with the amount of data available to us at present, we would not be able to have any meaningful information through that. It would take some months—I would imagine a minimum of probably 12 months—before you could get some comprehensive data together.

Senator CHRIS EVANS—I accept that, and I think that is reasonable, but what I am trying to get at is what you would test. What information would come to you that would allow you to make those sorts of decisions?

Mr Stevens—Hopefully, we could get some handle on the number of people who have taken up on the drug, those who have ceased smoking and who have continued to cease smoking after a period of 12 months. The studies for Zyban, for example, indicated that approximately one in three people continued not to be smoking after a 12-month period.

Senator CHRIS EVANS—Whose studies were those?

Mr Stevens—Those were studies that the sponsor company themselves presented to the PBAC.

Mr Lennon—That was data that was presented at the time that the decision to list was made.

Senator CHRIS EVANS—Yes, I think I remember discussing that with you the last time. What measures do you use to assess whether this is working, whether people are giving up, whether the comprehensive treatment program is being applied. I am just not sure how you test it. You get information on the number of scripts, which is fine—that tells you how many are getting written—but how do you know whether it is working, and whether the other measures you have required of doctors are being put in place? I accept that you do not have figures yet on that; I am just trying to find out how you measure it. How do you know, even in a year's time, or two years time?

Mr Lennon—As Alan indicated, Senator, we would be looking to use the Drug Utilisation Subcommittee, amongst others, to use our various data sources to get a handle on the numbers of individuals who were prescribed Zyban, and the numbers—more importantly—who ceased smoking, and over what period of time, so that we could link it to an improvement in health outcome.

Senator GIBBS—You said that the figures so far have shown that one in three actually give up smoking. Is that considered a good rate, or not?

Mr Stevens—They were clinical studies that were presented by the sponsor company to the PBAC when the drug was being considered for listing. Those particular studies indicated that that rate of success was far greater than the success rate for the likes of patches, for example.

Senator GIBBS—So they are happy with the one in three?

Mr Stevens—I do not know whether you can say they are happy with it. It might be higher, but it indicates that the results achieved by the drug, through the clinical trials, were much greater than the results achieved by other therapy.

Senator CHRIS EVANS—Is it fair to say you have no hard evidence yet as to the impact of Zyban—whether people are giving up smoking—and how it is being used?

Mr Stevens—No, we have not. You should be aware that this is part of a program, and because one might give up smoking for a short time does not mean you have success there. It has to be measured over a long period of time. That is why the studies look at a 12-month period.

Senator CHRIS EVANS—You will have a proper study at the end of 12 months to evaluate that, will you?

Mr Stevens—I would have thought that the data would be coming available at the end of 12 months. I would doubt that you would have a comprehensive set of results by the end of 12 months.

Senator CHRIS EVANS—Does the PBAC actually commission a proper study of the impact of this?

Mr Lennon—That is one of the matters that the Drug Utilisation Subcommittee is going to have to give very serious attention to, precisely how we monitor the prescribing of Zyban.

Senator CHRIS EVANS—They might authorise a study or ask someone to analyse the results. Is that within their power to initiate something like that?

Mr Lennon—They can seek to have such studies done or they can mine the data sources that are around publicly.

Senator CHRIS EVANS—In terms of the comprehensive treatment program that has been established, have you had any concerns expressed to you about doctors failing to comply with those requirements and just providing the scripts without the broader treatment plan?

Mr Stevens—I have certainly received none, Senator.

Senator CHRIS EVANS—What about the HIC?

Mr Stevens—I would have to ask the Health Insurance Commission.

Senator CHRIS EVANS—You have not had any serious complaints raised with you about the treatment program or the failure to offer anything other than the script?

Mr Stevens—No.

Senator CHRIS EVANS—Do you know how the special line funded by Glaxo to provide counselling and support has been going?

Mr Stevens—I have had no feedback on that at all.

Senator CHRIS EVANS—Do you know how many calls they have been getting?

Mr Stevens—No.

Senator CHRIS EVANS—I think we will go to Senator Harradine and come back to this later.

Senator HARRADINE—Senator Knowles indicated that I could raise this and the other access matter and then go to another committee. On the drug Implanon, what is the consumer price of Implanon under the PBS?

Mr Lennon—I am just endeavouring to get that data for you now, Senator.

Senator HARRADINE—Also, what is the wholesale price? I think the consumer price is $21.90.

Mr Lennon—For concessional patients it would be $3.50 and for general patients the maximum they can pay is $21.90. My colleague has the data here, I think.

Senator HARRADINE—Perhaps you could have at look at that and let us know what the wholesale cost is at some stage. What is the consumer price and what is the wholesale price?

Mr Stevens—Depending on what status the beneficiary is, a general patient would pay a maximum of $21.90, and a concessional beneficiary would pay $3.50 or if they are on the safety net they may get it free. The full dispensed price for the particular drug is $220.28 and the price to chemists is $197.78.

Mr Lennon—That price would incorporate the wholesaler's margin.

Mr Stevens—The price the manufacturer receives is $178.

Senator HARRADINE—The manufacturer gets the difference between $220.28 and $21.90 at minimum—whatever it is—from the taxpayer?

Mr Stevens—The taxpayer would be paying the difference between whatever the patient contribution is and the full dispensed price. If it is a concessional beneficiary, for example, the

total cost of the drug was $220.28. If a concessional beneficiary got it they would pay $3.50 and the government would pick up the remainder, which would be $216.78.

Senator HARRADINE—The maximum that anyone on a prescription would pay would be $21.90.

Mr Stevens—That is right.

Senator HARRADINE—So the taxpayer picks up the difference between $220.28 and $21.90 in most instances.

Mr Stevens—That is right.

Senator HARRADINE—On what basis was the PBS price set?

Mr Stevens—There would have been a negotiation between the government and the sponsor company. In this case it is Organon.

Senator HARRADINE—Who actually makes these decisions or made the decision?

Mr Stevens—Who makes the decision on price?

Senator HARRADINE—On this particular matter, yes.

Mr Stevens—On the pricing of this drug or any drug on the scheme, recommendations are made by the Pharmaceutical Benefits Pricing Authority to the minister and there would be a departmental officer who would negotiate with the company on behalf of the minister.

Mr Lennon—Prior to that point the drug would have had to have gone through the Pharmaceutical Benefits Advisory Committee and been deemed to have been safe, clinically effective and cost effective. Having passed that threshold it would then go to the Pharmaceutical Benefits Pricing Authority for the determination of the price and the subsequent processes that Mr Stevens just outlined.

Senator HARRADINE—Could I go on then from there: is the department aware of the known adverse effects of Implanon on women's health?

Mr Lennon—That is a matter for the Therapeutic Goods Administration; Dr McEwen from the TGA is here to answer that question, Senator.

Dr McEwen—Senator, I cannot tell you chapter and verse as to the adverse effects of Implanon. At the time of registration they would have been set out in the product information and that information would have been available. The information on the adverse effects including what is set out in the product information and what was found in the evaluations would have been available to the PBAC at the time of the assessment for listing and would have been taken into account in the cost-effectiveness assessment.

Senator HARRADINE—Are you aware that there are known adverse effects including amenorrhoea in 38 per cent of women, and increase in body weight? In fact in 20 per cent of women there is a body mass increase of over 10 per cent. There are precautions reported by the United Kingdom Drug Information Pharmacists Group, such as possible risk of breast cancer, thromboembolism, hypertension, liver function disturbance and ectopic pregnancy. If you are not able to answer that now, could you take that on notice.

Dr McEwen—We can take that on notice and get the product information.

Senator HARRADINE—In view of that, what steps are being or will be taken to ensure that women are fully informed of these known adverse effects?

Dr McEwen—I can perhaps answer in part. When the drug is approved there are two documents approved by the Therapeutic Goods Administration. One is the detailed product information which is intended for medical practitioners, health professionals primarily; secondarily there is a consumer medicines information which the sponsor must either put in the packs or have available for distribution, and that should set out the major side effects, important side effects, and direct the patient to ask the doctor about any other side effects. We can arrange to get copies of those for you.

Senator HARRADINE—Is the department aware that after 30 months Implanon has a known abortifacient action?

Dr McEwen—I cannot answer that, Senator.

Senator HARRADINE—Would you take that on notice.

Dr McEwen—I will take that on notice.

Senator HARRADINE—And, if so, what steps will be taken to ensure that women are fully informed of this abortifacient effect.

Dr McEwen—I will take that on notice.

Senator HARRADINE—I raise this question because I have raised Norplant before, and I do not want to have to say, 'I told you so,' but is the department aware of the significant numbers of law suits relating to Norplant, a long-term contraceptive implant similar to Implanon, that have resulted in the withdrawal of Norplant from the market in several countries, including the United Kingdom?

Dr McEwen—I would take that on notice, Senator.

Senator HARRADINE—Are you aware that at its introduction Norplant was also hailed as a safe long-term contraceptive when first introduced into the United Kingdom? Again I do not want to have to say, 'I told you so,' but could you have a look at that and respond and address the question of the possibility of law suits in respect of Implanon in Australia. Thank you. I have another one but perhaps I will put that on notice, too, in respect of another matter.

Dr McEwen—Thank you.

Senator HARRADINE—I have other questions relating to the outcome, and this is access to Medicare. I want to ask a question about the distribution of a Voluson 730D ultrasound and the likely cost that may be incurred and whether or not funds are going to the various states in respect of this. I am sorry that I have not anything more technical to go on than a recent newspaper article which I happened to grab at an airport and copy, but it shows the image of a 34-week-old foetus and it is a very attractive looking image.

Mr Maskell-Knight—Senator, it might assist us if you could provide the newspaper article so we can get the detail of what the machine is.

Senator HARRADINE—I have mentioned the machine number. Yes, it is an article in a newspaper recently; that is about all. I am normally far more accurate than that, but I will try and give you the detail. In respect of this Voluson 730D machine, it is being pushed by the manufacturers that it will improve the rate of early detection of abnormalities. It will allow the study of foetal behaviour and movement. The cost of it is between $300,000 and $350,000, and the Nepean Hospital and the Brisbane Ultrasound for Women are the first hospitals to use it. I am just wondering whether the department is aware of it and, if so, what effect it is likely to have on Medicare payments for such services. How much is spent from Medicare on ultrasound services?

Mr Maskell-Knight—Are you referring just to obstetric ultrasound, Senator?

Senator HARRADINE—Yes.

Mr Maskell-Knight—I think we might have to take that on notice.

Senator HARRADINE—Obviously you would have to take this on notice. Is this likely to increase the usage of such services?

Mr Maskell-Knight—I would doubt it, Senator, but I think it is entirely a matter for speculation on the extent to which there is a market for such machines out there. It sounds like the owners of current machines have been invited to trade up from a laser to a slightly more powerful model.

Senator HARRADINE—So we will see whether, as a result of the introduction of this, there are going to be more claims on Medicare.

Mr Maskell-Knight—Also, Senator, I should point out that ultrasound is covered by the agreement we have with the diagnostic imaging profession so that, while the volume of services may or may not increase over time, the Commonwealth's exposure to increased costs will be limited.

Senator HARRADINE—I am sorry, I did not follow that.

Mr Maskell-Knight—We have an agreement with the diagnostic imaging profession, which is essentially a price volume agreement so that, if the number of services increases above a certain margin, we reduce rebates for services, whereas, if the volume of services falls, the rebate goes up.

Senator HARRADINE—I come to the issue of the payment of Medicare for late-term abortions and for those abortions that are being taken because of suspected deformities. Actually this is an 18-week model, so I will have to get a more up-to-date one, but let me go back to the issue of the abortion of the 32-week old foetus because of suspected dwarfism. I raised this on the last occasion, and the minister representing the minister for health was to ask Dr Wooldridge—

Senator Vanstone—Sorry, Senator, I was distracted for a moment. Sorry, could you speak up.

Senator HARRADINE—On the last occasion on 19 February at page CA21, you were to ask Dr Wooldridge to respond to a series of questions I asked about the payment of Medicare benefits for late-term abortion of disabled babies, including babies with suspected dwarfism, and about what constituted a clinical relevant service and why it is left to the practitioner to make a judgment about what constitutes gross foetal abnormality and what does not. Minister, have you been able to seek that information from the minister and inquire of the minister?

Senator Vanstone—I have to say, Senator Harradine, I would have assumed that anything of consequence of a commitment I would have given you would in fact have been done. You are obviously asking me, because it has not been done. I will have to follow it up personally with Dr Wooldridge and see what information he can possibly provide you. I have not personally spoken to him. Normally what happens after these meetings is that officers from the various departments go through and proceed with commitments that are given. I have not followed it up myself personally but, now that you have drawn it to my attention, I will.

Senator HARRADINE—Is it the policy of the government to allow payments for the abortion of foetuses with suspected dwarfism, for example, as was the case in Melbourne with a 32-week-old foetus?

Senator Vanstone—Senator, this is not my policy area. I would simply have to get advice from Dr Wooldridge for you. Maybe the officers can help you with whether or not there has been a policy statement in that respect.

Mr McRae—The item on the Medicare schedule which is used in such situations is an item which deals with the management of second trimester labour with or without induction, intra-uterine foetal death, gross foetal abnormality or life threatening maternal disease. As with all claims on Medicare, they are to be made for undertaking services which are clinically necessary and the view of the practitioners undertaking the work is that the services are of clinical necessity.

Senator HARRADINE—You are talking about a clinical necessity. Isn't the department concerned that you have, not gross foetal abnormality, gross discrimination against persons with disabilities or even, in this case, suspected disabilities—dwarfism, if that is to be determined as a disability? Is it to be determined as a disability? Isn't the situation that on the one hand the department is paying out taxpayers' money because of the gross actions of abortionists taken in a discriminatory fashion against the disabled? Isn't that a matter of concern to you as a department, when on the other hand you have a whole group in the department who are working on upholding the rights of individuals with disabilities?

Mr McRae—Senator, it is hard for me to say more than I have said. It is always in the hands of the clinicians who are dealing with the patients at the point of time who have to make their judgments as to what is clinically necessary. They are making their judgments as to what they believe would be acceptable to the broad group of their peers—

Senator HARRADINE—Of their peers?

Mr McRae—Of their peers, yes, and that is the judgment which they must make.

Senator HARRADINE—What does 'of their peers' mean?

Mr McRae—Of other doctors in a similar situation and with a similar set of skills.

Senator HARRADINE—Like abortionists—of their peer abortionists. Are you saying that you the Health Insurance Commission pays out money and the definition of 'clinically relevant services' is determined by the abortionist's peers?

Mr Maskell-Knight—Senator, I think we have been around this loop many times. I think the definition of 'clinically relevant service' in the health insurance legislation is that which the body of the profession would consider to be appropriate. It is not for officers of the department to make judgments about whether a particular case would or would not have met that criterion.

Senator HARRADINE—The body of what profession?

Mr Maskell-Knight—The act refers to 'the medical profession', Senator.

Senator HARRADINE—What does that mean? We have just heard Mr McRae say it was the members of the profession in their group; now you are saying it is the whole body.

Mr Maskell-Knight—Senator, if you were talking about radiology, you would clearly be talking about the radiologist members of the profession. As the items concerned are used predominantly by obstetricians, I think you would have to talk about the obstetrician members.

Senator HARRADINE—Yes, but I thought you said the whole of the profession.

Mr Maskell-Knight—The act is cast in terms of the whole profession, Senator. I think you are quite right. As a matter of interpretation, you have to look at people that have a particular specialty. In terms of that particular item, it is used predominantly by obstetricians, and I believe they would be the accepted body.

Senator HARRADINE—Has it ever been put to the obstetricians?

Mr Maskell-Knight—Not that I am aware of, Senator.

Senator HARRADINE—Is the department unconcerned about late-term abortions?

Mr Maskell-Knight—The department's view is that these procedures are carried out under the legislation, if it is not clear that there is an offence being committed. If there is, it is a matter for state law. It is up to the doctor and his patient or her patient to make the judgment about what is appropriate for that patient at that particular time.

Senator HARRADINE—I will give you the example of a disabled unborn child who was aborted because of that child's not disability but suspected disability. You are sitting there and saying you will approve of that, because it is permitted under an interpretation of the act.

CHAIR—No, Senator; I am sorry. I will not allow a public servant to be verballed. I think the situation that Mr Maskell-Knight has described is one where that is a decision between the doctor and the patient, not a decision between the patient and the Department of Health and Aged Care. It think it is rather unfair—

Senator HARRADINE—I am sorry; if that was taken to mean Mr Maskell-Knight personally, that certainly was not the intention. What I am saying is that he has told us that the department proceeds in accordance with its interpretation of the law. The word 'interpretation' was his and not mine.

CHAIR—What I understood Mr Maskell-Knight to say was that those decisions about a termination, whether they be of a suspected disabled child or any termination, is a decision made between the doctor and the patient, not between the patient and the department and not between the patient, the doctor and the department. Is that right?

Senator Vanstone—The department is not involved in these individuals' decisions. It is very hard for officers to give you answers when you focus on individual cases, because that is not what the department does.

Senator HARRADINE—What about sex selection abortion?

Mr Maskell-Knight—I think you are asking a hypothetical question, Senator. As I said before, we do not intrude into the privacy of a doctor's consulting room, and we do not look behind the decisions that doctors and their patients make. The act does not allow us to do that.

Senator HARRADINE—I have asked that question on sex selection before. I asked, as a question on notice in November 2000:

If the Health Insurance Commission was informed that Medicare was reimbursing for sex selection abortion, what action would be taken?

And the answer is:

It would be referred to our Professional Review Division for further investigation as to the clinical relevance of the service performed.

Why can't you do it in respect of this particular matter?

Mr Maskell-Knight—I think the question is, Senator, if they were informed that something had taken place.

Senator HARRADINE—I am asking the department and the minister directly to take this matter up with the Professional Review Division. Why hasn't the department taken the matter up with the Professional Review Division?

Senator Vanstone—Senator, as you read the answer to me that you were apparently given, your question was: what would you do if something happened?

Senator HARRADINE—Yes.

Senator Vanstone—And the reply was in the context of: 'Well, if that happened, this is what we would do.'

Senator HARRADINE—Yes, I understand.

Senator Vanstone—There was no request for the matter to be taken any further. So to then say to officers, 'Why won't you do this?' when you did not ask for that to be done is, again, pushing the officers on a matter and—unless the wording you have read to me adds something you did not read—is not fair. You did not ask them to ask Professional Review Division what they would do. You asked, 'What would the department do if it was advised of something happening?' and they said, 'We'd send it to this division.' Unless they have subsequently had that advice that that has been happening, presumably they have not done it. Then you come in and say, 'Why haven't they done it?'

Senator HARRADINE—Minister, I asked you last time to bring matters forward to the minister. You have not done that. I am left in the situation where I thought we would have advanced the situation in the interests of persons with disabilities, in the interests of the view of the whole of the community, as to what disabilities mean and the need for the whole of the community to see that the most vulnerable are getting the chop.

Senator Vanstone—Senator, you did raise that with me last time. I am aware of your very long-standing interest in these areas. You are quite entitled to chastise me for not having personally—

Senator HARRADINE—I am not chastising you; I am asking you a question.

Senator Vanstone—Can I just finish? For not personally following up the matter that I had assumed the department would have followed up as a consequence of it being in the *Hansard*. Now, that has not happened. You are entitled to be annoyed or whatever with me for that and to demand that I pursue it between this estimates and the next. But that is another matter from asking the advisers one thing at the last estimates and then half purporting that you asked them something else.

Senator HARRADINE—I am sorry; I am not half purporting anything. I am saying that I asked these questions, similar questions, and I did not get a response which brought in the Professional Review Division. Now I am asking questions about the Professional Review Division. I am talking particularly about late-term abortions—those abortions which are taking place following viability; everybody knows what viability is. So that is what I am asking now. I am asking now: will the department raise with the Professional Review Division the concerns of quite a large number of people about late-term abortions that are taking place and are paid for by the Health Insurance Commission?

Mr Maskell-Knight—Senator, I think the Professional Review Division has to consider the behaviour of individual doctors. There may be large numbers of late-term abortions taking place. I have no knowledge of that. But the Professional Review Division is there to consider allegations of malpractice against a particular person in relation to the payment of Medicare benefits.

Senator HARRADINE—You say you are not aware of the late-term abortions being undertaken?

Senator Vanstone—No, he said there may be large numbers; he would not be aware of what numbers there were.

Senator HARRADINE—Could I directly ask, Mr McRae: how many late-term abortions were in fact paid for through Medicare?

Mr McRae—Senator, in the 12-month period leading up to March 2001 there were 681 terminations which were claimed under item 16525, which, as I said earlier, includes terminations undertaken for intra-uterine foetal deaths, gross foetal abnormality or life threatening maternal disease. We have no capacity within that 681 to know how many of them were undertaken for which of those reasons.

Senator HARRADINE—So there were 681?

Mr McRae—Yes, Senator.

Senator HARRADINE—At what stage would that be?

Mr McRae—I am sorry; I do not understand.

Senator HARRADINE—Sorry. At what stage from conception would that be? That would be 18 weeks?

Mr McRae—These are, as I understand it, to be second trimester terminations. The second trimester is, broadly, between about 14 and 28 weeks.

Senator HARRADINE—Do you have any there, for which Medicare has been claimed, for over 28 weeks?

Mr McRae—Not that I am aware of. We can only know what we are told within the items.

Senator HARRADINE—So these would mainly be performed in hospitals?

Mr McRae—I would assume so, Senator. That is something we can look up from the data, but I do not have that information with me.

Senator HARRADINE—Thank you. I have information here—I think it was provided as a result of that coronial inquiry which took place after the abortion of that 32-week-old foetus—that 44 such procedures in 1999 were performed at that hospital; namely, the Melbourne Royal Women's Hospital. How is that paid? That would not be paid through Medicare, would it?

Mr McRae—I obviously cannot be sure, but it is quite likely that they are undertaken within the public hospital system, Senator. I do not know.

Senator HARRADINE—I note that the Medicare statistics on termination of pregnancy have been aggregated in some instances:

To ensure that there is no inadvertent disclosure of confidential medical information because ... the number of services is small or where the number of providers or establishments rendering the items in question is small.

Could you explain to us how an individual or confidential information could be gained from the reporting of small numbers of claims?

Mr Maskell-Knight—Senator, we follow the long established practice of the Australian Bureau of Statistics in suppressing small cell numbers in reports. I agree with you: it is exceptionally unlikely that it would be possible, if you found out there were two procedures

done in a particular state at a particular time, to infer anything about anybody's affairs. Nonetheless, it may well be possible, so we follow the longstanding practice of the Bureau of Statistics in their public release in suppressing small cells.

Senator HARRADINE—Small cells about what?

Mr Maskell-Knight—I think it is less than six, but I could take that on notice.

Senator HARRADINE—What statistics are you talking about?

Mr Maskell-Knight—Any statistics that are about individual affairs of any kind, Senator. If you look up the ABS agricultural statistics, as I once did in a former life, you will not be able to find the number of vineyards in the Northern Territory, for example, because it is a small number; whether it is one or two or three, I am not sure. I think, if it is fewer than six institutions, events, bodies, people or whatever, the ABS does not release that.

Senator HARRADINE—Are you seriously putting statistics about this matter on the same level as the ABS statistics about vineyards?

Mr Maskell-Knight—Senator, I am merely saying that it is a long established practice that government does not release statistics where there are small numbers of people, companies, bodies, institutions, abortions or anything else.

Senator HARRADINE—I will think about that. Thanks for that information. Wouldn't you say that, because there are members of the profession who are involved who have taken some sort of an oath to respect the patient's anonymity, that would make some difference? I do ask the question and I ask it deliberately: how would it be possible to gain access to confidential information by reading in a statistical table that, say, five women had access to a particular type of abortion in a particular state or territory, given the oath of secrecy by the medical profession concerned?

Mr Maskell-Knight—Senator, I accept the point you are making, that it is very unlikely. I think it is unlikely in many cases, if not most cases, that publication of these small cells would not lead to identification of a person or a company. However, it is possible, and the safest way of ensuring that the privacy of patients, or anyone else who has a dealing with government, is assured is to cut off small cell numbers.

Senator HARRADINE—Mr McRae, I raised the baby J case before, and perhaps you could take it on notice. Did that case come within any of the categories that were mentioned under 6525?

Mr McRae—I do not know, Senator. I would have to take that on notice. I do not know whether the baby J case was a Medicare case, a public case. I can take the question on notice but I cannot answer it.

Senator HARRADINE—Thank you very much. Again, I raise the question of the baby J case. Has the department given further consideration to the issues that I raised about that matter on the previous occasion? Would you take that on notice as well, please? It was either at the last meeting or the previous meeting. Again, I raise the question of whether the department will refer to the division the issue of the abortions that I mentioned in my questioning.

Mr Maskell-Knight—Which abortions are they, Senator? If you are talking about the ones that Mr McRae referred to, the 600 and something, then I think the answer is no; we have no reason to believe they were not provided in accordance with the requirements of the Medicare schedule.

Senator HARRADINE—Are you saying that of all of them?

Mr Maskell-Knight—I have no knowledge otherwise, Senator.

Senator HARRADINE—I am asking you about the issue of late-term abortions.

Senator Vanstone—I think that is understood, Senator. What the officer is asking you for is clarification of what specifically you want in the answers next time. He is indicating to you that of the 600 and something late-term abortions indicated, the department has apparently no advice at this time that any of them were conducted other than in accordance with the legislation and, accordingly, there would be no further action taken by the department. He is simply seeking to clarify it from you because you have covered a range of abortion questions. When you say, 'Will you follow these matters up,' which specific matters do you want followed up?

Senator HARRADINE—All right, I will: those late-term abortions that are similar to those performed by Dr Grundmann in Queensland—those that use the method of using scissors to pierce the skull of the unborn child and to use a vacuum aspiration to dismember the child and pull the child out of the womb.

Mr Maskell-Knight—Senator, we have no information about how these procedures are carried out. It is not part of the data we receive.

Senator HARRADINE—I beg your pardon?

Mr Maskell-Knight—We have no information about the particular method that may or may not be used to carry these procedures out.

Senator HARRADINE—You don't?

Mr Maskell-Knight—We do not know which one is done which way, if indeed there is a choice—and I do not believe it is relevant to the matter at issue. The issue is that 600 and something procedures have been carried out. To the best of our knowledge and belief, they have been carried out in accordance with the relevant Medicare benefits law. I do not propose to refer to the Professional Services Review all 600 and something of them. There is no reason to believe they have not been carried out in accordance with what the Medicare benefits regulations say.

Senator HARRADINE—You asked me what type of abortions. I have told you what type of abortion in one particular instance and I have described the method of the abortion. I have asked that you raise that with the division.

Senator Vanstone—Senator, there might be a misunderstanding here. I want to try and be helpful and get absolutely clear what it is you want. The officers have indicated the number of late-term abortions that took place in the relevant period. They have indicated to you that they have no advice that any of those were conducted other than in accordance with the legislation. You then raise a specific example which may or may not come within that particular grouping, but let us assume for the purposes of the exercise that it does. I think what the officers would say to you is the same: at this point they have no advice that any of those were conducted other than in accordance with the legislation. Therefore, it is difficult to see what you are asking.

You surely cannot be asking—but clarify for me if you are—that the department should set up an investigation into each and every one of those late-term abortions. If you are asking that, I think it is worth clarifying. I am only trying to get down to exactly what you want. But the department's position at this point is that they have no advice to indicate that any of those

have been conducted other than in accordance with the legislation. I presume the department would say that if they got advice that was relevant it would be acted on, but at this point they do not have it. So are you asking for an investigation into each and every one of the 600 or so conducted in the period about which you asked?

Senator HARRADINE—Minister, do not put words into my mouth. I have been asked by Mr Maskell-Knight to describe what abortions. I have described the abortions that are conducted at least in Grundmann's area in Queensland and in some other places. I have described the method of abortion and I have asked him, or was about ask him, to refer that to the professional services review committee—a committee that is established under section 93 of the act.

CHAIR—Senator, can I try to be helpful here? I, too, am struggling to know what it is you are wanting.

Senator HARRADINE—I have just asked—

CHAIR—But I just wanted to try and clarify it. Given that Mr Maskell-Knight has already said that the department has no way to distinguish which type of procedure has been conducted—am I correct in saying that?

Senator Vanstone—Yes, that is correct.

CHAIR—Therefore, you are asking that the department now to get the division to investigate a particular type of procedure out of the 600 or so that were done. I do not know but, from what I have heard the answers to be, that is not possible. Am I correct in saying you have no way of identifying each and every individual procedure one from the other?

Mr Maskell-Knight—That is correct, Senator. We do not know which of those procedures is carried out for which of the clinical indications given there.

CHAIR—Senator Harradine, what we are trying to find out from you and what the minister was trying to establish is what it is that you want, given the parameters of information availability and the practicality of it. What is it you want and how are you suggesting that that information be made available, if there is no such information available as it is?

Senator HARRADINE—Madam Chair, I asked that question and I am waiting for a response. I was asked the question by Mr Maskell-Knight: what type of abortion? I gave him my response. My response—

Senator Vanstone—Senator—

Senator HARRADINE—I am sorry; would you kindly allow me to respond? Anybody would think that I was some sort of a monster for raising the question on behalf of these most vulnerable of all people.

CHAIR—No, Senator. We were trying to get to the bottom of your question.

Senator HARRADINE—And also on the question of those who are aborted because of disabilities. I am talking about the discrimination aspect as well. But going to the late-term abortion, I was asked what type of abortions. I have given my answer. I have even described the procedures, and the question is whether they are clinically relevant services or an appropriate practice, as is contained in 82, definition of an inappropriate practice. Why can't you refer that to the professional services review committee? Why can't they refer that question to the professional review committee so that they can come up with some

consideration as to whether that would be a clinically relevant service? Why can't that division ask that?

Senator Vanstone—Senator, as I understood what Mr Maskell-Knight said, the particular group you referred to—the professional committee—looks at complaints about individual doctors in relation to their use of the Medicare system. They do not have advice with respect to each of these number of late-term abortions, as to the type of procedure that was carried out. When Mr Maskell-Knight asked you, 'Which ones?' in response to your general question about following up these questions about abortions, I did not understand him to mean, 'Which of the late-term abortions are you referring to?' I understood him at the time to mean: are you referring to the earlier questions you asked about gender preference possibly being exercised? Were you referring to the earlier questions you asked in relation to dwarfism? Or were you focusing particularly on late-term abortions?

There was obviously a misunderstanding because you took him to be saying to you, 'Which late-term abortions?' I do not think he was saying that, because he has no additional knowledge with respect to each of those late-term abortions and no capacity to get that knowledge. Senator, you have then cited a particular example of a type of medical procedure. If that is an inappropriate medical procedure, that may be something for the state medical registration board to pursue. But what Mr Maskell-Knight and the department are concerned about is whether it is an appropriate use of Medicare.

Senator HARRADINE—Exactly. That is what I am talking about here: the appropriate use of Medicare. Is it not a fact that one of the reasons the professional services review committee was established under section 93 of the act was precisely that: to consider whether or not abortions which are subject to payment under Medicare are, in effect, clinically relevant services and whether or not they are appropriate practices.

Mr Maskell-Knight—Senator, we have no evidence to suggest that they are not. If you have evidence to suggest that they are not, then I suggest you make it available. I do not have any, and I do not propose to refer all 681 procedures to the professional services review committee on some sort of exercise to invade people's privacy to decide whether they were appropriate or not. I do not believe it is appropriate for women—who have unfortunately suffered an intra-uterine death—or their doctors to give evidence to the professional services review committee about what the circumstances surrounding the procedures were.

Senator HARRADINE—Madam Chair, I object very strongly to Mr Maskell-Knight putting words into my mouth. That is not what I asked at all. I was asking the question as to whether or not late-term abortions—that is, late-term abortions which are paid for by Medicare—were clinically relevant services having regard to a number of issues, not excluding the type of practice used in performing that abortion. That is one of the reasons I explained the type of practice, and why can't that issue be forwarded to the professional services review committee? It is a review committee established under the act. If that cannot deal with the question or consider the question, who can? Who can consider it?

Senator Vanstone—Senator, Mr Maskell-Knight might have something further to add. The situation is that the body to which you say this should be referred is not the appropriate body. As Mr Maskell-Knight has said on a number of occasions, that is the body that looks at individual cases in relation to doctors where there is an allegation that there has been a misuse of Medicare.

Senator HARRADINE—Where in the act does it—

Senator Vanstone—He can come to that, but that is the answer that he has given. That is what I have understood him to say to be the case.

Senator HARRADINE—Where in the act?

Senator Vanstone—Senator, we will come to that, but I just want to repeat the advice that Mr Maskell-Knight has offered on a number of occasions—that is, in relation to each of these, the department does not have advice as to the type of medical procedure that was used in the particular procedure. The officers do not have those details, so it is not possible for them, in relation to any or all of them, to make an assessment on that basis. That is not information that they have.

Senator HARRADINE—Is there nobody in the Department of Health and Aged Care that knows? Is there not one person in the department of health that is aware of the type of practice and the method of late-term abortions?

Mr McRae—Senator, people are aware of the clinical methods people use. There is no way within the information which comes to us, which is simply Medicare claims, that we can go beyond that.

Senator HARRADINE—I understand that. I understand what you are saying. What I am asking is: where in the act does it prevent the professional services review committee from considering the questions that I have asked about late-term abortions and the methods used—whether the methods are appropriate and whether the late-term abortions are clinically relevant services?

Mr McRae—Senator, I will talk a little bit about process. We picked up on this because of an answer we gave earlier in writing where we talked about referring something to the Professional Review Division, which is part of the Health Insurance Commission. That is part of the Health bureaucracy and things can be passed on for them to look at. The professional services review committees you are talking about, in section 93 of the act, only get formed as part of a whole process whereby the Health Insurance Commission firstly refers an individual doctor to the Professional Services Review Agency. The agency reviews that doctor and decides whether or not they should form a committee to investigate the activities of that doctor.

Senator HARRADINE—Yes, I know.

Mr McRae—To get anywhere near the committees you have to go through all of those steps. The only thing that was said in response to the earlier letter about sex selection was that should such a case be brought to our attention, we would ask people in the Professional Review Division of the commission to have a look and decide whether anything further should be done.

Senator HARRADINE—Yes, I understand.

Mr McRae—We can only do that in the context of really quite specific cases.

Senator HARRADINE—Yes, but I cannot see anywhere in the legislation where you could not refer the issue for consideration to the professional services review committee as to whether or not they are clinically relevant services or whether they are appropriate practices. In respect of the clinically relevant services, how is that determined? Is it determined on the consideration of the abortionist that his peers would approve of what he is doing? Do you see what I am getting at? This issue is so subjective and it relates to the late-term abortions. Wouldn't it be useful for the practitioners to know, as well as those who are involved in the Medicare payments area, that there is some authoritive review of what are clinically relevant

services? They would have to consult, for example, the professional group; in this case presumably the Os and Gs. Isn't that so?

Mr McRae—Should a case be referred from—

Senator HARRADINE—No, I am not talking about a case being referred. Please advise me what is in the act which would prevent a reference of the matters that I have raised.

Mr Maskell-Knight—The professional services review committees are established to consider complaints of misbehaviour against a particular person.

Senator HARRADINE—Can you point in the act to what would prevent the professional services review committees—

Mr Maskell-Knight—It is not their function, Senator.

Senator HARRADINE—I have looked at the act. Can you show me in the act, either now or on notice, where they are prevented from doing what I have asked?

Senator Vanstone—Senator, you have offered that it be taken on notice. We will take it on notice.

Senator HARRADINE—Okay, thanks.

Senator Vanstone—It may be that what you are suggesting is something more appropriate for the state standards associations of the medical profession to do.

Senator HARRADINE—We are talking here about the payment of taxpayers' money and the federal act.

Senator Vanstone—I understand that, Senator. I am just saying the question you have put may be one that would be more appropriately addressed by a state standards authority, but we will take it on notice and get back to you.

Senator HARRADINE—Finally, has the department any information on costings for unlimited Medicare coverage for IVF treatment cycles?

Mr Maskell-Knight—Sorry, Senator—I missed the first part of that.

Senator HARRADINE—Has the department any information on costings for the unlimited Medicare covered IVF treatment cycles?

Mr Maskell-Knight—You mean removing the current limitation, Senator?

Senator HARRADINE—Yes.

Mr McRae—Bear with me and I will see if I can find it.

Senator HARRADINE—Perhaps you could send it around.

Mr Maskell-Knight—We are happy to take it on notice, if you wish, Senator.

Senator HARRADINE—I will be asking questions on notice, but if you have it there I would be grateful—and the actual increase in the cost to the taxpayer of this decision and a comparison with figures for limited treatment cycles costs. Perhaps you could take that on notice.

Mr McRae—Happy to.

Senator HARRADINE—Has any study been done by the department about whether or not, as a result of this decision, women concerned have felt under a little more undue pressure? I have heard of cases where women were happy that there were six cycles, wasn't it? They knew that that was it and they were able to get off the program.

Mr McRae—Senator, we have done no such studies.

Senator HARRADINE—Thank you.

Senator DENMAN—Has there been any increase in prescriptions for antidepressants?

Senator Vanstone—It is tempting to assume there has been, Senator.

Senator DENMAN—I want to know if there had been, yes.

Senator Vanstone—I am not a big pill popper myself. Perhaps I will leave it at that.

Senator DENMAN—You need a lunch break, Minister.

Senator Vanstone—Yes.

Mr Lennon—The short answer to your question, Senator, is that there has been a significant increase in the number of prescriptions for antidepressants funded through the Pharmaceutical Benefits Scheme.

Senator DENMAN—Do you know whether there has been an increase in prescriptions for younger people?

Mr Lennon—No, I do not, Senator. I imagine that the increase would be across the board.

Senator DENMAN—Thank you. That is all I need to ask.

Senator WEST—I move to practice nurses, if I may. I want to get a bit of an understanding of what is the aim of this, how it is anticipated that it will work.

Ms Briggs—The employment of practice nurses is designed to reduce workload pressures that general practices have and to improve the efficiency of general practices in rural and remote Australia and provincial and urban fringe areas. The idea is that patient care will be improved by the availability of clinically trained support staff to rural general practitioners and the employment of practice nurses will improve the sustainability of rural general practice.

Senator WEST—By what mechanisms is it proposed that this be funded?

Ms Briggs—The intention, Senator, is to provide support to general practitioners in part through the Practice Incentives Program, the PIP, but also there will be some payments that pick up support for education and training of nurses, but also for nursing scholarships.

Senator WEST—How much is expected to go to the Practice Incentives Program? What is the breakdown going to be for Practice Incentives Program and nurse training?

Ms Briggs—I have that information, Senator. Over four years the figure is $85.6 million. For education and support of nurses the figure is $11.6 million and for re-entry scholarships, $5.2 million.

Senator WEST—The Practice Incentives Program is $85.6 million.

Ms Briggs—Yes, Senator.

Senator WEST—How is that going to be administered? What is the process going to be? You say it is going under that program, but what is the process going to be? How are the practices going to be identified and that sort of thing?

Mr McRae—The payments are to be made through the Practice Incentives Program, which is a program in which we already have 85 per cent of all practices identified. We yet have to work through with the profession the detailed implementation of this to set it up in ways which both protect us from spending money when we should not and minimise the

degree of red tape for the profession. The expectation is that it will be basically through a claims type process from the profession, from the practices which have the nurses within the rural and identified urban areas.

Senator WEST—So you do not know yet how you are going to implement it?

Mr McRae—We do in the broad, but the detail needs to be worked through.

Senator WEST—In the broad is what?

Mr McRae—As I said, Senator, we would expect a claims type process from the profession, from the practices.

Senator WEST—A claims type process. How much do you think they are going to be claiming per practice nurse?

Mr McRae—The system is set up so that you would expect that on average the claim would be of the order of $8,000 per full-time equivalent doctor.

Senator WEST—Eight thousand dollars per full-time equivalent doctor.

Mr McRae—That is correct, Senator.

Senator WEST—They will have to pay the rest of that practice nurse's salary—presumably that goes towards the salary?

Mr McRae—One would assume so. It is fundamentally an incentive payment, but there will be situations where, if you have a larger practice, they will get more than one set of the $8,000. There will be situations where people choose to take on part-time nurses.

Senator WEST—So if you had an eight-person practice they could get $80,000?

Mr McRae—No.

Senator WEST—A 10-person practice is $80,000.

Ms Briggs—Sixty-four thousand, Senator.

Mr McRae—There will be a limit. I think it is five.

Senator WEST—So they get $40,000.

Mr McRae—Up to the equivalent of five people. The equivalent of about $40,000.

Senator WEST—Right. That still more than covers the cost of employing a nurse. How are you going to identify the areas of greatest need?

Mr McRae—There are two area selections: one is those areas defined as RRMA, rural and remote index 3 to 7; within the urban areas there is a selection process based upon the availability of doctors in a socioeconomic index.

Senator WEST—How is that going to work?

Mr Tongue—Senator, what we have done as the basis for developing the measure is look at work force availability in RRMAs 1 and 2 and identify those areas that have a short supply of general practitioners. In order to sift those, we have looked at the socioeconomic status of the locations around those practices, to determine the highest priority areas.

Senator WEST—How much are you going to give to RRMA 3 to 7 and RRMA 1 and 2?

Mr Tongue—Senator, as a guide there are practices in around 78 divisions of general practice eligible for the program. Around 66 divisions of general practice are in RRMAs 3 to 7, so the bulk of the funds will go to RRMAs 3 to 7.

Senator WEST—Have you worked out any ratios that you are going to be sticking to, or that you would expect?

Ms Briggs—Can you clarify what you are asking, please, Senator?

Senator WEST—I am wanting to know how much is going to go to RRMA 1 and 2 and RRMA 3 to 7.

Mr Tongue—Senator, I would be testing my memory, but of the roughly 1,500 or so practices likely to be eligible for the program, around 1,300 of them would be in RRMAs 3 to 7 and around 200 in RRMAs 1 and 2, so the program is predominantly targeted at rural and provincial remote areas.

Senator WEST—Of course, though, you have 1,300 in five RRMA groups and you have 1,200 in two RRMA groups, so there is a little distortion there. You are saying there are about 1,300 practices. I cannot do my maths off the top of my head. How many GPs are we talking about in these 1,300 full-time equivalents?

Mr McRae—It is about 3½ thousand, I think, Senator—perhaps a bit more, but of that order.

Senator WEST—When I do a quick calculation of 35,000 full-time equivalent GPs at $8,000 each, I come up with a total of $28 million. Is that going to work over four years, going quickly on my maths?

Ms Briggs—Here is a build-up of the costings to help you a bit, Senator. In terms of the Practice Incentives Program, in the first year it is $11 million, in the second year it is $23.4 million, in the third year it is $24.8 million and in the fourth year it is $26.4 million, so you can see the gradual trend up.

Senator WEST—In the first year you are going to have $4.1 million spent on other things, on the education and re-entry scholarships. Is that correct?

Ms Briggs—In the first year, Senator, we are going to spend about $3.5 million on education and re-entry scholarships and, of course, there is some departmental money that is additional to that.

Senator WEST—How much departmental money?

Ms Briggs—I am just looking for that, Senator.

Senator WEST—I hope it is going to come to $0.6 million.

Ms Briggs—That should be about right.

Senator WEST—If it is not, your PBS is wrong.

Ms Briggs—No, it is right, Senator. It is $0.55 million.

Senator WEST—With rounding, that is pretty close to $0.6 million. What are the out years for education and re-entry? Do you have those separately?

Ms Briggs—Yes, I have them, Senator. Education support to nurses is $2.3 million in 2001-02, then $2.6 million, then $3.1 million, then $3.7 million.

Senator WEST—Re-entries?

Ms Briggs—Re-entry scholarships: $1.3 million, $1.3 million, $1.3 million, $1.3 million.

Senator WEST—It does say in this that the nurses will be carrying out procedures. What procedures do you expect them to carry out that are over and above their nursing training, and what qualifications will you expect of these people?

Mr Tongue—Senator, in part we have to negotiate these arrangements between the medical profession and the nursing profession. We anticipate that we will be seeking experienced registered nurses and we are seeking to, effectively, purchase from the practices the nurses' engagement in chronic disease management and population health activities—for example, in undertaking health assessments that are part of the enhanced primary care items; working with those new measures around screening diabetes; asthma; and participating with patients in patient education around population health type initiatives.

Senator WEST—When you say you are seeking to negotiate, you have not at this stage. Prior to this coming in, there was no negotiation or consultation with any of the professional organisations?

Mr Tongue—This is an issue that has been abroad in general practice for about 18 months, and the Royal College of Nursing and the Royal Australian College of General Practitioners developed a position statement on the sorts of potential roles that they saw emerging for practice nurses.

Senator WEST—Have you involved the New South Wales College of Nursing in the consultation process?

Mr Tongue—To date, Senator, our discussions have principally been with general practice and the Royal College of Nursing. We have not gone further than that.

Senator WEST—I have to compliment you on at least going to the college rather than telling me the ANF wanted something. The college is the appropriate professional standards setter. How would these nurses vary from nurse practitioners? What is the role variation there?

Mr Tongue—Senator, we see that these nurses will be working as part of a team in general practice in primary care, where the GP is still the person accepting responsibility for prescribing, for example, whereas nurse practitioners might be working in a solo environment where they have some limited prescribing rights under state legislation.

Senator WEST—Because there is no doctor there?

Mr Tongue—Yes, often.

Senator WEST—This is going to help those communities that have medical practitioners in them. What are you going to do to assist those areas where there is no doctor and currently all they have is the registered nurse in the health centre, relying usually on the backup of the RFDS? What are you doing to assist them in their additional training and support?

Mr Tongue—Senator, it depends a little bit on the setting in which they are working. If it is something that is principally funded by the state government, it is the state government's responsibility.

Senator WEST—What is the difference between the work they are doing with the RFDS, usually as a backup, and what these practice nurses are going to be doing?

Mr Tongue—I anticipate, Senator, that many of the roles would be very similar. Say the nurses out at Tibooburra, for example, who—

Senator WEST—I was thinking Wanaaring was probably an even better example.

Mr Tongue—Yes. In that instance, part of their professional development is covered by our contractual arrangements with the RFDS.

Senator WEST—How much is there in the RFDS that you pay to undertake that?

Mr Tongue—I might ask Joanna Davidson to handle that one.

Ms Davidson—At the moment we give the RFDS about $18 million a year in funding. There are also, I think, a couple of additional smaller—

Senator WEST—Is that $18 million just for nurse education or is that the total?

Ms Davidson—That is the total funding. The funding we provide for the RFDS is for a variety of services, so I could not give you something that indicates how much is for nursing. There are a few other things I should mention, though, that we do in terms of supporting rural nurses. We have already in existence some postgraduate scholarships that the Royal College of Nursing administers for us for rural nurses. We have provided funding, as well, to the states to do some training in midwifery in rural areas. That was a joint arrangement between us and the states. We provided two years of funding for that. We also have provided funding to CRANA, which is involved in remote area nursing. There is a range of other initiatives we have where we provide support to rural nurses.

Senator WEST—Is the RFDS going to be eligible to tap into this program as well, given that they have what amounts to general practitioner services that they run across the remote areas, backed up by what would appear to be practice nurses or nurse practitioners?

Mr McRae—The answer to that, Senator, depends on whether the RFDS groups are currently registered with the Practice Incentives Program. I am not aware that any of them are.

Senator WEST—So they have not been included in any of the discussions that have taken place to date about this particular issue, or are likely to take place?

Mr McRae—No, as Mr Tongue said, we have basically only talked to the colleges to this point.

Senator WEST—Will the practice nurse actually have to be located in the physical office or the main practice of the doctors, or in fact would they be able to have—I am thinking of Hill End, now—a main practice in Bathurst and employ a practice nurse out in, say, Hill End?

Mr Tongue—Senator, we anticipate, subject to our negotiations with the two professional colleges, that practices might engage in a range of set-ups, if you like, depending on the nature of their patient population and the circumstances in which they are operating.

Senator WEST—So it will be quite possible for a practice to have a practice nurse and in fact for some sessions the registered nurse could be the one that is sent out to actually conduct sessions in an outlying practice, an outlying surgery?

Mr Tongue—Subject to our negotiations with professional colleges that it was appropriate for that to be included in the scope of the program, Senator.

Senator WEST—Which brings me back to possible duplication. If it is possible to do that, and you already have practice nurses, what is the difference, and why are you not looking at what is already in existence in some areas and working in consultation there? What consultations took place with the states?

Mr Tongue—None prior to the budget, Senator.

Senator WEST—None? So, regarding the states which have already entered into some sort of initiatives—at least New South Wales has—along this nurse practitioner line, you have ignored the work that they have done, or would appear to have done, to come up with your own model, which involves the doctors very heavily, or appears to involve the doctors very heavily. Have any of you read Betty Mitchell's oration given last year to the New South Wales College of Nursing graduation on oration night?

Mr McRae—No.

Senator WEST—No. I suggest you do, because that actually looks at this issue, and identifies some conflicts that are taking place on the ground and out in the real world, and the criticism that I keep getting from doctors because they want to control what nurses do. I hope this is not just another mechanism, through the back door, of allowing doctors to maintain, or attempt to maintain, that control of the nursing profession, because, if it was, I would be furious—not to mention that my nursing colleagues would be furious. So why was no consultation held with the states when the states have already moved in some of these areas?

Ms Briggs—Senator, in budget matters there are degrees of confidentiality which the government wishes to maintain, and it was not deemed appropriate to have these consultations with the states beforehand.

Senator WEST—But there have been negotiations with the doctors and the College of Nursing?

Ms Briggs—There have been, Senator, on a confidential basis.

Senator WEST—And the colleges of nursing and the doctors are more likely to keep the confidence than the states? Is that what you are saying?

Ms Briggs—I did not make a comment either way about that, Senator.

Senator WEST—Okay. I suppose it is up for me to make the comment, or think, or draw whatever conclusions I wish. Will the work that is undertaken by the practice nurse be a rebatable item?

Mr McRae—Senator, the rebatable items are always the work that is undertaken by the doctors. Doctors frequently now delegate work to the practice nurses for various minor activities—well, I should not say 'minor activities'.

Senator WEST—Excuse me. Yes, thank you—if you don't mind!

Mr McRae—Yes, I tried to claw that back as it came out!

Senator WEST—Yes, it came out too fast. I am a bit sensitive about all this, you know.

Mr McRae—I understand. I will say for those activities which are appropriate, including some vaccinations and all sorts of other things that go on within the practice. In those situations, the doctor takes responsibility; the doctor sees the patient, the nurse can undertake the tasks, and the doctor makes the claim. Those situations will be maintained.

Senator WEST—I have a slight problem there with the doctor taking the responsibility, because there are some issues for which the nurse will be taking responsibility.

Mr McRae—Most of those situations are situations which obtain now. We are not fundamentally looking at a change in the relationship between doctors and practice nurses; we are looking at trying to encourage more practice nurses into practices.

Senator WEST—There is a shortage of nurses across Australia. How is this going to impact upon the shortage of nurses?

Mr Tongue—Based on data available from the Australian Institute of Health and Welfare. They indicated that there were around 6½ thousand trained nurses not currently working in nursing in rural and remote areas. Around 40 per cent of those were either engaged in other employment or had family responsibilities. We have worked this measure up on the basis that there is a pool of nurses out in rural areas that might be attracted to this sort of work.

Senator WEST—That is fine; it is highly commendable. Are you going to undertake the same support for nurses to actually get them back into not just practice nursing but into public hospitals and so on?

Ms Davidson—The scholarships that we are offering for people who want to re-enter nursing were specifically designed not to go to nurses who are interested in going into the public hospital system, because a number of the state governments are already doing quite a bit in that area; a number of the states are offering scholarships and providing courses. So we have geared ours to complement what the states are already doing.

Senator WEST—How are you going to ensure that what you do complements what the states are already doing?

Ms Davidson—Making our scholarships available to people who want to either go into the community sector or into practice nurse situations, rather than to those who want to work in the hospitals.

Senator WEST—You say it is for practice nurses, but I wonder whether if a large practice was to employ a physio, a speech therapist or an occupational therapist that might also be a very good contribution to the practice, the work that is undertaken by the practice. But this will not help them do that, will it?

Ms Briggs—No, Senator, it will not cover that area. But, as you are aware more broadly, through programs such as the more allied health services arrangements that the government announced in the budget, but also through the Regional Health Services model, the government is putting more money into supporting allied health professionals more generally in the bush.

Senator WEST—When are you going to evaluate all the bits and pieces that you have done?

Ms Briggs—There is no evaluation schedule built into the More Doctors, Better Services strategy as far as I am aware, Senator.

Senator WEST—There is no evaluation built into this practice nurse strategy?

Mr McRae—In the practice nurse strategy, Senator, only inasmuch as we do regularly review the PIP program and, as this becomes part of that program, it will be a part of the evaluation of that, which we do probably every couple of years.

Senator WEST—What evaluation was done of this proposal before you actually announced it in the budget?

Ms Davidson—Sorry, in terms of evaluating the practice nurse proposal?

Senator WEST—Yes.

Mr Tongue—Senator, around 36 per cent of practices in Australia currently have practice nurses, but those practices tend to be larger, metropolitan practices. Over recent years, we have funded a number of projects that have looked at the roles of practice nurses in those practices, and, in part, we built this model based on that experience, and also the evidence

available to us from the UK and New Zealand, where in the order of 90 per cent plus of practices have practice nurses.

Senator WEST—I do not think it is really possible to compare general practice in Australia with New Zealand and the UK, is it?

Mr Tongue—No, Senator, but we try to draw on the lessons from their experience, about how to integrate, if you like, health professionals in a primary care setting.

Senator WEST—I thought we had a very wonderful system operating about 25 years ago, called community health, but anyway. Maybe you can take this on notice, but I would like the evidence that you used from the UK and New Zealand and I would like to have a look at the projects that you funded that obviously form the basis for this proposal. You do not think this is another way for doctors to earn a bit more money?

Mr McRae—Senator, the purpose is quite clearly, as I said earlier, to help doctors to be able to take on practice nurses, to enable both parties to do their jobs better.

Senator WEST—If you have a patient coming back each day for a dressing, they are not going to be charged, or is the doctor going to trot in, pat them on the head and walk out again? Swipe the card?

Ms Briggs—Under the MBS system the doctor is required to actually see the patient, Senator. One of the reasons that the funds towards the practice nurses initiative is being paid through the PIP is that that will sometimes not occur in this instance and indeed the person will go direct to the practice nurse.

Senator WEST—What agreements have been reached with doctors in relation to this form of incentive that is going to be introduced?

Mr McRae—There have been no agreements reached at this stage, Senator. We have to go through those processes yet.

Senator WEST—When do you expect that will happen?

Mr McRae—Over the next few months.

Senator WEST—And when do you expect to start making payments?

Mr McRae—Can you just bear with me while I look it up. Sorry, I should remember this. The funds allowed or the arithmetic done was based on a first payment in the February payment run of the PIP.

Senator WEST—So we are looking at February 2002?

Mr McRae—That is correct, Senator.

Senator WEST—What qualifications will you expect the registered nurses to have?

Mr Tongue—Senator, that is one of the issues we want to negotiate with the respective colleges to ensure that we are pitching—

Senator WEST—What additional training is going to be necessary?

Mr Tongue—It will depend on the outcome of those negotiations and the skill level that is out in the labour market, Senator.

Senator WEST—Who is going to be undertaking the training? How is this education money going to be expended and to whom?

Mr Tongue—Subject to those negotiations, Senator, some of it might be undertaken by the royal college; some of it might be undertaken by universities. We would anticipate that we would try and build some support structures around existing mechanisms, such as divisions of general practice, for ongoing professional support.

Senator WEST—What relevance do the divisions of general practice have for nursing education and ongoing support?

Mr Tongue—Senator, divisions are part of our infrastructure for dealing with general practice and, for example, through divisions practice managers might get access to further education and training opportunities. As we are doing this in the context of general practice, we would like to take the opportunity to broaden the role of divisions of general practice out of it to ensure that they cover the totality of general practice.

Senator WEST—I have this concern. You seem to be making doctors the lead and the control and the superior group in all of this, when in fact it should be more of a flat structure, with all of the professionals working together at an even level, because in some areas doctors will not have the lead on a particular decision that needs to be made, particular work that needs to be undertaken. It will be one of the other health professionals. Why is it the division of general practice doctors that are going to be doing all the leading and not incorporating somehow the information and the support that is available from not just the colleges of nursing and the universities but also the other health colleges, social work, speechies, OTs?

Mr Tongue—We view this as a fairly significant change process in general practice. We are taking a fairly traditionally based cottage industry and trying to build it as part of a set of primary care infrastructure, and in working this measure through we have to take general practitioners on a bit of a journey with us. If we started out tomorrow saying the world is going to change, we would lose an awful lot of them, and our potentially very worthwhile initiative would just founder.

Senator WEST—How do you intend to take them on this journey?

Mr Tongue—In rural areas we have already started, where divisions are engaged in the more allied health services program and also the regional health services program, and with the addition of this initiative we will be asking divisions and we will be working with them to broaden their horizon from that traditional, very narrowly focused GP-centric view of the world, to a broader engagement in primary care.

Senator WEST—And what involvement in the more allied health professionals has, say, the college that sets the standards for occupational therapists got?

Mr Tongue—For the moment, Senator, we have treated that as a funding initiative to increase the work force and we have been focused on that aspect of it, but then we will move on in the context of the regional health services initiative to broaden our engagement with those other colleges.

Senator WEST—Are you going to move on to do it in the future? It raises again my concerns that you have this initiative out there but you do not seem to be giving the college of the occupational therapists, for example, or physios or whoever the same support financially to enable them to participate.

Mr Tongue—I would characterise our engagement in this area as a relatively recent one. Typically the Commonwealth for 25, 30, 50 years has funded mainly general practice and pharmacy. Now we are moving into other territory and we are working through the implications of all of that, how we do business and who we have business relationships with.

Senator WEST—I have to say I think that is wonderful, the federal level to national level. It has only taken us a hundred years. Whereas the colleges did it some time ago, we are beginning to recognise that there is a role to be played. Maybe you can take it on notice and set out for me what you are actually undertaking—what you have done, what you are planning to do—to ensure that all of those colleges, the appropriate peak professional standard setters, not the union—I am not opposed to the union either—are actually beginning to have some involvement and what role you see them having in this division of general practice, which will presumably become more than general practice meaning doctor/ GP; it will actually mean rural practice or community practice. You might even want to consider a name change to get away from that very heavy medical model—

Ms Briggs—No, you are quite right, Senator. In some parts of the country discussions are occurring, even as we speak, about having divisions of primary health care. I think Alice Springs is certainly a case in point. That has already been done. Our thinking is that it would be appropriate to do so. Can I just clarify, Senator, what specifically you would like us to provide in response to your questions so that we can deliver what you need.

Senator WEST—I want to know what you have done and what you are planning to do—you are already starting to tell me the things that you are planning to do—to make this quantum leap from doctor orientation to a more broad, holistic medical—that is the impression I am getting from you.

Ms Briggs—We would be very happy to do that, Senator. We have quite a lot, probably 20 or 30, different developments that are happening in the primary care area, and we could provide that information. It will not be a short answer, but we will give it to you.

Senator WEST—This department is not good at getting its answers out speedily, so I expect it to be coming with the rest of the answers. I might leave practice nurses. How many scholarships for that $1.3 million?

Ms Briggs—400 a year.

Senator WEST—400 per year?

Ms Briggs—Yes, Senator.

Senator WEST—And what do you expect them to be doing when they undertake this?

Ms Davidson—It is primarily aimed at nurses who are already qualified who wish to re-enter nursing to do re-entry courses. There are quite a few of those.

Senator WEST—A refresher. Maybe I can put my hand up. How much is it going to be? I cannot do my maths here quickly.

Ms Davidson—It is up to $3,000 but it will not be a standard amount. It will depend on the course.

Senator WEST—It won't be? Why not?

Ms Davidson—Because the courses are of different lengths.

Senator WEST—In different states?

Ms Davidson—Yes.

Senator WEST—It really begs the question of when are we going to get a common refresher course. Anyway, I will take that up with my nursing colleagues. On the education side, what is that going to fund? Is that 2.3, 2.6, 3.1 and 3.7 going to go to institutions to provide the training courses?

Mr Tongue—Again that is something we would like to negotiate a little bit with the relevant colleges, to get their assessment of the level to which we need to train people and then work through the most appropriate mechanisms. It might be that it is a combination of some assistance to individuals, coupled with building some things in universities, coupled with some money to the colleges and divisional support. I envisage that it will be a range of players needing to work together.

Senator WEST—What changes are going to be necessary under the individual states' nurses registration acts to enable these people to undertake this role, because there seems to be an extension of the role. You are implying that they will be undertaking a number of procedures which are not normally expected to be undertaken by nurses. What is going to be required by each of the state's nurses registration acts for amendments that will be necessary there?

Ms Briggs—None. As I think Mr Tongue said earlier, a number of practices right across the country are already employing practice nurses in these kinds of areas. This is merely an expansion of that approach where the government is providing support for general practitioners in areas of doctor shortage to engage practice nurses.

Senator WEST—Why will this help in areas of doctor shortage? The real areas of doctor shortage have not got a doctor at all.

Ms Briggs—It will help in areas of doctor shortage because it is targeted to areas of doctor shortage, Senator.

Senator WEST—Which brings me back to the areas where there are no doctors at all.

Senator CROWLEY—That could be improved on. Could we please have another attempt to answer that.

Mr Tongue—As part of our rural doctor initiatives, where we are trying to encourage more rural doctors, we are making headway but we are conscious that communities do not have access to appropriate primary care services. We believe that by assisting those practices in rural areas to employ practice nurses, some of the work that GPs are currently doing in rural areas through sheer lack of availability of other health professionals might be able to be shared between the team of GP and practice nurse, such that the GP can devote themselves to their role principally as gateway to the pharmaceutical system, and the practice nurse might be able to pick up some of the responsibilities the GPs are currently discharging.

Senator WEST—I like the gateway to the pharmaceutical system. Of course, then that expands out to the fact that you need the whole of the health professionals there.

Mr Tongue—True.

Senator WEST—You don't think they will require any amendments to the nurses registration acts in any of the states?

Mr Tongue—No.

Senator WEST—Have you looked at the training that is being undertaken in New South Wales for those who are eligible to practise as nurse practitioners?

Mr Tongue—No, Senator.

Senator WEST—Are you going to?

Mr Tongue—I anticipate that we will have to engage very broadly with the whole regime of nursing training to ensure that we can sustain this measure in time.

Senator WEST—You could have looked at that without undertaking any divulging of what you are planning to the states. You didn't look at what training and additional qualifications are required by the nurse practitioners to get recognition in New South Wales?

Mr Tongue—No.

Senator WEST—I hope you will do so. I might leave the questions there, thank you.

CHAIR—Thank you. There is more for this particular outcome after lunch. Could we have an indication of how long you think outcome 2 will go. We are trying desperately to plan the arrival of further officers and I do not want to have them sitting here unnecessarily.

Senator WEST—I am sorry, Madam Chair. My leader is not here to tell me. Just bear with me.

CHAIR—All right. We will adjourn now and return at about 10 to 2, which is just over an hour, and hopefully we will have an indication then. Is it fair to say that outcome 2 will go for at least another hour?

Senator WEST—Yes, another hour.

CHAIR—We can organise personnel around that time frame. Thank you very much.

Proceedings suspended from 12.45 p.m. to 1.57 p.m.

CHAIR—I reconvene the meeting and I call on Senator Gibbs.

Senator GIBBS—I have a few questions on additional practice nurses for rural Australia and other areas of need. According to the PBS here this is to improve medical services in rural and regional Australia. The problem is in places like Queensland—and I am sure in the rest of Australia—is that quite often there is no doctor in town at all and there is a real shortage of doctors in rural and, indeed, regional towns. How will this impact there and how will this measure help people in those areas?

CHAIR—We have basically dealt with that question, Senator.

Senator GIBBS—The thing is this is for rural and regional, but the problem is that in a lot of these places there are not doctors.

Ms Briggs—The chairman is quite right; we dealt with that question before lunch, but I can just cover briefly what the government is doing in terms of trying to get doctors into rural and remote Australia. You might recall in the last budget, as part of its More Doctors, Better Services rural health strategy, the government announced some bonded scholarships and extra provider numbers so that extra people would train in medicine so they could become general practitioners. As well as that the government announced an increase of 50 places under the vocational training program and that takes the total number of places in that program for training in rural and remote parts of Australia to about 200 out of the 450 places in that program a year.

In addition, the government provides a number of other supports through various rural incentives programs to assist doctors and to encourage them to move to rural and remote Australia. The practice nurses initiative will build on this by providing a supportive environment in rural and remote areas and where, for example, there is only one doctor, it will free up some of that doctor's time to focus on the very important areas of treatment and diagnosis and the practice nurse will be doing other things. So, while you are right that in some parts of Australia we do not have doctors, the government's policy and its implementation of that policy is very definitely to increase those numbers of doctors.

Senator GIBBS—Thank you very much.

CHAIR—Any further questions.

Senator CHRIS EVANS—I want to ask about a couple of programs that were in last year's budget. I want to know what has happened to them: the Better Medication Management System and the Quality Incentives for Prescribing Pharmaceuticals. Both were large saving measures in the last budget. Sorry, one was in the last budget and the other was more recent. As I understand it, the Better Medication Management System was due to start on 1 July. Is that right?

Ms Badham—It is certainly true that in last year's budget it was scheduled to start on 1 July this year. It will not be. It has been deferred. In this budget we have done a phase adjustment of the savings and the incentive spending to 1 July next year.

Senator CHRIS EVANS—Does that mean it will not start until 1 July next year?

Ms Badham—That is right. There may be trials before that but it will not be rolled out nationally until at least that date.

Senator CHRIS EVANS—So at least 1 July 2002?

Ms Badham—That is correct.

Senator CHRIS EVANS—All right. Can you show me where that is in the budget papers? Is it hidden or is it not?

Ms Badham—I do not think it is explicit, no.

Senator CHRIS EVANS—Not 'hidden,' sorry.

Ms Badham—No, Senator, it is not explicit in the budget papers.

Senator CHRIS EVANS—It is not explicit in the budget papers, no. Could someone take me through then the impact that had. Last year I think you said you were going to save $21.6 million this year. I assume we did not save that.

Ms Badham—That is correct. Last year's $21.6 million is actually the spend, not the saving.

Senator CHRIS EVANS—That is the spend, is it? I see. You were going to spend early and save late, were you?

Ms Badham—That is correct. It is effectively budget neutral over a four-year period. What we have done is that the development costs are still what they were originally planned to be because deferring the implementation does not defer the development of the IT infrastructure and so on. But the PBS savings and the expenditure on incentives for doctors and pharmacists to participate have both been deferred by one year. The numbers are not quite the same because a proportion of PBS is saved against the different PBS estimates. The amount the proportion comes out at has changed slightly.

Senator CHRIS EVANS—You said 'budget neutral' but the figures I had looked like we were still spending a bit more than we were going to save. Have I got that wrong? I had 21, 15 spends and then 9 and 16 saves. Do we have the same figures?

Ms Badham—It was actually a net saving, but it was approximately $134 million over the four years.

Senator CHRIS EVANS—Net saving?

Ms Badham—The net saving—

Senator CHRIS EVANS—I had it that we were going to spend $21.6 million in health this year, $15.6 million next year and then save $9.7 million and $16 million and there were some very small amounts for Veterans' Affairs. Is that wrong?

Ms Badham—Yes, $21.6 million expend, $15.6 million expend, $9.7 million save and $16 million save, yes. Then an ongoing saving, yes.

Senator CHRIS EVANS—That does not get anywhere near $120 million saving, though. That still has a—

Ms Badham—This is the net figure. The figures that are in the budget papers are the net figure. Sorry, the $134 million that I was talking about was the gross figure. I do not think it is in the budget papers at all. The $134 million is the four years total expenditure and total savings approximately. The figures that are in the budget are the net each year.

Senator CHRIS EVANS—Yes, so there was going to be a net cost over four years in any event.

Ms Badham—A small net cost, yes.

Senator CHRIS EVANS—We were going to spend $21.6 million on Better Medication Management System this year. Did we?

Ms Badham—That is correct. Yes.

Senator CHRIS EVANS—So we spent the $21.6 million this year, or we will spend it.

Ms Badham—We will be spending 21.6 million.

Senator CHRIS EVANS—That is basically on budget.

Ms Badham—That is basically development costs.

Senator CHRIS EVANS—Will we spend $15 million next year?

Ms Badham—No.

Senator CHRIS EVANS—What is your revised estimate for that?

Ms Badham—Can I get back to you with that one? I will have to take that one on notice, Senator.

Senator CHRIS EVANS—Can you give me a rough idea? Is that net cost likely to be of the same sort of order?

Ms Badham—It will be of the same sort of order. None of the numbers have changed significantly. Each of those numbers, both the incentive payments and the PBS savings, have adjusted by approximately the same.

Senator CHRIS EVANS—So even though we are not running the program we are still spending the same amount of money.

Ms Badham—As I said, the development costs are the same. It still costs a certain amount of money to build the computer systems.

Senator CHRIS EVANS—I accept that.

Ms Badham—And to run the consultations and—

Senator CHRIS EVANS—It does not seem to make sense if you say, 'The program has been delayed a year but we are still going to spend exactly the same amount of money.' I accept that the development costs might be the same.

Ms Badham—Yes.

Senator CHRIS EVANS—But you seem to be saying it is the same for the out years as well. It just seems a bit counterintuitive; that is all.

Ms Badham—There is a core amount of money that comes down to about $15 million a year, which is the consultation, the communication, the IT costs. It starts as development costs and becomes operational costs. Then there are incentive funding and savings that offset each other, and those are the ones that have been deferred. Senator, I have the revision now. For 2001-02 there is a reduction in the spend of $6.275 million, for 2002-03 there is a reduction of $4.864 million, for 2003-04 there is a reduction of $1.282 million, and for 2004-05 there is an increased spend of $694,000.

Senator CHRIS EVANS—Are those net figures or the spends?

Ms Badham—That is the net figure, so that is the difference between the PBS savings and the expenditure on incentives.

Senator CHRIS EVANS—When you say in 2002-03 it is a reduction of $4.8 million, you say we are not going to save $9.7 million any more; we are going to save $9.7 million less $4.8 million?

Ms Badham—No, Senator. We are going to save more than $4.8 million that we did not expect to save because we have decreased the spend on incentives.

Senator CHRIS EVANS—I think it might be best if you took this on notice. Could you give me the chart which says, 'This is what we were going to spend and this is what we were going to save under proposal 1 and this is what we're going to spend and this is what we're going to save under the revised proposal.'

Ms Badham—By taking it on notice, I can give you a table which separates it rather than dealing with net figures.

Senator CHRIS EVANS—All right. If you could deal with both what was the original proposition and now what we are going to do, we would appreciate that. Otherwise I think we are going to go around in circles. I gather there is legislation underpinning this medication management scheme. Is that right?

Ms Badham—That is correct, Senator.

Senator CHRIS EVANS—Has the draft legislation been released?

Ms Badham—The exposure bill was released yesterday.

Senator CHRIS EVANS—How has it been received?

Ms Badham—I do not think it has been received yet.

Senator CHRIS EVANS—Is there a time frame for comment and implementation?

Ms Badham—We will be asking for the comments to be back to the department by 9 July.

Senator CHRIS EVANS—But as you are not starting the scheme until 1 July next year, I gather that means it will be in time to get the legislation passed, et cetera.

Ms Badham—That is part of the reason. We are also planning to have the legislation in place before the trials, before the field tests, which would occur on current schedule in the early half of next year.

Senator CHRIS EVANS—You need the legislation before you can do the trials, do you?

Ms Badham—It would make it much easier. It is not necessary but it does make it much easier.

Senator CHRIS EVANS—Have you selected who is involved in the trials, et cetera?

Ms Badham—No.

Senator CHRIS EVANS—What is the extent of the trials?

Ms Badham—That has not been decided either.

Senator CHRIS EVANS—Can I ask about the money we saved on quality incentives for prescribing pharmaceuticals?

Mr McRae—This was a measure that was put through two years ago. The idea behind it was that, with appropriate education, you could provide incentives to general practitioners to change some of their prescribing in directions which improved the quality of prescribing and saved money at the same time and, should this happen, some of those savings would be able to be redirected back to the medical profession. This was only ever really going to work in that form if we had substantive support from the profession, and this is one of those areas where we had in fact talked to them before the thing was put in place in the budget. However, in the post-budget period they had second thoughts and it became clear we were not going to get the sort of strong support we would need for this to work in its original form.

We have therefore been through obviously quite prolonged—because it is two years ago—consultation and negotiation and toing-and-froing with the profession to try and rebuild something that works along the same lines. The proposal currently in place, which is yet to be finalised, is that rather than any funds that go back to the profession going back to individual doctors they would go back through divisions for divisions to undertake appropriate programs within their areas. This is still something we are working through. It means in terms of savings that clearly none have been achieved because it has not happened. There are still savings on the books but they are to begin next year now rather than a year or two back, when they were originally expected to begin, because they have been pushed out over time.

Senator CHRIS EVANS—We have given up on the savings of $28 million and $38 million for 1999-2000, 2000-01. How have we dealt with that in terms of the budget? Where is that reflected in the budget?

Mr McRae—It does not get reflected in the budget papers per se because they are outlays under the Pharmaceutical Benefits Scheme, which is a special appropriation. Being a special appropriation, it is not necessary to explicitly appropriate any additional funds. They come through in the normal course of events.

Senator CHRIS EVANS—This partly explains why we had the $700 million increase in the PBAC costs, does it, in the sense that those savings were not achieved?

Mr McRae—In mechanical terms I guess that is right, Senator, yes.

Senator CHRIS EVANS—That is what I was trying to understand. I was not trying to hold you to a political comment. That is where we would have seen the impact if they had been achieved. They have not been, so what have you now budgeted for next year and the year after from savings from this proposal?

Mr McRae—The savings we expect to get on the pharmaceutical benefits side now are $4.7 million next year, 2001-02; $14.9 million in 2002-03; $32.3 million in 2003-04; and $59.2 million in 2004-05.

Senator CHRIS EVANS—A much more modest target than you first set out with.

Mr McRae—Indeed, for a number of reasons, one of them being that the original proposal was that the funds to be returned to the profession would be targeted much more directly at individual doctors. Targeting them back through the divisions is a much more diffuse way of doing it, so the individual impacts will not be quite the same.

Senator CHRIS EVANS—I do not quite understand what that means, Mr McRae.

Mr McRae—Sorry. The proposal was that the savings be shared with the profession and the funds go back to the profession. In the original notion the funds could have gone as direct payments to doctors. Under the current version they will go as payments to the divisions of general practice so that those divisions can expand their programs within their areas of interest. This will mean that there are more services being provided in those areas. Some of those may well be provided by some of the doctors who are engaged in the program.

Senator CHRIS EVANS—What sorts of services will the divisions be providing, though, with this money? What do you mean by 'services they will provide'?

Mr McRae—They provide educational services for their members. They take people on sessional payments to run clinics. Divisions do a vast range of different things.

Senator CHRIS EVANS—But less likely to be services to citizens and more likely to be services in terms of education—

Mr McRae—No. My second example was that they do run clinics. They take doctors in on sessional payments to do clinic type work of the sort that is not normally charged under the medical benefits schedule. There is scope for them to do quite a range of things. Some of them would be for the doctors and some of them would be for the community.

Senator CHRIS EVANS—Is there any meat on this proposition yet? Where are we at with that proposition?

Mr McRae—Where we are at is that the Australian Divisions of General Practice, which is the national coordinating body of the divisions, has put together quite a formal proposal to work this through, so there is quite a lot of meat on that. That is now being worked through with the other GP representative groups before we can sign off on it.

Senator CHRIS EVANS—When would you have to have that signed off for it to be effective for next financial year?

Mr McRae—One could start this at virtually any point in the year, when you are organised to do so. For the amounts of money we are talking about, which are really quite small, if we could get the thing moving by the end of the calendar year we would be okay, so if we can get agreement within the next three months we should be okay.

Senator WEST—Can I turn to the relative value study, please. I understand that was a review of the Medicare Benefits Schedule over six years. Is that correct?

Mr McRae—Yes.

Senator WEST—It was intended to develop a new MBS which would encourage scheduled fee compliance and provide a basis for review?

Mr McRae—There was a series of terms of reference, which I do not have in front of me, but that is certainly part of it. It was intended to make the schedule more up to date and fairer.

Senator WEST—There were a number of consultancies undertaken to constitute the study; is that correct?

Mr McRae—That is correct, Senator.

Senator WEST—When was the report of that given to the minister?

Mr McRae—There was a first report given in late 1997 or early 1998 on the first terms of reference around structure of attendance items. There were three major reports given to the minister on 21 December just gone.

Senator WEST—Am I correct in assuming that at that stage the study was effectively terminated?

Mr McRae—I would not have said so. Those three reports of themselves do not complete the task.

Senator WEST—What will complete the task?

Mr McRae—If you want to put together a new schedule you have to actually bring those three studies together. They are three quite separate tasks that need to be brought together to provide a new schedule.

Senator WEST—Has that been done?

Mr McRae—Those three reports each contained a reasonable number of components on which there was not agreement either from the consultants or between the members of the Medicare Schedule Review Board. The actual methodology for bringing those three things together was also not agreed within the board. If I take your question as being whether it has been done in a formally agreed, uniform, one and only way, the answer is no. Clearly you would have seen from the media that the AMA has tried to pull those things together in one way. The department has been working on pulling them together ourselves. We have managed to do that too but under what we assume is quite a different set of decisions on the undecided things, since we have somewhat different answers.

Senator WEST—Is it correct that there was an announcement in the budget of expenditure of $300 million over four years for GP rebates?

Mr McRae—That is correct, Senator.

Senator WEST—How did the department arrive at the expenditure figure of $300 million?

Mr McRae—That $300 million over three years is $85 million in a full year. That was fundamentally a policy decision as to an appropriate amount of money to spend coming from the government rather than an explicit outcome of the study.

Senator WEST—Would you like to run that one past me again? I will just think about it.

Mr McRae—The government, in its budget processes, has some areas in which it chooses how much it wishes to spend on some things. The outcomes of all our work on the study showed that GPs generally were behind, particularly relative to the moneys paid on procedures. It was appropriate that it be considered that more money be provided to general practice through the rebates. The decision as to the amount of money was almost a policy decision of government rather than a technically driven number.

Senator WEST—So it was something that basically came out of cabinet? I am not asking for what was given to them or anything, Minister, but I just wanted to clarify that it was a decision that was arrived at by cabinet in the ERC process.

Mr McRae—I think that is the way to describe it, Senator.

Senator WEST—Was the figure based on any form of modelling?

Mr McRae—As I was saying, clearly we have been doing modelling, as has the AMA. The figure is not driven in any explicit way by that modelling but it is not inconsistent. If you like, we can give you copies of that modelling.

Senator WEST—I would love that, thank you. What will the new RVS fee be for a level B consultation? That is an and/or 15-minute GP consult.

Mr McRae—I am sorry, I cannot answer that. The reason I cannot answer it is—I note it was in the papers—it was the intent of the government to negotiate with the profession so that this new money works towards supporting longer attendance items and works towards the new proposed item structure which the RVS put out in late 1997 or early 1998. This means, therefore, that we will actually have to work that through. The way in which that $80 million a year will be divided, if you like, is yet to be worked through. We do not know.

Senator WEST—So the process has not yet been determined?

Mr McRae—There is a process in the sense that we have a GP memorandum of understanding group with whom we will work. The way in which that group and we will eventually determine to spread the money is certainly not determined.

Senator WEST—Will that be in consultation with the group?

Mr McRae—Yes.

Senator WEST—Any idea when this process is expected to be completed?

Mr McRae—We hope to put the changes into the Medicare benefits schedule for 1 November.

Senator WEST—Will specialist consultations and procedures be adjusted to implement the RVS?

Mr McRae—There is no proposal at this stage to do that.

Senator WEST—At this stage?

Mr McRae—No.

Senator WEST—There was some speculation through some media leaks, for which Mr Max Moore-Wilton is likely to cop a pay cut.

Senator CHRIS EVANS—Not as much as some members in government.

Senator WEST—I think I recall seeing on the copy of the leaked document that it was certainly speculated that it was a possibility, but at this stage it is not going to happen?

Mr McRae—That is correct, Senator, it is not.

Senator WEST—What does the department's modelling show in relation to these groups?

Mr McRae—Sorry, which groups?

Senator WEST—Specialist consultations and procedures.

Mr McRae—It fundamentally shows that procedures are currently overfunded.

Senator WEST—That is in that bundle of modelling.

Mr McRae—It is in the book. It shows that the consultations for specialists and consulting physicians are somewhat underfunded and GPs are rather more underfunded.

Senator WEST—What is the total cost to the government of conducting the RVS over the six years?

Mr McRae—The figures that are floated are between $8 million and $10 million. I will have to take on notice the precise figure.

Senator WEST—That is fine, thank you. That has finished RVS.

Senator DENMAN—I have some questions on the PET scanner. Mr Keith, I am assuming that it is to you I ask these questions. Can you tell me what were the distinct roles played between the two groups looking at this and advising the department: the supporting committee and the steering committee?

Mr Keith—The supporting committee was established under the auspice of the Medical Services Advisory Committee, which is established by the government to provide specialised information on whether items should receive public funding. The steering committee was established to advise the government on how PET services should be established across Australia. So one was a technical medical committee, a scientific committee, and the other one was a policy committee. If the scientific committee said that this was the technology that should be publicly funded, the other committee was a policy committee on how it would operate.

Senator DENMAN—Was there any overlap between those committees as far as personnel are concerned?

Mr Keith—Yes.

Senator DENMAN—How many?

Mr Maskell-Knight—Subject to correction from my colleague, once he has his spectacles on, there was an overlap of two. The chair of the steering committee was an ex officio member of the supporting committee and, the other way round, the chair of the supporting committee was an ex officio member of the steering committee.

Senator DENMAN—Has there been conflict between those two committees?

Mr Keith—Not that I am aware of, Senator.

Senator DENMAN—I am aware of some conflict.

Mr Keith—I think there has been some conflict from providers with the report of the technical committee. There has been a difference of view as to what was appropriate and what was not appropriate, and that is not unusual in that arena where people are using the technology. They believe it is state-of-the-art technology and that it should receive public funding. When that technology is reviewed, the specialist technical committee may come up with a different view.

Mr Maskell-Knight—I might just intervene, Senator. I have just read the lists again. I would like to add to my earlier answer. Dr John Primrose, who is a medical adviser in the department, was also a member of both committees.

Senator DENMAN—From my information, there was quite a difference in the recommendations that were made here in Australia and that were made in America. Can you comment on those?

Mr Keith—There is a degree of discussion about whether PET has progressed to become a technology which has moved beyond the research process. There are different views as to the usefulness of PET throughout the world, in fact. It is approved for certain things in America. A review in several countries of Europe has suggested that it is not a proven technology.

When MSAC looked at it there was concern about its cost effectiveness and therefore people were cautious about whether it actually passed that particular criteria.

Senator DENMAN—Have MSAC looked at the uses of the PET scanner beyond cancer?

Mr Keith—Yes.

Senator DENMAN—Are they going to investigate that further for use here in Australia?

Mr Keith—Yes. MSAC are at the stage of just concluding a report on a number of additional indications and, once that is concluded, they are going to move on to other indications.

Senator DENMAN—Can you tell me whether there are going to be any of these scanners in public hospitals? There are none in Tasmania in a public hospital, for instance. Is there going to be one? Do you know?

Mr Keith—The report of the policy committee, the steering committee, said that there should be seven publicly funded machines in Australia: one in Queensland, two in New South Wales, two in Victoria, one in South Australia and one in Western Australia.

Senator DENMAN—So Tasmania misses out yet again.

Mr Keith—Currently, tender processes are being developed for where those scanners would go in each state.

Senator DENMAN—If, for instance, a Tasmanian physician or surgeon wanted to recommend a patient to have one of these scans and they had to go to Melbourne for it—a public patient—who would bear the cost of that? That happens frequently in Tasmania and, because of the lack of equipment, we are shipped off to Melbourne usually because that is the closest place.

Mr Maskell-Knight—I believe if it is a patient in the public hospital system then it is the responsibility of the state government to arrange transport to wherever that technology is.

Senator DENMAN—Can you tell me what the Medicare rebate will be? Has that been set for one of these procedures?

Mr Keith—That is currently the subject of discussion for establishing the tender process, so the answer is no. There are currently fees which are between, from memory, $1,900 and $2,500 for the two existing machines—one in New South Wales and one in Victoria—but they will be revised.

Senator DENMAN—Why haven't the tenders been called for PET scanning, as recommended in August in the review?

Mr Keith—The process has been far more complex and complicated than we first envisaged in terms of establishing standards in consultation with the profession, in determining what the appropriate fee should be and awaiting MSAC's report on the particular indications that should come under PET.

Senator DENMAN—Are you aware of the growing waiting lists across the country for this scanning procedure? I believe there is quite a large number of people on a waiting list.

Mr Keith—That is not the evidence that we have. For instance, in South Australia the state government have established a PET machine at the Royal Adelaide Hospital. They get their radiopharmaceuticals from Victoria and, from discussions, we do not understand that they are under pressure for more radiopharmaceuticals.

Senator DENMAN—That is not the impression I have been given. Do you know whether the quality of life issue has been looked at—I am using cancer but I realise it has wider implications as well for other diagnoses—as to whether a cancer can be more accurately diagnosed and therefore a decision made about whether surgery ought or ought not to occur?

Mr Keith—I could have a stab at that answer. I would rather defer to Dr Primrose on that.

Dr Primrose—In general, the main role of positron emission tomography in the management of cancer is to detect hidden or occult metastases. The rationale is that, if you have a patient who apparently is suitable for radical treatment, whether it be surgery or radiotherapy, on the basis of clinical examination and routine investigations including CT scan, we know that a certain proportion of those patients are still going to have metastatic disease that is not detected. PET has been shown in the case of several diseases to be advantageous in detecting those hidden secondaries.

Senator DENMAN—It has been looked at, according to Mr Keith, in a wider area than just cancer. It has been suggested to me that it can also be useful to diagnose Alzheimers and those sorts of things.

Dr Primrose—Yes. The first round of the evaluation also looked at the role of PET in detecting areas of the heart muscle or myocardium which had an inadequate blood supply and thus could be potentially salvaged by a surgical revascularisation. The other area that was looked at was refractory epilepsy. With people who have epilepsy that cannot be controlled by standard medications we are looking for a small epileptic focus, like an area of scarring or a small tumour, which could be resected and thus alleviate the epilepsy. Probably in the third or fourth round of the evaluations we will be looking at the role of PET in the assessment of people with dementia.

Senator DENMAN—When will that occur?

Dr Primrose—I would have thought, at this stage, we would probably be looking at the report on that by the first half of next year.

Senator DENMAN—Do you see it as a cost saving measure to have more of these scanners? If we were able to do what you have just suggested, then surely in the long run it would save governments on their budget, even though I know it is an expensive procedure.

Dr Primrose—If the theoretical promise were achieved it could be cost effective. You are adding PET to other investigations, but the potential pay-off is in avoiding radical treatment which is costly in terms of money and side effects which would not have an outcome. The problem is that for most applications of PET we have information on its safety—and we know it is very safe—and in many cases we know it has diagnostic accuracy that is superior to or else equal to competing modalities like CT and MRI, but we have very few where we know that it actually has an impact on clinical decision making or patient management and even fewer where there is a direct link to health outcomes. We really need to have that data to show that the promise of PET is actually translated into clinical reality and thus into economic outcomes as well.

Mr Keith—Can I just add to that, Senator Denman, that if it had been demonstrable that there was a cost saving I see that many hospitals would have made an investment in that to achieve that saving down the track. They have not done that, so there is a question mark over that. Part of the limited release of PET for public funding is to establish appropriate data collection so that we can test the hypothesis to see whether we do get those benefits rather than just putting it on the open schedule, and that is another technology that has—

Senator DENMAN—How much do these machines cost?

Mr Keith—The cost of the machine is between $1.6 million and $3 million. The supporting cyclatron, where they need to produce their own radioisotopes, is between $2.8 and $4 million. It is quite an investment.

Senator DENMAN—Thank you.

Senator CHRIS EVANS—I would like to ask a couple of MRI questions while we are on expensive machines. I will start generally. As I recall, the 1998 MRI agreement was for three years. Has that been renegotiated?

Mr Keith—Yes, that has been renegotiated for an additional two years.

Senator CHRIS EVANS—Is that in place now?

Mr Keith—Yes.

Senator CHRIS EVANS—When was that effective from?

Mr Keith—It was done as part of last year's budget.

Senator CHRIS EVANS—How much over were we in terms of the agreed number of scans in the last agreement? It was about 400,000 scans, was it not?

Mr Keith—In the first three years of the agreement we paid for, under the agreement, 403,000 scans which can be nominally broken down into 100,000 in the first year, 148,000 in the second year and 155,000 in the third year. In the first year we were about 7,500 scans over which, in terms of the government top-up contribution, was worth $3.2 million. In the second year we were 15,500 scans over, which is $6.54 million. In the third year we are projecting that we would be about 20,000 to 30,000 scans over at an estimated cost of $13.25 million.

Senator CHRIS EVANS—You are saying that is an estimate. Is that third year this year?

Mr Keith—That is this year.

Senator CHRIS EVANS—Yes, because you said it was part of last year's budget, but the new agreement does not come in until next financial year.

Mr Keith—We added an additional two years onto the three years and we were at the end of the second year. That was the third year this year and then the two additional years.

Senator CHRIS EVANS—You will have to say that to me again, Mr Keith. I think that lost me. We had a three-year agreement that started in 1998. Was that based on financial years?

Mr Keith—Yes.

Senator CHRIS EVANS—So it was 1998-99.

Mr Keith—It was 1999-2000.

Senator CHRIS EVANS—So that would have the first agreement ending at the end of June this year.

Mr Keith—That is right, but we extended that agreement for a further two years.

Senator CHRIS EVANS—But the extension does not start until next financial year. Is that fair?

Mr Keith—That is right.

Senator CHRIS EVANS—So you have the results of where you were over the first agreement? Short of a month you have an estimate?

Mr Keith—Yes.

Senator CHRIS EVANS—You are pretty close; you know where you are going. What have you contracted for in the agreement for the next two years?

Mr Keith—We are currently negotiating that. When I said we had extended the agreement, that meant the whole diagnostic imaging agreement of which this MRI is a component.

Senator CHRIS EVANS—So you actually have not finalised an agreement on the MRI numbers.

Mr Keith—No.

Senator CHRIS EVANS—So we do not know how many scans you have agreed to fund or target to fund for these next two years yet.

Mr Keith—No.

Senator CHRIS EVANS—When will we know that?

Mr Keith—I am not sure, Senator. That is subject to negotiations between ourselves and the profession, but I would envisage by the end of this financial year.

Senator CHRIS EVANS—All right. Have you been able to do a breakdown on the number of scans funded for each machine eligible for Medicare?

Mr Keith—I do not have that data here.

Senator CHRIS EVANS—Can you take that on notice?

Mr Keith—Yes.

Senator CHRIS EVANS—Part of the argument was this distributional argument about where they belong, wasn't it? I would be interested in that, if you could take it on notice.

Mr Keith—Could you indicate how you would want that information? Do you want it in terms of a spread rather than individual machines?

Senator CHRIS EVANS—I think I am happy to be guided by you in terms of how it comes in the sense that I do not want to create a lot of additional work. If you have it organised in a particular way then I do not want to set you off on another tangent. I am just interested in, as you say, the spread and the locational issues about whether we are funding the right machines in the right places. Could you take that on notice?

Mr Keith—Yes.

Senator CHRIS EVANS—That leads me into the questions I wanted to ask on the Blandford report about seven new MRIs. I think you put six licences up for tender, didn't you?

Mr Keith—Yes.

Senator CHRIS EVANS—What is the timing on the tender process?

Mr Keith—The tenders close on 26 June.

Mr Maskell-Knight—They were advertised the Saturday before the budget.

Senator CHRIS EVANS—Everything happens a week before the budget in relation to MRI, doesn't it? There is a nice symmetry about it all. That is good.

Mr Keith—We did not want to make it difficult for you.

Senator CHRIS EVANS—At least it was advertised more widely this time, I presume. Anyway, we have six licences rather than the seven. I am going to do my impersonation of Senator Denman and say, 'Why did WA miss out?'

Mr Maskell-Knight—One of the recommendations of the Blandford review was that there should be an MRI monitoring and evaluation group to oversee future policy in that area, and that monitoring and evaluation group has been in charge of developing the tender criteria and tender process. It formed the view that there was not a need for another machine in Western Australia at this time. One of the criteria it took into account was that we found there was another machine in Western Australia which became eligible for benefits.

Senator CHRIS EVANS—Where did you find this machine?

Mr Maskell-Knight—It is called the Perth Imaging Group. They lost their eligibility some time ago as a result of the revised cut-off dates for units on order. They subsequently argued that the unit was replacement equipment for a unit ordered under a pre-existing contract and, after advice from the Australian Government Solicitor, we and the Health Insurance Commission concluded we had to let it back in.

Senator CHRIS EVANS—This was one of those that was ruled out on the basis that it was ordered after the budget decision, was it?

Mr Maskell-Knight—Yes.

Senator CHRIS EVANS—It was not one of the ones subject to legal action?

Mr Maskell-Knight—I do not know, Senator. I cannot comment on that.

Senator CHRIS EVANS—I thought you guys or the HIC were responsible for that action. Who would I ask if you do not know? Should I invite the HIC to the table?

Mr Maskell-Knight—We will get our colleagues from the Health Insurance Commission to answer that, Senator.

Senator CHRIS EVANS—I am interested in this machine owned by the Perth Imaging Group that has been let back in for eligibility for Medicare rebates. Could you explain from your perspective the status of that machine and that application?

Dr Harmer—Senator, I am not sure that I have all the detail of that with me but, as I understand it, it was a machine that we believed initially was a new order, but Perth Imaging claimed that it was a replacement machine that had been on order. When we put the information sent to us from Perth Imaging to the Australian Government Solicitor, the solicitor confirmed that on the evidence it was an eligible machine because it was a replacement machine. Therefore we had, we believed, no choice but to reinstate it.

Senator CHRIS EVANS—Just refresh my memory. Machines were not eligible unless it could be proved they were ordered before budget night under the revised regulation, as I recall.

Mr Keith—In place or ordered.

Senator CHRIS EVANS—And the claim for this one is that it was a replacement of one they already had in place. Is that right?

Dr Harmer—Correct.

Senator CHRIS EVANS—And you did not know they had it in place?

Dr Harmer—Senator, I would like to take the specific question on notice in this and we will get back to you. I do not have the detail of that with me, I am sorry.

Senator CHRIS EVANS—Could you identify for me the status and how you treated that and why?

Dr Harmer—Yes, we can.

Senator CHRIS EVANS—We have been debating this for some years now. We did find out that this was a replacement machine rather than a new machine, but why didn't we know that two years ago?

Dr Harmer—Senator, it is a complicated story. I would prefer to take that element on notice. I do not have a recollection and I would prefer to take that on notice, if I could.

Senator CHRIS EVANS—All right, Dr Harmer. No-one would argue that this is not a complicated story, least of all me.

Dr Harmer—It is indeed.

Senator CHRIS EVANS—You are on safe ground there. When did this machine come to light, then? When did the department make the decision that it was to be treated as an eligible machine?

Dr Harmer—To try to be helpful, Senator, I am going to take a stab at it, but it would be subject to correction in my written response.

Senator CHRIS EVANS—Thank you. Within a couple of months would be good.

Dr Harmer—I think it was towards the end of last year. I suspect it was November or December last year, from memory. Sorry, I am already corrected. It was earlier this year, I am told.

Senator CHRIS EVANS—It was quite recent?

Dr Harmer—It was.

Senator CHRIS EVANS—We did do a fair deal of examination of machines, orders, potential legal action—HIC and DPP. We have been through them at length. Why, again, so late in the piece did we suddenly get what seems to be new information?

Dr Harmer—Again, Senator, I would prefer to take that on notice for fear that I have already misled you once by having a stab at the date. It was on the legal advice. We had determined that we did not believe it was eligible, but with information—

Senator CHRIS EVANS—But that was a decision you would have taken, what, a year or more before? When did you take that decision? That was in 1999?

Dr Harmer—Again, Senator, I am sorry.

Senator CHRIS EVANS—But there is no doubt that that was a decision taken some time before, wasn't it?

Dr Harmer—It was some time ago. That is correct, yes.

Senator CHRIS EVANS—All the estimates roll into one, I know, but we did that a long time ago. You had a new regulation and it was not eligible under your call. We discussed before the fact that there seemed to be claims being made long after the regulation had been changed and long after the cut-off date had been set, and that they seemed to be particularly slow coming in. But I fail to understand, after the media attention, notoriety, legal action, et cetera, how it took so long for this to come to light.

Dr Harmer—Again, Senator, I would prefer to take it on notice, other than to say that I think we were seeking legal advice and it took some time before we were able to confirm that it was indeed an eligible machine and a replacement machine. I suspect that part of the delay was waiting for the legal advice, but again I would prefer, for fear of misleading you on that issue and because I do not have a recollection, to take it on notice.

Senator CHRIS EVANS—There was some sort of legal advice being sought and some interchange, no doubt, with Perth Imaging about whether or not it was a new machine or a replacement machine.

Dr Harmer—Exactly.

Senator CHRIS EVANS—And that dragged on until the end of last year or early this year before that was clarified?

Dr Harmer—Correct.

Senator CHRIS EVANS—I would appreciate what information you could give, Dr Harmer, on notice about that matter. From the department's point of view you then notified at some stage early this year that there was another machine eligible for Medicare rebates. Is that all?

Dr Harmer—That is correct, Senator.

Senator CHRIS EVANS—Does that mean you have backpaid the rebates on the machine for the interim period?

Mr Keith—As I understand it, they have been paid back to 1 November 1999.

Senator CHRIS EVANS—They maintained a record of treatments, et cetera, and then had to await this decision before they could seek payment?

Mr Maskell-Knight—I am not sure how it would have worked. I am not sure if our colleagues can help us, but I am not aware of that.

Dr Mould—Perth Imaging had maintained records of the investigations they had performed up to the date on which the machine was reinstated. They have submitted those claims and they are in the process of being paid now.

Senator CHRIS EVANS—What sort of amount are we talking about for that period?

Dr Mould—I cannot correctly advise you of that. However, I can find out for you.

Senator CHRIS EVANS—If you take that on notice I would be interested. Why was it a November 1999 date? Was that the change of the regulations?

Dr Harmer—Yes.

Senator CHRIS EVANS—We now find we have an extra machine located in Western Australia. But the Perth Imaging Group, as I recall—I think they are around the corner from my place—are Perth located, aren't they?

Dr Harmer—They are at Mount Medical Centre.

Senator CHRIS EVANS—It is a long corner, but not far. As I understood this, the need identified in the Blandford report was for the south-west of Western Australia. We had a shortage of services available in the south-west. I gather you are now telling me that we have decided not to have a machine in the south-west because we have one in the centre of Perth.

Mr Maskell-Knight—I did not say that was the only reason, Senator, but it was certainly a contributing factor. There was a range of factors that, as I understand it, the committee took

into account, including the transport patterns within the area, where outside Perth would be an appropriate place to put a machine so that it would be accessible generally to people in that area. A range of factors was considered by the committee.

Senator CHRIS EVANS—But in effect you have not put any machine in. You have taken a decision not to put a machine in. Isn't that a fair enough statement?

Mr Maskell-Knight—We have not advertised for a machine in Western Australia, yes.

Senator CHRIS EVANS—Yet?

Mr Maskell-Knight—Yes, I said. Yes, we have not.

Senator CHRIS EVANS—There is no suggestion that it is on hold or whatever. You are currently only tendering for six and that does not include Western Australia. Part of the explanation for that is that you actually have one more in Perth than you thought you would have. Is that fair?

Mr Maskell-Knight—That is fair.

Senator CHRIS EVANS—What are we doing about the need in the south-west that was identified by Professor Blandford?

Mr Maskell-Knight—At the moment, I suppose the short answer is nothing. The committee will continue to review usage and utilisation patterns, and at some stage in the future it may reconsider the decision.

Senator CHRIS EVANS—Has the department had any negotiations or contact with a group about placing a machine in the Bunbury hospital?

Mr Maskell-Knight—I believe officers in the division have been contacted by people from Bunbury expressing disappointment that there was not a Western Australian area of need identified in the tender.

Senator CHRIS EVANS—It was more a question about whether you had any contact with a firm called Imaging the South prior to the calling of the tenders, which I understand operate a machine at the Bunbury hospital. It is about what contact you had with them and how you would characterise your contact with them.

Mr Maskell-Knight—We will have to take that on notice, Senator. Not all the staff that might have had such contact would be here today.

Senator CHRIS EVANS—I appreciate that, Mr Maskell-Knight. I just wondered whether you or any of the officers here had any knowledge of contact with the company or with the Bunbury hospital about the location of the machine. Are you aware that there is an MRI machine located in the Bunbury Regional Hospital?

Mr Maskell-Knight—I am now, yes.

Senator CHRIS EVANS—I would not just take my word for it.

Senator WEST—Don't trust him, he might lead you astray.

Mr Maskell-Knight—I did know, Senator, but personally this is not my area of responsibility. I only found out about it last week.

Senator Vanstone—What is this—attack public servants day?

Senator CHRIS EVANS—I think Mr Maskell-Knight would attest that he has had the easiest run he has had in years so far. I have not even started on him yet.

Senator Vanstone—You can be a bit nicer. Give it a go.

Senator CHRIS EVANS—I just want to be very clear about what the department knows. You said you would take that on notice and that is fair enough. I would like to know what negotiations or contact you had with Imaging the South and/or the Bunbury Regional Hospital, and how you characterised those discussions and any understandings reached.

Mr Keith—Senator Evans, the branch has been contacted by many providers of MRI who have ineligible machines throughout the country.

Senator CHRIS EVANS—As I understand it, there is only one in the south-west of Western Australia, which was identified as a target group.

Mr Keith—From the information available in the Blandford report?

Senator CHRIS EVANS—Yes.

Senator WEST—Was central western New South Wales identified as a target group or not?

Mr Keith—It is declared an area of need.

Senator WEST—Are Mayne Health and Medical Imaging Australasia, in their joint venture as Orana, having discussions?

Mr Keith—No-one is having discussions at the moment. This is subject to a tender process. No-one is having discussions with the department whatsoever.

Senator WEST—They are obviously doing their groundwork first before they go to you then, I would suggest.

Mr Keith—I think the process is such that they will not be able to have those discussions. They will be required to submit a tender. As I understand it, there is a meeting on Friday to which all prospective tenderers have been invited to answer questions. We are very concerned to be sure that all tenderers get the same information. Quite a rigorous regime has been introduced across my branch and in the department, so people are not inadvertently giving out information on the MRI tender process.

Senator WEST—Good, that actually helps me. Thank you for that answer.

Senator CHRIS EVANS—Just in general, in terms of this tender process, what guidelines are in place to ensure that public hospitals which do not have access to an MRI get some sort of priority? Is there any priority for them?

Mr Maskell-Knight—There is no priority as such, Senator. The criteria would possibly make it easier in some senses for public hospitals. It might assist you if we provide you with a copy of the RFT on notice. You can get it off the web site but you may as well get a hard copy version. That sets out the criteria that the—

Senator CHRIS EVANS—What was that? The IRT—

Mr Maskell-Knight—It was the RFT, the request for tender document. That includes a number of criteria. I am just trying to find them in my voluminous briefing here. It includes advantage in terms of patient access within the area of need—so where the location is, how long it takes to get there, how physically accessible it is and where it is in relation to transport routes. It includes patient affordability: the most advantageous arrangement for patients will be preferred. It has criteria in terms of location: co-location or proximity to a tertiary referral centre, which is where public hospitals may well derive some advantage. It includes location

of the specialist referral base relative to where the machine is proposed and, finally, there are the hours of operation in terms of after-hours availability and emergency services.

Senator CHRIS EVANS—What is the relationship to cost? Is it a cost based tender?

Mr Maskell-Knight—No, it is not. What this tender will do is confer on the successful tenderers' access to Medicare rebates. There is no financial consideration between us and—

Senator CHRIS EVANS—And what it costs them to install it or set it up is their business in a sense. It is no concern of yours.

Mr Maskell-Knight—Yes.

Senator CHRIS EVANS—Thanks for that.

CHAIR—Thank you to the officers for outcome 2.

[3.10 p.m.]

Mr Borthwick—Some programs went across outcomes. We have a few in that category coming up: diabetes, asthma and mental health. They can be treated under outcome 2, outcome 9 and outcome 4. If there are any questions on those three areas, it might be good if we deal with them under outcome 4.

CHAIR—Then we will move to outcome 4.

Senator CHRIS EVANS—Can I ask a bit about the after-hours emergency primary care initiative to start with? I wanted to start with this initiative just to get a sense of the description in the budget on the night. It seemed to envisage a whole range of quite different arrangements. Is this to be taken as a sign of a bit of a trial of different arrangements? It did not look as if it was one model to be applied more broadly. I see there are up to 32 sites listed, but then it talks about quite different arrangements, so I just want to get a sense of what is actually proposed.

Ms Briggs—I am sorry if there is any confusion around this. You may be aware that the department, under the government's auspices, has been supporting some trial sites in after-hours emergency care across Australia. I think Dr Pegram will have talked to you about that previously. This government initiative builds on those trial sites but also some activities that have been happening more broadly in the context of the government's memorandum of understanding with general practice and also some Practice Incentives Program improvements that have occurred in the last six to 12 months. What the package itself provides for is the expansion of the existing after-hours services trials into fully functional after-hours services. That bit of it costs $6 million over the four-year period.

Senator CHRIS EVANS—How many of those are there?

Ms Briggs—There are six.

Dr Pegram—There are five trials currently running, of which three have provided us with proposals for extension beyond the trial situation. Two of the trials have not done that.

Senator CHRIS EVANS—It is $6 million for three trials?

Ms Briggs—Yes, it is for three trials. I stand corrected.

Senator CHRIS EVANS—It is double the cost.

Ms Briggs—As well as that, Senator—and this is probably the most substantial initiative as part of the package—the government intends to develop up to 32 new after-hours services.

That is at a cost of $12 million over the period. On average those sites will cost somewhere, we think, between $300,000 and $500,000 per site.

Senator CHRIS EVANS—Is that per annum?

Ms Briggs—Per site. It is kind of the set-up framework for the site.

Dr Pegram—That is correct. Perhaps I could elaborate a little bit on how the trials have fed into this proposal. It might help to clarify the costings a little bit. The existing trials vary quite a bit in their scope, size, cost, the way they are set up and how they interact with other existing forms of funding such as MBS payments, funding from state health and area health services, and so on. Because there are so many variables in terms of sources of funding, size of funding, geographic coverage and infrastructure costs, depending on the way things are set up, it means it is very difficult to be precise about what a site ought to cost in terms of annual cost. We have made an estimate based on what the trials have cost us to date. From the cheapest to the most expensive, we have adopted a middle ground and said that, based on our experience, we think that a typical new site ought to be developed over a one- to two-year period at a cost of somewhere between $300,000 and $500,000. That is the basis on which this was developed.

Senator CHRIS EVANS—The new sites are to be operated much the same as the three trials that have been extended. Is that right?

Dr Pegram—We are developing a set of selection criteria which are based on what we have learnt from the trials as to what appears to work and what does not. We will be seeking expressions of interest against those criteria once they have been finalised. For example, all of the trials have a first point of contact telephone triage service as a feature, so we would expect that new models would have that as a feature. But there are other aspects which are unique to one trial rather than another, so they may crop up in some of the expressions but not in others.

Senator CHRIS EVANS—The first thing that strikes me is that, if you are going to pay $6 million for the three trials to be extended but you are going to be able to buy the new ones for $300,000 to $500,000, clearly you are funding slightly different things here, aren't you? The trials have been of 24-hour or after-hours service centres, have they?

Dr Pegram—The trials have been about 24-hour access to primary medical care.

Senator CHRIS EVANS—Which are the three you are going to extend? Where are they?

Dr Pegram—The three trials that have provided us with extension proposals are the Maitland trial in Newcastle under the auspices of the Hunter urban division in the area health services, the trial in western Victoria under the auspices of the western Victorian division of general practice in the area health service there and the trial in Tasmania which is based on the deputising service in Hobart.

Senator CHRIS EVANS—You are basically saying you are going to fund them to continue on their extension?

Ms Briggs—And to expand some of their operation. For example, the proposal that we have from the Hunter proposes an expansion of the services they provide so that they can operate over several sites. The 32 I was talking about earlier were 32 new sites, for example.

Senator CHRIS EVANS—You have the extension of these three in different ways and the other two have dropped out, basically, have they? Are they discontinuing?

Dr Pegram—The trial in Perth was a time limited exercise in that for the Perth call centre which was established in Perth a couple of years ago we funded a 'trial' which involved evaluating the impact of the call centre on existing after-hours services.

Senator CHRIS EVANS—This is the state government health care line, is it?

Dr Pegram—That is right. The other component of the trial was to fund the development of a GP database that could feed into and be part of the call centre. That was really a time limited set of tasks which have been largely completed.

Senator CHRIS EVANS—So it was not really a trial. It was a like a research project, rather than a trial as such?

Dr Pegram—That is right. I like to think of the trials as building a knowledge base, and it was part of that process, yes.

Senator CHRIS EVANS—Yes. So that did not fit into the model for ongoing work. What was the other one?

Dr Pegram—The other one is a central Sydney trial which had two components. The first was an after-hours call centre that was based in the ambulance centre in Sydney, providing calls from the metropolitan area of Sydney or central Sydney metropolitan area, and it also trialled the idea of providing distance call centre support for Broken Hill. The second component of the trial was to establish a GP run after-hours clinic at the Canterbury Hospital, which was near to the emergency department in that hospital.

Senator CHRIS EVANS—And why did you discontinue that?

Dr Pegram—The Canterbury Hospital clinic closed down in January this year. There was an assessment, both by the local evaluators and nationally, that it was not achieving its objectives in the sense that patient throughput was very low, so therefore the cost per patient seen was very high, and that it was not a cost-effective operation; so it was closed. The call centre trial winds up in June, I believe. I can get you the precise date. At this stage, we do not have a proposal for any continuation of that.

Senator CHRIS EVANS—Thank you. Turning now to the 32 new sites, when you say 'establishment costs', what are you talking about there? Are you paying for the buildings? Are you tendering this out to groups of GPs or to companies to supply services?

Dr Pegram—We have not defined what we mean by 'site'. What the trials tell us—and not only the trials, but other groups of GPs and providers around the country who have been talking to us at workshops and in other research—is that a site could be a division of a general practice, it could be a large hospital, it could be a GP cooperative, it could be a small state. In fact, the Tasmanian trial is seeking to develop a statewide model. 'A site' is one of the variables that we have not defined. Some of the trials involve private companies, deputising service; some of the trials are based on a public system such as the Maitland one, which is where the patient does not pay at all. There are a variety of models, and we are setting some basic criteria and principles on which those sites will be selected without being prescriptive as to how the site is set up.

Senator CHRIS EVANS—So we have 32 'somethings'.

Dr Pegram—Thirty-two new services, yes.

Senator CHRIS EVANS—Yes. And they are going to cost between $300,000 and $500,000 but we are not quite sure for what. What are you purchasing?

Dr Pegram—One of the things that the site applications will need to demonstrate is that they have identified a gap between current service supply and community need in terms of after-hours primary care, and identified a potential solution which they wish to apply to that problem.

Senator CHRIS EVANS—So you are not necessarily specifying what sort of service provided you are convinced there is a gap in the services provided in the area. Is that it?

Dr Pegram—That is correct.

Senator CHRIS EVANS—What is your time frame for development of these sites?

Dr Pegram—We have started work with an experts advisory group that has been overseeing the trials to date—the Evaluation and Policy Advisory Group. That group has been teasing out, if you like, the criteria and principles which they believe define a good after-hours service from the trials. Obviously, we could not be too precise about where that might go prior to the budget announcement. Since the budget announcement we will be working with that group to tie that down in more detail, so that we should have a framework for expressions of interest by early July, with a hope to go to a call for expressions some time in either late July or early August.

Senator CHRIS EVANS—So you call for expressions then, and you would provide them with some framework about what they are supposed to be expressing?

Dr Pegram—Yes.

Senator CHRIS EVANS—I am just not quite clear what that is. What are you saying you will fund them for? You will fund them for payment of wages for doctors? You will fund them for telephone lines? You will fund them for buildings? Or you will fund them for medical services? What are you buying?

Dr Pegram—It may in fact be a combination of those things. I will explain how some of the trials are set up in terms of what we are funding. In the Maitland trial, for example, we are funding the actual service provision as well as the infrastructure cost, as well as the cost of running the trial itself—the data collection, evaluation, governance and so on. The area health service has provided the building, and has provided some cash as well. So in the Maitland model there are a variety of things that the state or the area health service is funding, and the rest is being picked up by the Commonwealth.

Contrast that with the west Victoria model, where we are funding a nurse based triage service and the infrastructure of the trial, but the service provision in terms of face-to-face consultations with patients is still being funded through general practice through the MBS, as it always has been. So it depends on how the service is set up as to which bits we will be funding in a precise way.

Senator CHRIS EVANS—It does not sound to me like you are going to be bringing these services on line in the next couple of months, though. I see you have almost as much in the first year as you have in the out years—a bit less, but not considerably. When do you realistically think these 32 sites will be coming on line?

Dr Pegram—The existing trial sites finish their contracts in terms of funding for the trial phase in July, and the national evaluation of that will come in. Clearly, if we need to keep those services ongoing—

Senator CHRIS EVANS—That is easily fixed.

Dr Pegram—we can do that fairly soon. So there is some need to get that funding out fairly quickly, and I would anticipate that there will need to be a start-up phase of some of those 32 new sites which would need some front-end funding perhaps towards the end of this year, at the latest early next year. So there is a need for some funding up front, yes.

Senator CHRIS EVANS—For what? For just evaluation and that sort of thing?

Dr Pegram—The up-front costs involve setting up the governance, setting up the infrastructure, possible purchasing of hardware and software if there is a triage service, training of staff, recruitment of staff, possibly local consultation processes with the community and other providers—all those things need to be in place before we press the green button for a full service.

Senator CHRIS EVANS—Yes. Where are you at with the formal evaluation of the current trials?

Dr Pegram—All of the trials have completed a local evaluation, which is with us. Each of the trials had a local evaluation, and there was a national evaluation, which was sort of an umbrella over the top looking at some common data sets from each of the trials.

Senator CHRIS EVANS—Who does the local evaluation?

Dr Pegram—The local evaluation is within each trial contract. It is a different evaluation in each trial.

Senator CHRIS EVANS—It is not self-evaluation?

Dr Pegram—No.

Senator CHRIS EVANS—They contract someone to evaluate them?

Dr Pegram—The terms of the contract are that they have an external evaluator, but at the local level. There is a single national evaluator who is looking at some common data sets across the trials, as well as doing some extra quality assurance evaluation and some economic and data analysis, trying to build some economic models from the trial data.

Senator CHRIS EVANS—When will those be available?

Dr Pegram—The final evaluation report of the national evaluation is due in July. However, we have been talking to the national evaluators on an ongoing basis and they have presented interim data as it has become available. The local evaluation reports, apart from Perth, are with us. We received the last one recently.

Senator CHRIS EVANS—Clearly this was locked into the budget some time ago, so is it fair to say that you made the decision before those evaluations were received, that the trials were encouraging and that you were going ahead with this decision?

Dr Pegram—We have had some previous workshops at which interim data was presented, and certainly by March of this year, when we had our last workshop, there was enough convincing evidence that, faced with the choice of doing nothing or building on the trials, the balance of evidence was that we should be prepared to build on the trials and what they had shown us.

Senator CHRIS EVANS—Just for my own personal interest, what is your sense of the evaluation of the Perth trial and the success of that call line and what your interaction with that was.

Dr Pegram—Three things, I think. It is clear from the data that the call centre has been able to provide to us that the call centre in Perth is very popular with consumers as a point of

access. Bearing in mind that the Perth trial is not an after-hours service—it is a 24-hour call centre, and whilst there are overlaps there are also distinctions between the two—consumers like it very much. I think the second thing that is clear is that, at least in the early phases, it probably caused an increase and certainly not a decrease in demand for other services. Some of the existing after-hours general practice services in the community have recorded an increase in demand since the call centre was operating. The data in terms of—

Senator CHRIS EVANS—Sorry. Were they able to quantify whether that was a result of the call centre referring people to them or not?

Dr Pegram—I believe two of the clinics in the Perth area have been able to record that, but I can certainly try and get some hard data for you.

Senator CHRIS EVANS—Yes, if you would not mind. I would just be interested to see it.

Dr Pegram—The issue with respect to emergency department attendances is less clear because it has been very difficult to extract hospital data, and that work is ongoing under Professor Michael Clinton in Perth. He is still completing that analysis. One of the interesting pieces of data we do have in from the national evaluation is that there appears to have been a reduction in the number of claims against the eight emergency after-hours item numbers in the MBS, which suggests that there are more consumers being directed to site based clinics for after-hours care rather than relying on home visits.

Ms Briggs—I might make another point about this: the Western Australians provide a quite interesting presentation on this trial, and as part of that presentation they emphasise that the number of indigenous callers was significantly higher than their representation in the Western Australian state, and that suggests, firstly, a reflection of the remoteness of Western Australia but, secondly, it may be that telephone health information services are actually attractive to indigenous Australians, or more attractive than other forms of health care. So we need to explore that a bit more.

Senator CHRIS EVANS—Yes, there are a few other things that might impact on that, aren't there, obviously in terms of general wealth, ability to purchase?

Ms Briggs—Absolutely, Senator.

Senator CHRIS EVANS—If you get a locum out to home, you know about it.

Ms Briggs—Absolutely. It is I think a very important statistic, and we need to follow it through as part of our work.

Senator CHRIS EVANS—I would suspect they are also over-represented in the emergency and casualty ward admissions.

Ms Briggs—That would be the case. We know indigenous Australians have a higher usage of hospital services than average Australians.

Senator CHRIS EVANS—Is this evaluation the West Australian government's evaluation, or your evaluation of their programs interfaced with yours? I am not sure what it is you were funding in the Perth case, given that the line was there as a state government initiative.

Dr Pegram—The initial set-up of the call centre of course was jointly funded by the state and Commonwealth government. There was some Commonwealth money into the set-up.

Senator CHRIS EVANS—Was there?

Dr Pegram—What we essentially wanted to know was what the impact would be on existing services, particularly general practice in the area, and that is essentially what we funded and what the local evaluator, Professor Michael Clinton, is doing.

Senator CHRIS EVANS—You do not sound all that confident about whether you are going to get the answer. Is that fair?

Dr Pegram—One of the problems that I was going to mention is that the local evaluator in Perth changed during the process, so there has been some delay in completing the work because of that transference. We do have some data that is starting to come out around the utilisation of the call centre, and the question, of course, that hangs with us is how transferable and transportable that data is in terms of the rest of Australia and other sites.

Senator CHRIS EVANS—Certainly my anecdotal evidence has been that it has been very popular, as you say.

Dr Pegram—Indeed.

Senator CHRIS EVANS—I know for instance when my children were young we used to use Ningana, who had a similar thing for advice dealing with young children, and I know they were always stretched. Having talked to people in the community, I think there is a growing awareness of the line and an appreciation of having the service available, because I think certainly the after-hours locum services are pretty problematic from most people's experiences. Thanks for that.

Senator GIBBS—In the PBS on 141 there is an additional $6.4 million over four years to Diabetes Australia; when did the renegotiation of the national diabetic service scheme reach the stage of agreement on an increase in co-payments in exchange for more money for Diabetes Australia?

Mr Piperoglou—The negotiations with Diabetes Australia are still continuing. They have not yet concluded. As far as I am aware, there was no agreement in the way that you have enunciated.

Senator GIBBS—There is no agreement? Wasn't the original plan to increase co-payments for diabetes by $10 million over four years and give $8 million of this back to Diabetes Australia?

Mr Piperoglou—I can only reiterate what is in the budget papers, Senator, and that is that there is no change to the current arrangements with respect to co-payments.

Senator GIBBS—I see. So you know nothing about the renegotiation, or the outcome recommended? Wasn't this outcome recommended by the department and taken by the minister to ERC?

Mr Piperoglou—There are a couple of processes, Senator, which obviously are interlinked, but it would be perhaps worth while if I can separate them. The first process is the negotiation with Diabetes Australia of the agreement to implement the NDSS. Those negotiations are nearing completion and hopefully will be completed before the end of the financial year. Apropos the other issue you have mentioned—it is an issue which of course came up in the budget context, as these things do—all I can do is to reiterate what the outcome of that was and that is that there is no change in the current co-payment arrangements.

Senator GIBBS—This basically happened after a media leak, did it not?

Mr Borthwick—Senator, I think the answer you have got covers what the government's policy is. You are trying to delve into the processes that got it to that policy decision and I do not think that is appropriate.

Senator CROWLEY—Process is fair game, Mr Borthwick. Policy decisions are separate. Process is fair game.

Mr Borthwick—No, you are trying to search behind the budget announcement and I do not think that is appropriate.

Senator CROWLEY—Of course, Mr Borthwick, but we appreciate that it is a fine line and we cannot pursue policy—or at least we can, but it is perfectly improper for you to be expected to answer. My understanding of that is that we can ask the questions and you can respond. It is not proper to ask the public servants to give advice about policy matters, but the process is a separate issue.

CHAIR—As long as that process involves giving recommendations to the minister and vice versa in the debate. You should know that as a former minister, I would have thought, Senator Crowley.

Senator CROWLEY—That is right, but the—

Senator Vanstone—We can short-circuit this. Give us your questions and we will put them on notice. To the extent that it is appropriate you will get answers and to the extent that it is not, you will not. Are you happy with that?

Senator GIBBS—Sure, I suppose I will have to be, won't I? I do not think I am going to get an answer.

Senator Vanstone—Why don't you save yourself a bit of time then?

Senator CROWLEY—Because it might be reasonable to test this: questions about the timeliness of when advice was sought.

Senator Vanstone—We can, but we have got until 11 o'clock tonight and how many more of these have we got to go?

Senator CROWLEY—If you would listen to the question, Minister, we would waste not one second. Questions about when a person was asked for information seem to me entirely proper questions. What they were asked is a separate question. I thought Senator Gibbs asked a question about when.

Senator GIBBS—Were the negotiations reopened after the news of what was intended to happen leaked out to the media?

Mr Maskell-Knight—Negotiations with Diabetes Australia have been ongoing for some time. They have not reached a conclusion yet. As Mr Piperoglou has indicated we hope they will before the end of the financial year.

Senator GIBBS—On the incentives offered to doctors for diagnosing better management of diabetes, who made this decision and what exactly will the incentives be?

Mr McRae—The decision was made by the cabinet as part of the budget process. I do not think there is much more I can say on that. The nature of the incentives is really still to be worked through in detail with the profession. There are a number of objectives that we want to achieve in terms of having incentives for doctors to work towards earlier diagnosis and better management of diabetic patients. There are various ways that can be done, a number of

which we have talked about with the profession over some time, but we have not yet reached the point of knowing precisely what the incentives will be targeted at.

Senator GIBBS—So you have not really worked out how you are going to detect the early diabetes. I would imagine that doctors would be able to have certain processes where they can actually detect this early. What sort of barriers are there at the moment?

Mr McRae—Indeed, the doctors certainly have those processes in place. What we have to work through, in terms of incentives, are ways in which to measure that these things are being done and being done in ways which change. Probably the best example to talk about—and this may or may not be where we end up—is that good management of diabetes, according to all the guidelines, should include the use of a good diabetic register which allows recall of people at appropriate times. For example, it is possible that we may come to the view, after consultation with the profession, that one of the best incentives to have in place would be an incentive to have a diabetic register with a recall capacity. There are things like that which we can use to enhance the quality of care.

Senator GIBBS—A register of patients, is that what you are saying?

Mr McRae—A register of patients within the practice who have diabetes, yes.

Senator GIBBS—How would that improve the situation?

Mr McRae—Fundamentally because you would then have a recall system built in so that the patients are being recalled for their tests at all the appropriate time periods and things are kept in place so that it is easier for the doctors to know when to send people off for foot checks and eye checks, as well as to give them blood tests and such like.

Senator GIBBS—This register interests me. Who will keep this register and will it be a national register?

Mr McRae—No, there is no suggestion of a national register. We are talking about within practice registers, which many practices—

Senator GIBBS—But doctors would know who their diabetic patients are now, would they not?

Mr McRae—That is not what we understand, Senator. Clearly some practices do have registers and do know those things now, but it is by no means all of them.

Senator CROWLEY—How much more money per practice do you anticipate this will be?

Mr McRae—I will have to look that up.

Mr Wells—The program is meant to be firstly for better diagnosis and the current estimates are that while there are 400,000 people diagnosed with diabetes there are another 500,000 who are not.

Senator GIBBS—That is scary, is it not? Do you mean there are 500,000 of us walking around with diabetes and don't know it?

Mr Wells—Potentially.

Senator GIBBS—Scary.

Mr Wells—The second thing is to have a better management program in place for each patient by the GP. Rather than a series of discrete visits, the GP sets up a management program for that particular patient, based on evidence based guidelines and that incorporates

certain tests and referrals, as Mr McRae was saying. That is the purpose of having this register at the GP level, such that they can be better managing their patients. The issue about payments then is what are the trigger points that would be able to be used as a basis for the incentive payment.

Senator GIBBS—I see.

Mr Wells—That is the bit that has been worked through with the doctors.

Senator GIBBS—That was actually going to be one of the questions—how were you going to assess the—

Mr Wells—That has been worked through with the doctors.

Senator GIBBS—So, if you have the bonus, that is how the incentive payments will be determined. Fine.

Senator CROWLEY—Which doctors, Mr Wells?

Mr McRae—In terms of working through the trigger points?

Senator CROWLEY—Yes.

Mr McRae—There are basically two groups. There are the general practitioners themselves, with whom we are working, and there is also a diabetic committee that my colleagues here also work with. We will have to work through something which is amenable to both of those groups.

Mr Wells—Dr McLoughlin can talk further about it.

Dr McLoughlin—We are in the process of setting up a new national diabetes group called the National Diabetes Strategy Group, which would include a range of expert clinicians, colleagues from the state and territory governments and consumer representatives, as well as Diabetes Australia and some other non-government agencies. That group is intended to provide strategic direction about advice for improving the care for people with diabetes in Australia.

Senator GIBBS—How much will the doctors receive? Has that been worked out yet?

Mr McRae—We can tell you a certain amount. The actual budgeted amount for general practice is $11 million coming from the budget in a full year. The general practice profession, through the memorandum of understanding group, has also contributed $8 million a year. There will be altogether about $19 million a year in a full year, which is something like $1,300 or $1,400 on average across all GPs. Clearly some will get it and some will not, so the amounts will vary around that but that is the average across all full-time general practitioners.

Senator CROWLEY—Was that the figure that was first thought of in the budget proposal? I understand in the budget proposal the moneys for this program changed.

Mr McRae—I think we have just been through a set of discussions about budget processes, Senator.

Senator CROWLEY—Yes, but we have also spent a lot of time on the pre-budget process involving MRI. We are not talking about the policy advice but we are talking about a significant change in the amount of money for this program. It is reasonable for us to wonder why it happened; why the change?

Mr McRae—I cannot comment on anything to do with that, Senator.

Senator CROWLEY—You have just done it, or your colleagues have, in the MRI process.

Mr Maskell-Knight—I was commenting about processes of government, Senator Crowley.

Senator CROWLEY—Facets of government?

Mr Maskell-Knight—Aspects of the government process or the budget. I think there is a distinction to be drawn here. You seem to be pursuing what decisions government might have made and how they might have changed them over time. I do not see it as our brief to explicate that process. We are here to explain what the outcome was.

Senator CROWLEY—It is not unreasonable for senators to want to know the process by which a policy that was proposed suddenly got more money for the doctors in this area of diabetes. It is not an unreasonable question.

CHAIR—It is a policy decision of government.

Senator CHRIS EVANS—Maybe we will go back to the detail, which was the question to Mr McRae about how much that meant for each practice.

Senator CROWLEY—Yes.

Senator CHRIS EVANS—You were looking that up, I think.

Mr McRae—I was trying to enunciate it then, Senator. There is $11 million in a full year coming from the budget. The general practice itself, through the memorandum of understanding group, has in fact diverted other funds worth $8 million a year to this purpose, so there will be $19 million in a full year. If this is averaged across all general practitioners it averages out somewhere between $1,300 and $1,400 per full-time practitioner. In practice, of course, not all practitioners will get the money, so those who get it will probably get somewhat more than that and some will get somewhat less. That would be the average across all doctors.

Senator CHRIS EVANS—Is that to make up for the money that they missed out on with the incentives for prescribing pharmaceuticals and better medication management schemes?

Mr McRae—I think this is a measure which is actually aimed at improving the lot of diabetics in the country.

Senator CHRIS EVANS—Just explain again where that $8 million came from.

Mr McRae—It was in the general practice memorandum of understanding. There is an obligation on the Commonwealth to spend a fixed amount of money from the GP MBS rebate pool over a three-year period, which was initially $7.67 billion over three years. As time has gone by one would expect that we would either be somewhat above or somewhat below that in actual expenditures. What has happened is that we have been somewhat below that. The $7.67 billion was estimated based on a certain number of services. In fact the number of services has been somewhat less. This has meant that the GP MOU group was then invited to look at ways to spend the additional money to bring them up to the total, which the Commonwealth had obliged itself to spend. Most of that additional money came through increases in rebates. On 1 May this year there was a 50c increase in the standard rebate. They also chose to reallocate $8 million of that money from the rebate pool into incentives for diabetes.

Senator CHRIS EVANS—When you say ‘chose’ you mean in negotiation with you and agreed?

Mr McRae—The MOU group comprises the government and three medical—

Senator CHRIS EVANS—They weren't to know otherwise that you were going to have a national diabetic initiative, et cetera. This is a negotiation process, isn't it? I am not trying to put words in your mouth. I just want to understand. You said they chose to do it as if they rang you up and said, 'We're going to use that $8 million for this.' Is that how it works?

Mr McRae—You are right. We sit around a table and say, 'Look, this is what's available, doctors. What do you want to do?' and between us we work through some options.

Senator CHRIS EVANS—If they say, 'We'd like to buy a Volvo,' you do not say, 'That's okay.' You say, 'We've got some priorities as a government. That might help you buy a Volvo and if you treat diabetics this will help.'

Mr McRae—That is one way of putting it.

Senator CHRIS EVANS—In agreement you threw $8 million out of that pot in together with $9 million out of this year's budget. Is that right?

Mr McRae—I am not sure how much it is this year. It is $11 million at the end. I think $9 million this year sounds about right.

Senator CHRIS EVANS—Is the $8 million an annual figure or is that across the four years?

Mr McRae—It is an annual figure.

Senator CHRIS EVANS—They are putting in $8 million and the budget is putting in $9 million to $11 million per annum. Is that right?

Mr McRae—That is right.

Senator GIBBS—I understand you when you say it will be approximately $1,300 per practice. What is the qualifying requirement here? What are the criteria of this and is that per patient?

Mr McRae—We were saying earlier that we still are working through with the profession what the qualifying requirements will be. We do not know what they will be and nor do we know precisely what the payments for reaching the qualifying requirements will be. We will have to work that through, in a sense, interactively. If we have a qualifying requirement which is really easy to reach, then obviously the money has to spread more thinly.

Senator GIBBS—All right, thank you very much. That is all I have.

Senator CROWLEY—Who is going to be negotiating with the GPs on the agreement and the criteria? Are they the same people who arm-wrestled them for $8 million?

Mr McRae—You could put it that way, Senator.

Senator CROWLEY—Thank you for that. It is the same people?

Mr McRae—Indeed, except obviously we will call upon help from our colleagues who are diabetes experts.

Senator CROWLEY—Just very quickly, the national group is to be set up?

Dr McLoughlin—It is in the process of being set up now. Professor Don Chisholm from the Garvan Institute has agreed to chair that group and membership nominees are being solicited from a range of agencies.

Senator CROWLEY—How will that be funded?

Dr McLoughlin—In terms of the committee remuneration arrangements, they will occur through the standard remuneration tribunal arrangements. They will be funded through some available diabetes funding.

Senator CROWLEY—Sorry, will that come out of the $11 million or the $8 million?

Dr McLoughlin—We have an existing amount of money of $4.16 million a year.

Senator CROWLEY—That will cover the meetings of that national group?

Dr McLoughlin—Yes, Senator.

Senator CROWLEY—Anything else? Sitting fees, something of that sort?

Dr McLoughlin—Yes.

Senator CROWLEY—Is it $4.16 million per annum?

Dr McLoughlin—The $4.16 million is an existing budget allocation for diabetes.

Senator CROWLEY—Per annum, okay. So these people might have a say about what are the agreed criteria?

Dr McLoughlin—This group will have a great deal of interest in the program and they will certainly be keeping an eye on the effect for people who have diabetes.

Senator CROWLEY—Will it be a requirement that any general practice that comes on board or asks for an incentive payment will have to show evidence of a register?

Mr McRae—We have not worked that through, Senator. I talked about registers earlier as one of the easiest examples to talk about. That may be the best trigger point for words that were used earlier. There may be others which are better. We are still trying to work that through.

Mr Wells—Senator, what will happen is the expert group, which is under Dr McLoughlin's administration, will in this sense set some of the criteria. There will be an interaction with the GP MOU group and when we have agreement as to what those criteria are and what the trigger points are, doctors who wish to participate will have to meet those agreed criteria. It will be worked out between the two processes is what I am saying.

Senator CROWLEY—Can I know the names of the people who will be involved in the negotiation, on notice?

Mr McRae—Yes. Fundamentally the memorandum of understanding group comprises the government, the Royal Australian College of General Practitioners, the Australian divisions of general practice and the Rural Doctors Association of Australia. I am happy to give you the names.

Senator CROWLEY—Thank you. How long do you anticipate it will be before these criteria are established?

Mr McRae—In theory we have adequate funds to start payments in the November payment run of the Practice Incentives Program, if we can get ourselves organised that fast. That would mean we would have to be organised within three months and I am not sure if that is practical.

Senator CROWLEY—How are you going to test that doctors are up to scratch and abiding by the criteria?

Mr McRae—It will depend on the particular criteria that are set. Some criteria can be measured by working off Health Insurance Commission data and sources like that; other

criteria may be set by in fact asking the doctors themselves to sign up—which is what we do in a number of the other components of the Practice Incentives Program—and having an audit process.

Senator CROWLEY—Who does the auditing?

Mr McRae—The Health Insurance Commission.

Senator CROWLEY—So they will pop around from practice to practice to check how many people are diabetic in the practice and how many are on the books and how many are getting what done to them?

Mr McRae—That is most unlikely. It would depend very much on what the criterion was. If the criterion was that the practice has a register of a certain type, the only way we can collect that information realistically is by asking the practices and having an audit process that checked that for a percentage of practices. If the criterion was related to clinical activity that can be measured by the Health Insurance Commission directly through the central databases, then obviously you do not need to go out.

Senator CROWLEY—So how are all of the things that are not measurable through the HIC going to be measured?

Mr McRae—As I said, depending what they are, it may well be that they will be measured by getting doctors to tell us what they are doing by collecting information from them about what they are doing.

Senator CROWLEY—Who will collect that information?

Mr McRae—The Health Insurance Commission manage the Practice Incentive Program and makes all the payments, so they would collect such information.

Senator CROWLEY—And how would they inform earnest senators like me of what they have found out? Will they be publishing the results? Will there be an annual report? Will it be in the back folder of estimates?

Mr McRae—The way in which the Practice Incentive Program works now is that there is no secrecy. There is material, I believe, on the web sites about the sort of percentage take-up of the program, the percentage of people who are doing electronic prescribing and so on. This will simply become another component of that program.

Senator CROWLEY—So I might as a patient dial up the docs and say, 'This person signed up to be part of the diabetic scheme. Grandma has diabetes. I'll pop around there'?

Mr McRae—No, sorry, we would not put on the web site what individual doctors were doing. What we would put up there is what the overall aggregates are, what percentage are doing this and doing that.

Senator CROWLEY—How will you then know which practices are good and which practices are not so good?

Mr McRae—I am sorry, Senator. Which 'you' are you talking about?

Senator CROWLEY—You, the Health Insurance Commission.

Mr McRae—Us as a payment system?

Senator CROWLEY—How would one?

Mr McRae—Those of us representing the payment system, working out the payment arrangements, would either have information from the central systems, in which case it is

fairly straightforward, or we would collect information from the practices, which they would be signing up in virtual stat dec type form, and for which we would have an audit process.

Senator CROWLEY—If you could provide us with any more detail of how in fact that audit process will operate, I think the committee would appreciate that, or at least this senator would. This, in the end, becomes quite a large amount of money and I do believe it is reasonable for us to have some sense of what the criteria will be. You say that hopefully you will be able to pay people or practices by November. That means you are going to have to get the criteria in place and give the doctors or the practices time to sign on before November, presumably. You are not going to give them money before they have signed on.

Mr McRae—Again, that depends on the nature of the criterion, Senator. Eighty-five per cent of practices are signed on to the Practice Incentive Program now, so they automatically become part of things that we can measure. If we were to look at something like registers, you are quite right, we would have to go out to them to find out about the registers. If it were something that we could do more directly, then we can just sort of do it, but we would obviously want to tell them what was happening so that they understood how the incentives worked and could look at changing their practices to better meet good practice in the ways which the incentives encouraged.

Dr McLoughlin—Senator, if I might just supplement my colleague's answer: the existence of the national diabetes strategies group I believe will actually provide another mechanism to ensure that this funding is used effectively for the care of people with diabetes because I think it would be the one arrangement within the Practice Incentive Program where there will be an external group who have expertise who are interested in the outcome and who will be ensuring that there is an appropriate national evaluation in place.

Senator CROWLEY—A lot of good work for diabetics, as I understand it, is done by diabetic nurses, community outreach. Is that going to continue?

Dr McLoughlin—I would certainly imagine so. Part of this program is to also engage with the states and territories to seek models of best practice in terms of improving diabetes care, and to ensure that there is some ability to exchange that knowledge and information across professional groups across Australia.

Senator CROWLEY—There is nothing under this incentive program to provide assistance to community nurses, community diabetic nurses?

Mr Wells—Not from this funding, Senator, but this does not replace existing funding. It is in addition to, and the information we have is that about 80 per cent of services to diabetics are in fact provided through general practitioners.

Senator CROWLEY—Will you be writing to all the diabetics about this initiative? Will the minister be writing to all the diabetics?

Dr McLoughlin—I would say that is a matter that we will be discussing with Diabetes Australia, who will be a member of the new national group and certainly do have a great interest in this proposal. We have already spoken to them about it.

Senator CROWLEY—You are saying yes, a letter will go from the minister to all diabetics?

Dr McLoughlin—It is not envisaged at this stage that a letter would go from the minister to all diabetics. I am saying that we are having a conversation with Diabetes Australia about ways in which we can work with the community to assist the community to engage with this program.

Mr Wells—By definition, part of this is to find out more who the diabetics are. There are a lot of undiagnosed diabetics around.

Senator CROWLEY—It would not be appropriate to call it a sweetener, would it, Mr Wells—not for diabetics. Thank you. I have some questions on the mental health program.

[4.08 p.m.]

Senator TCHEN—I am Victorian. I am particularly interested in mental health. The government has provided in the budget $120 million over four years to improve the quality of care provided through general practitioners to Australian mental health illness. How would this work and how would the funding be allocated? I am also particularly interested in the rationale of distributing this funding, directing this funding through a general practitioner rather than through say a mental health psychologist.

Mr Casey—Senator, you will excuse me if I have to give you a rather long answer because I think you have asked a rather complex question.

Senator TCHEN—That is okay. It is an important issue.

Mr Casey—Fundamentally why this program is directed through general practitioners is that epidemiology shows us that 75 per cent of the population who seek help with mental health problems go to their general practitioner, so it seems to make sense that that is the point at which you organise support structures around them. The package provides essentially five elements. It provides incentive payments to general practitioners to carry out better care management through assessment, care planning and review of patients who present with mental health problems.

It provides education and training to improve the skill base of general practice in responding to people with mental health problems. It provides funding to allow for greater access to allied health services, such as psychologists, that would be made available for GPs to help them in the support and care of their patients. It provides an element of case conferencing access for psychiatrists, equally, in response to the needs of general practitioners to get better advice and consultancy from their specialist colleagues—I think that is five, or have I missed one? Sorry, it does provide one additional element, which is for those general practitioners who have the appropriate level of skill in psychological interventions, that they will be able to access an MBS item of mental health counselling.

Senator TCHEN—It is not just a backdoor way of increasing GPs' income?

Mr Casey—It is not a backdoor way of increasing their income, because the expectation in relation to this is probably twofold in relation to GPs. Not all GPs, we know, see their skills or their interest specifically in managing people with mental health conditions.

I think, as you would appreciate, in this country as in many countries our acknowledgment and appreciation of the significance of mental illness in the community has been somewhat late in coming over the last decade, so many doctors find it difficult to deal with people's mental health problems. It will not be something that all GPs would see as becoming an essential part of their practice. The other is that the expectation of the specific work that will be undertaken in terms of assessment, diagnostic tools, review and care planning with their patients will involve them in significantly additional work to what we understand is current practice for many GPs.

Senator TCHEN—Mr Casey, how would this new program relate to other work that is being done in the mental health area? Is it going to take funding away from the existing programs?

Mr Casey—This is additional funding of $120 million over four years. It does not impact on our existing funding which comes through, for national initiatives, the National Mental Health Strategy and also comes through the Australian health care agreements in the funding that we provide to states and territories. It does not have any impact on our existing funding base other than to increase it.

Senator TCHEN—Would the community be able to have any input into the actual details of how the program is going to work?

Mr Casey—Yes. In the development of our thinking around these issues, particularly over the last 18 months to two years, the Mental Health Council of Australia is a significant player in the dialogue along with the professional groups representing general practice, psychiatrists and psychologists, and that includes the Beyond Blue national depression initiative.

Senator CROWLEY—When did the department receive this proposal from Beyond Blue and what steps were initially taken to include it in or exclude it from the budget?

Ms Briggs—We have probably been working with the profession on the base package for as long as about 12 months. However, it is true to say that we received a developed-up proposal from a group of interested parties earlier this calendar year.

Senator CROWLEY—As I understand it, the minister publicly stated that the Beyond Blue proposal had been received too late to be considered in this year's budget, so why was the initiative revived?

Mr Casey—The discussions around this initiative have been ongoing for a considerable period of time. The submission was not just from Beyond Blue. The College of General Practitioners, the Australian Divisions of General Practice, the Royal Australia and New Zealand College of Psychiatrists, Beyond Blue and the Australian Psychological Society placed a joint submission. I cannot comment on why the minister said it was too late to include that. All I know is that the discussions and the development of this work have been under active consideration for a long period of time and that the concepts that are underpinning this initiative have been developed since we started the national primary mental health care initiative two years ago.

Senator CROWLEY—It is interesting, though, that on the record the minister did say that this proposal was too late to be included in the budget and something awfully similar, less something like $30 million, is in the budget. Can you help us?

Mr Casey—Only to say, Senator, that the advice to government on this submission has been made long before the detailed submission that was received from this group and that the outcome has been that there is a budget initiative. It is difficult for me to comment on what the minister's thinking was through that process.

Senator CROWLEY—Indeed, but it is worth noting again that the minister has publicly rejected it, saying it was too late for the proposal to be in the budget, and then suddenly it was, albeit $33 million less.

Mr Casey—Their submission, which has very many similar elements—it was not the submission on which the work of the department has been going on for a long period of time on this sort of development—was completed long before we received anything from this group, although I think it would be fair to say that because we have dialogued with these organisations over a considerable period of time there is great synergy between the ideas that they have and the ideas that are in our budget, but that is probably because we have very good

relations with our stakeholders and we do have a very cooperative dialogue around the sorts of developments that are needed in mental health in this country.

Senator CROWLEY—When did the department receive the proposal from Beyond Blue?

Mr Casey—I cannot remember the exact date.

Ms Briggs—I think it was March, Senator.

Mr Casey—That would be about right.

Senator CROWLEY—March this year. Thank you. Are there any other differences between their proposal and what we now have in the budget, excluding the fact that it is $33 million less?

Mr Casey—Not fundamentally different. Clearly there is a difference in the amount of spending that their submission addressed and that amount of money that is in the budget and, accordingly, the sort of degree to which it may achieve different outputs. There may be fewer outputs that we would predict that we would get through this than they would have. But their submission is not detailed in the sense of the detail that we go into when we try and model what we expect to be able to get out of the investment that we have. It is much more general. I think there is a stronger focus in terms of the amount of money that they would have put into the education and training component.

Senator CROWLEY—Sorry, you are saying your proposal puts in more or theirs would have?

Mr Casey—Their proposal has suggested a greater investment in that area than the amount of money that is available in this budget.

Senator CROWLEY—Education and training of?

Mr Casey—General practitioners.

Senator CROWLEY—What steps has the department taken to evaluate this proposal and assess its effectiveness?

Mr Casey—At this stage, Senator, the only element of the package that starts in the forthcoming financial year is the education and training and the actual triggers for the other items will be in the 2002-03 financial year. That is going to give us a period of time to discuss a number of things, including how we might evaluate the impact. Part of that is going to be dependent on our discussions and consultations and agreement around the sort of information that we would like to avail ourselves of in terms of how patients are being treated and what their outcomes are. It is certainly our wish—and we have had discussions with these groups—that some form of health outcomes measure should be included in the process of care management—not necessarily for that information to be returned to the government in any way, but that it forms the basis for our ongoing evaluation of the effectiveness of care and treatment. It is those sorts of elements that we would like to start building up, which would build up our potential for researches, appropriately covered by appropriate ethics, et cetera, on confidentiality, to start to explore how effective we are in addressing mental health problems.

Senator CROWLEY—What kinds of things, briefly, would you include in the prospect of outcomes criteria? What kinds of things could you tick off?

Mr Casey—There are a number of well-trialled health status measures such as patient questionnaires, things like the SF12. There are different depression scales that one might use to show from the patient's perspective how they perceive their situation has changed from

point A to point B. We would like to encourage greater use of these sorts of diagnostic tools in our understanding of mental health. One of its biggest problems is that it is a bit different from many aspects of physical health. It is hard to determine when somebody's health has actually improved and it is also important in that assessment that improvement is something that they recognise and internalise rather than just being externalised by some form of diagnostic or physical testing. It is those sorts of tools. We have not been prescriptive because I think that there is still a great deal of rightful sensitivity around the stigma associated with mental illness and I think we have to be careful in balancing our desire to give a greater focus to that, particularly in specific programs of care, and the sensitivity of many in the community about being able to discuss their mental health problems. I think we have to find a balance between those two, which is why we have left ourselves some time to have full consultations on how we take this step forward.

Senator CROWLEY—Does that mean you do not yet know what form the proposed incentive payments will take, nor what amount per GP would be determined, nor what are the qualifying requirements?

Mr Casey—We have done calculations based across the care plan and assessment initiative which we have envisaged as three major tasks. One is assessment or diagnosis, the other is good care planning and the other is review. The three elements are probably split over a three- to six-month period and the calculations that we have done in terms of possible outputs have seen an additional payment across that care package of about $140 per patient.

Senator CROWLEY—Per patient per year?

Mr Casey—Per patient per year for a proper care package of mental health care.

Senator CROWLEY—I am sorry, Dr Briggs, I cut across you.

Ms Briggs—That is all right. I wish I was a doctor, Senator, on occasions like this. I think it is important to clarify there as well that we are working within a broad framework of a cost of about $56 million over the four years and so we need to work with the profession on the balance between those levels.

Senator CROWLEY—This $140 per patient per year would be different from, or extra money to, the medical benefit schedule item.

Ms Briggs—No, Senator.

Senator CROWLEY—Is the medical benefit schedule item only for psychiatrists?

Ms Briggs—The way this will work is that extra funding will be provided through the Practice Incentives Program.

Senator CROWLEY—Right. There is no new item for GPs, only for psychiatrists?

Ms Briggs—No, that is not right, Senator. As Mr Casey said earlier, there is an additional MBS item for GPs who have appropriate training in counselling.

Senator CROWLEY—I did think I heard that and then I read the wrong thing here. Thank you for that. There are two dot points that confirm that. How do you imagine the new medical benefit schedule item for psychiatrists to provide consultancy assistance to GPs in emergency situations is going to work?

Mr Casey—In our discussions with the professional groups and the consumers, the emergency situations that we are envisaging—and again we need to have further consultations—are those circumstances when a general practitioner has a patient who they are

seriously concerned about, perhaps that they may harm themselves, and they need urgent advice in terms of how to manage that. We have been given information that there are occasions in a GP's life when they are in a situation where they have to spend extensive periods of time managing somebody who they are quite concerned about—say for example, letting them leave their surgery even—or wanting to get some urgent activity for. Currently to get access to a psychiatrist for an assessment of a patient can be anything from six weeks to three months. We have this facilitation of an emergency item which would build on the normal care planning case conferencing type of approach and may facilitate the psychiatrist being more freely available to give GPs urgent assistance with emergency cases.

Senator CROWLEY—Has that medical benefit schedule item been agreed on yet, the amount of it?

Mr Casey—No, there has been no discussion in terms of—

Senator CROWLEY—Neither that one, nor the GP one.

Mr Casey—the details on how that would work, but it is building on the case conference. The essential element there is to provide better case conferencing access for GPs, psychiatrists and other mental health workers around mental health care. The emergency element is that we have indicated we would be happy to discuss how we could allow that to be a one on one situation between the GP and the psychiatrist in emergency situations, but only in emergencies. At other times it would be more akin to the EPC case conference structure albeit that we have indicated that three professionals in relation to the person's mental health, rather than four, would be something that again we would be willing to consult with on that sort of model.

Senator CROWLEY—Would you anticipate that the item would be available for a psychiatrist for a phone hook-up?

Mr Casey—I would anticipate in an emergency situation it would be certainly available by phone. In terms of the structure of the case conferencing, in particular given the maldistribution of psychiatrists in this country, I would anticipate that we would be looking at the case conference being one that could be done through electronic communication. Most of our psychiatrists practise and live in three cities in this country. If we are to get the sorts of consultancy and care planning where people need it then, yes, we are going to have to look at videoconferencing and teleconferencing around the care planning items.

Senator CROWLEY—Which cities?

Mr Casey—Adelaide, Melbourne and Sydney.

Senator CROWLEY—Thank you. Beyond the Blue program—I am perfectly prepared to say I am not fully cognisant of it—carries with it the sense that it is about depression.

Mr Casey—The decision to use the term 'depression' was made after a great deal of consideration. It is not depression purely in the clinical sense in which a clinician would define depression as, say, against an anxiety disorder, but the term 'depression' was used because it is our understanding that in the community people find it easier to talk about depression in a generic sense than they do about mental illness. So 'depression' is used in its generic sense, not in its clinically disordered definition sense. It does not exclude the other major group of disorders, the anxiety disorders, which in fact have a higher prevalence rate than the depressive disorders, the mood disorders. It is not exclusive in that sense. It is more about popular parlance and, again, I think it goes to the heart of one of the problems in mental

health in that there is still significant stigma attached to somebody saying, 'I've got a mental health problem.'

Senator CROWLEY—Beyond the Blue does not also describe people in a roaring manic phase; they do not feel blue at all.

Mr Casey—No.

Senator CROWLEY—They are lit up.

Mr Casey—The decision to call it—

Senator CROWLEY—Can they see the doctor under the heading of Beyond Blue when they are glowing?

Mr Casey—Do they? No, I do not think so. But I think the decision to use that term was a decision made by the board of the company that was set up to take forward this initiative, after discussion. They did a bit of focus testing with people and they felt it was one that conveyed the essence of what this was about.

Senator CROWLEY—It is important—and I would hate anybody to think that I was in any way disparaging of any initiatives in the area of mental health, because I am not—certainly for our young people between 12 or 15 and 25 when it is hard to know whether these people are depressive or schizophrenic or something else. It is a very critical thing, particularly as so many of them manage to succeed in suiciding. I am not in any way flippant about this.

Mr Casey—No, I understand that, Senator.

Senator CROWLEY—I appreciate the importance of the blueness of people's lives, but I am just a bit concerned that we would not see psychiatric illnesses confined to that. There are others that are not really in the depressive range. Can I be confident that this program is going to encourage our GPs to pick up and talk with their psychiatrist about other things besides depression?

Mr Casey—In relation to this budget initiative, we see it as going across the board of mental health needs, without any sort of limitation on that. It is fair to say that the general practitioner, certainly in the first instance, would see a mixture of both the psychotic and non-psychotic groups of disorders. In fact we would hope that for those, say adolescent schizophrenia, this would again encourage that sort of early pick up and early take up of mental health problems when they occur, without any differentiation of what those problems might be.

Senator CROWLEY—Is there a process by which you will work with this program and the state mental health services?

Mr Casey—We of course have in existence the national mental health working group which is a Commonwealth-state group that has been in existence since 1993 and that meets regularly. As with all of the things we do in mental health, we try and keep that national collaborative and collective focus that we are all working together. So we continue to work with the states and territories through that. In fact, in the Victorian budget I understand this week an announcement was made about mental health funding again for depression. There is a great deal of synergy in the way in which mental health responses are developing in this country, away from some of the older models that we have had in the last 20 years.

Senator CROWLEY—However, one of the things that is consistent is that as the large institutions have been closed, theoretically to be replaced with community services, the

community services have not been provided in sufficient amount to support the community needs—at least that is the word across the whole of Australia.

Mr Casey—All I can say in response to that, Senator—and I am not quite sure we always ever have enough—is that all of the money that has come out of institutional care has gone into community care, plus 30 per cent in real terms. I cannot say whether it is enough or not enough. All I can say is that all of the money that was saved through changing the structure of services has gone into community services in this country with a 30 per cent increase in real terms.

Senator CROWLEY—If you have a day and pop into any of those aforementioned capital cities and case the women's shelters, or the supported accommodation, or the really cheap boarding houses, you can come back and tell me what you think about sufficiency of community services for psychiatric patients.

Mr Casey—I am not saying that it is always sufficient, Senator. I do not think we always will have sufficient services for all of the mental health needs. All I can say is that there has not been a loss of resources over the last decade, as far as our very careful monitoring has gone in relation to the efforts of both Commonwealth and state governments in mental health in this country. There has been no reduction in resources. In fact, there has been a significant increase.

Senator CHRIS EVANS—Are you able to provide the committee with the statistics that back up that claim you have made?

Mr Casey—Yes, Senator, in the National Mental Health report which is published by the Commonwealth. I am happy to provide a copy. It is on our web site. We have monitored very closely the expenditure.

Senator CHRIS EVANS—I am not disputing your claim; I am just interested in having a look at the figures.

Mr Casey—I am very happy to provide that.

Senator CHRIS EVANS—Like Senator Crowley, you know, you run into the argument about the institutionalisation and loss of services all over the place, both in mental health and in disability services, it seems to me. It is an issue I am grappling with in terms of disability services. I would be interested in having a look at that. If you can give us the reference we will look it up.

Mr Casey—It is on our web site at www.mentalhealth.gov.au. We have had this problem before, Senator.

Senator CROWLEY—I am not at all sure that 'mentalhealth.gov' should be out there in the ether. One criterion that one might presume would be easy to measure would be a reduction in the admission rate to psychiatric institutions. I am interested in how you plan to put admission rates or return visits into your assessment of care.

Mr Casey—I would have thought a more accurate evaluation might have been the extent to which patients, say, complete a period or an episode of care, the extent to which patients do return to their general practitioner for review and follow up and the extent to which there is an improvement in periods of time in their mental health. As to the admission rates into the acute sector, they are albeit a very small proportion of people with mental health needs—and I am not sure that one would necessarily have any change in the impact on admissions to acute psychiatric care beds as a result of this initiative, because I think they are slightly different populations; not that that population is excluded. What one might see is improvements in the

coordination and integration between the general practitioners and the responsiveness of the acute sector to when they believe that a patient requires in-patient care. It might be more around the better integration rather than the actual change in admission rates.

Senator CROWLEY—I do not know whether you can confirm this or not, but a few years ago the figures, I understood, were that something like 80 per cent of schizophrenics were treated by their general practitioner, were very well managed and went to work, lived a perfectly ordinary life in the community and never sought admission, never had to be admitted. Are those figures still more or less the same, as far as you know?

Mr Casey—I would not be able to comment specifically on that. What I can refer you to, Senator, is that as part of the Australian national survey of mental health and wellbeing, there was a study undertaken into what was called low prevalence disorders, which are predominantly the schizophrenia group of disorders. I would be happy to provide a copy of that report by Professor Assen Jablensky. It is considered to be of world standing in epidemiology in this area. What his report has found more fundamentally is that approximately 80 per cent of people with psychosis are in touch with medical services and receiving medical support. Where we perhaps fall down as a community is that their social supports, their access to education, their access to employment, et cetera, are somewhat lagging in what we would like to achieve; there is not enough social support. But I would be very happy to provide you with a copy of that report.

Senator CROWLEY—Thank you.

Senator WEST—You should not have directed me to your web site. It is a dangerous thing to do. I notice you have a lot of brochures on there, a lot of other documents. What are your printing and publishing costs per year? Where does that come from? I am serious. This is all part of accountability. Where does it come out of?

Mr Casey—To give you a detailed answer to that I would have to take it on notice.

Senator WEST—That is fine.

Mr Casey—But I can give you a breakdown of what comes from departmental and what comes from administered funds for those.

Senator WEST—That is okay. I am happy to have that on notice.

ACTING CHAIR (Senator Tchen)—I have a quick question on the $2 million set aside for the safety of Australia's blood supply.

Ms Briggs—Your question, Senator?

ACTING CHAIR—Has a problem or problems been identified with the safety of Australia's blood supply?

Ms Briggs—No, the funding in this budget relates to the department's work flow in the area of blood and blood products. Key amongst the requirements for the department in the next 12-month period are our preparations and, indeed in some cases, negotiations of contractual arrangements with CLS Ltd for plasma products and so on, but also contractual discussions—'discussions' is probably the wrong word—working through our relationship with the Australian Red Cross Blood Service and how we manage that relationship. The extra funding in the budget is going to enable us to bring in some experienced commercial and economic expertise and some legal expertise, as well as some blood management expertise, to enable us to deal with those challenges before us.

In addition to that, the government has recognised that the Commonwealth needs to have appropriate ongoing financial management arrangements for its contracts or its arrangements in these areas and there is some money as well for some additional staff to work in the blood area. Clearly, we are increasing the amount of resourcing we are putting into the management of blood and blood products, in view of the challenges before us.

ACTING CHAIR—I understand the Stephen review into the blood bank and plasma safety is still ongoing. When do you anticipate there will be a report?

Ms Briggs—Senator, the minister has received that report and has it under active consideration. I would hope that a response to the report and the report will be released shortly.

ACTING CHAIR—All right. That would be apart from this measure announced in the budget.

Ms Briggs—Yes.

ACTING CHAIR—Thank you.

Senator CHRIS EVANS—How much of that money is for this public communications strategy?

Ms Briggs—We have $140,000 to provide information to donors, contractors, decision makers and the general public.

Senator CHRIS EVANS—And that is, broadly speaking, called the public communication strategy, is it?

Ms Briggs—Yes.

Senator CHRIS EVANS—And what form is that likely to take? Do you know?

Ms Briggs—We will employ, for about 30 days, a public relations person to work with us, but as well as that the significant contribution is around preparation, publication and distribution of a booklet.

Senator CHRIS EVANS—A booklet?

Ms Briggs—Yes.

ACTING CHAIR—I think we were at outcome 4. We will go on to outcome 5.

[4.41 p.m.]

Senator WEST—I think I might go and do some more nursing. Can you tell me about the rural nursing scholarships?

Ms Davidson—In total 110 have been provided for undergraduate study, 10 of which have been earmarked for indigenous students, and they are targeted at people from rural areas. So that would be in RAMUS classification 3 to 7. We will be looking to get an organisation to administer the scholarship scheme for us. We have not yet had discussions with the groups that we are considering.

Senator WEST—So what sorts of groups are you considering?

Ms Davidson—At the moment we have some postgraduate scholarships that are administered for us by the Royal College of Nursing, so we are going to have discussions with the college about the possibility of them administering the scheme.

Senator WEST—This is only going to go for four years?

Ms Davidson—Only in that government funding is provided in that sort of time period. I do not think there was an expectation that it would end at the end of that period.

Senator WEST—So there are 110. There are 100 that are going out and there are 10 that are for indigenous students. Do they get the scholarship for the full three years? Do they get it as a first-year undergraduate or when it is going to be—

Ms Davidson—The scholarships will be available for the full course of study, and they are available from first year.

Senator WEST—I have just been trying to work out the figures in the book that you have given us.

Ms Davidson—They are worth $10,000 a year. Basically they are going to be similar to the RAMUS scholarships that we have for medical students.

Senator WEST—Does that mean when it gets up and running you will actually have 300 scholarships on the go each year?

Ms Davidson—It does mean, yes, that it will build up each year. I have not actually got the figures but, yes, we are providing 110 new ones per annum.

Ms Briggs—By three is 330.

Senator WEST—Yes, and if it was only going to be 100 you were going to have to do some really fast explaining. Where is the rest of the money going to go? You are talking a million dollars here. What is the go?

Ms Briggs—There is some money available, about half a million dollars each year, for support measures in and around the scholarships. Ms Davidson might be able to give you a more precise breakdown of that, but some of that is around the indigenous scholarship holders and the requirements that we have found in various departmental programs over the years for support and mentoring—indeed in some cases some additional money for those scholarship holders so they can continue their course and stay in it.

Senator WEST—It is easy to say when it is fully operational that it will be 300 a year, because it is a three-year course. Will that mean that there are 300 additional nursing places at university or the same number of university places but just that 300 are getting—

Ms Davidson—Senator, my recollection was that there was something in the education portfolio about places at rural universities, but you would need to check that. We do not have specific additional places because we were advised by the department of education that this extra number was quite reasonably able to be accommodated within their existing arrangements, in terms of places.

Senator WEST—How will it be divided up amongst the universities? That is the next question, because the students who nominate to study for the majority or the entirety of their degree in a rural campus means not just rural universities but also some of the sandstones that have rural campuses. Is that correct?

Ms Davidson—Yes, Senator.

Senator WEST—They do not have to do all of their degree at the rural campus?

Ms Davidson—No, and we would be taking that into account. In states where that is not an option, we would not exclude people from rural areas who had a commitment to nursing in rural areas if it was not feasible for them to actually study—

Senator WEST—Does Tasmania have a campus for nursing that is not in Hobart?

Ms Davidson—I am not sure, but I know it is not possible in all states, so people will not be precluded if there is not an option of studying at a rural university in their state. It would be part of the criteria that we would take into account.

Senator WEST—That is fascinating, because that comes back to my question that we went through with the RAMUS scholarships: how are you going to define a rural student? Have you worked that one out?

Ms Davidson—We were going to define them in the same way that RAMUS has defined them.

Senator WEST—So that one is sorted out.

Ms Davidson—It means they need to have spent five consecutive years or eight cumulative years during their formative years in a rural area.

Senator WEST—What is the shortage of nurses in the country? When I say country, I mean Australia.

Ms Davidson—Australia wide?

Senator WEST—Yes.

Ms Davidson—I do not have information on that. We could take that on notice.

Senator WEST—You are probably not the right area to be asking. What is the right area to be asking? I will serve it up at the correct time.

Ms Davidson—It would be in outcome 9.

Mr Wells—Senator, I could deal with it now, if you like.

Senator WEST—All right.

Mr Wells—The answer is that I do not think we have a figure on that. ARMAC has set up a committee called the Australian Health Work Force Advisory Committee, which is to look at the health workforce other than the medical workforce. Part of that committee's job will be to come up with those sorts of numbers. At the moment we do not have a number that we would put up as the national figure.

Senator WEST—I am just wondering what benefit this is going to be in the short and medium term to the shortage of nursing staff in rural and regional Australia.

Ms Davidson—It is based on the premise that people from rural areas, if they study nursing, are more likely to return to rural areas to undertake a nursing career. It has a similar premise to the arrangements we have made in terms of medical training, to try and get more people from rural areas into health professions, and to try and get more of that training occurring in rural areas.

Senator WEST—I just think of those I trained with. We are all high, wide and handsome. There is a swag of us who are not even in the industry. I am trying to think of staff I see working in hospitals, and I would think that nursing is one area where you get a lot of travel and mobility in new graduates. If I had time I would pursue hat with the work force group in outcome 8, but obviously I am not going to have time. You say 300. What is the attrition rate of nurses out of universities, or out of any course?

Mr Wells—Senator, we do not know that. In fact, the government has just established a national review of nursing education jointly between education, training and youth affairs,

and health and aged care. That, I would expect, would be one of the questions to which we could get an answer from that review.

Senator WEST—I would have thought there would be some figures around from the last 50 years, because the attrition rate is fairly high, I think.

Mr Wells—Senator, it has only been in about the last 10 or 15 years that we have predominantly done our nursing education through universities.

Senator WEST—Yes, and the attrition rate of training in hospitals was high, too.

Mr Wells—Yes.

Senator WEST—When are you going to pay the scholarships?

Ms Davidson—From next calendar year.

Senator WEST—What time of the year will they be paid?

Ms Davidson—We would still need to discuss that with whomever we get to make the arrangements for us.

Senator WEST—What criteria will there be when you get the situation of someone who gets a scholarship and dips out after, say, the end of first semester and you have already paid them the scholarship? What is going to be the situation?

Ms Davidson—That is part of the details that we would need to develop in terms of developing detailed guidelines to administer the scholarships.

Senator WEST—Will you be having 100 for first year, 100 for second year and 100 for third year? Is that the way you will be divvying up the money?

Ms Davidson—It is actually 110 when we include the 10 indigenous ones.

Senator WEST—Yes.

Ms Davidson—We are primarily targeting first-year students. Sorry, Senator, I have forgotten your question.

Senator WEST—I want to know what is going to be the break-up of the money. The hypothetical is that you have a whole lot starting first year, by the beginning of second year you have had a drop-off and at the beginning of third year you have had a further drop-off. Once they have got to halfway through third year they usually complete.

Ms Davidson—Yes.

Senator WEST—It is in the first 18 months, I am told by academics, when there is a big attrition rate. How are you going to ensure that you are targeting this money to those who are actually going to complete their studies?

Ms Davidson—Part of the criteria that we have envisaged—although it is still something, as I said, that we need to develop further—would be trying to look at people's commitment. Also, Ms Briggs indicated there is some funding available for mentoring of these scholarship holders to try and support them through their courses. But from discussions I have had in the past with Queensland Health, which have been offering scholarships for a number of years, they have found that if you screen who you provide the scholarships to in the first place you can get a better rate of people completing their courses.

Senator WEST—What is the screening process going to be?

Ms Davidson—I do not have the details, Senator. As I said, we have some idea of some of the criteria we would look at, but we basically want to develop how we would do it in conjunction with the body that was going to administer it for us.

Senator WEST—What are the criteria you are going to look at?

Ms Davidson—We are going to look at some criteria which are similar to those for the RRMA scholarships: the length and recency of time the applicants have spent in rural areas, the financial need of applicants, their commitment to practise in a rural area and their current residency status. We are going to look at whether or not there is a rural campus, as we indicated, in the student's state and at the commitment of the students to doing rural clinical placements during their degree.

Senator WEST—The National Rural and Remote Health Support Program has no money attached to it.

Ms Briggs—The reason for that is—I think as Dr Wooding explained on another matter yesterday before the committee—that the ongoing funding for that was already in the forward estimates, so what this budget does is confirm it as an ongoing program.

Senator WEST—Does it suffer any drops or any changes in the amount of money?

Ms Davidson—No, it is ongoing at the existing level.

Senator WEST—The Advanced Specialist Training Program is still operating?

Ms Davidson—Yes. That was one of the things that we funded out of that money.

Senator WEST—How many specialists do you have out there now? Where are they and how long are they going to be there for?

Ms Davidson—In 2001 there are 34.

Senator WEST—How many did you have last year?

Ms Davidson—Last year we had 33 posts. This year we have not completed an agreement with the New South Wales government but our understanding is that they actually are operating the posts. If I include those, there are five in New South Wales, six in Victoria, two in South Australia, two in Tasmania, five in Western Australia, four in the Northern Territory and 10 in Queensland.

Senator WEST—What are rural and remote nursing projects?

Ms Davidson—We have provided funding to CRANA, which I think I mentioned this morning.

Senator WEST—Yes.

Ms Davidson—As well as providing direct funding to the organisation, we provide funding for the bush crisis line, which is a telephone support service for isolated rural and remote health practitioners that CRANA operates for us. They also get funding to operate first-line emergency care training for nurses in remote areas.

Senator WEST—There is no change to the variations of amounts within that program; it is similar to last year.

Ms Davidson—Yes.

Senator WEST—What is happening about regional health services? Regional health services is indicator 4 on page 166. It is mentioned somewhere else, too—in relation to better health services for rural Australia.

Ms Davidson—Senator, at the moment we have 109 regional health services that have been approved. Eighty of those are operational. Twenty-nine of them have been approved but we do not yet have the contract in place and they are not yet operating. A number of those approvals represent approvals for planning projects. As I have indicated, about half of the proposals are actually for service planning.

Senator WEST—Maybe you can take it on notice and give me a list of where all the successful 109 are, or the 80 plus the 29 that are obviously in the planning stages, and a brief idea as to what the service is that is being offered. I will go back to my multidisciplinary thing again. That has got recurrent funding, I take it?

Ms Davidson—Yes. I am happy to take that on notice and provide it to you, but I can indicate that most of the funding that is going into that program is for allied health nursing services across a range. There is palliative care. Mental health is featured prominently. We can give you some more information on that.

Senator WEST—Communities are beginning to understand the breadth of their health needs.

Ms Davidson—Yes.

Senator WEST—What is the number of applications that you have received up to date? It was about 400 or something, I recall.

Ms Davidson—This is the question you asked on notice, Senator.

Senator WEST—Yes.

Ms Briggs—In answer to your question, we said as of March we had 245 proposals and about 94 of those have been rejected as they did not meet the funding criteria.

Senator WEST—Can you give me some idea as to why they did not meet the funding criteria? I do not want to identify any particular place. Is there a trend?

Ms Davidson—A lot of the ones that were rejected were in New South Wales, where a different process was run. Our New South Wales state office advertised for proposals, whereas none of the other states went down that track. I think as a consequence of doing it in that way, they got a lot of proposals that did not fit within the sorts of guidelines we were looking for or were not able to demonstrate real community involvement. I do not have the exact figure but I think a large number of them in the 94 would be from New South Wales, whereas what tends to happen in other states is that often we work with the community before they put in their application. I think I explained to you last time that not too many people get rejected outright; we might go back and try and work with them to modify their proposals. But a large number of these were because of New South Wales.

Senator WEST—How much of your budget has been spent in that negotiation and working out process and how much has been spent on actual hands-on delivery of a service, or provision of money so they can deliver the service?

Ms Davidson—I do not think I can give that to you today. I would have to take that on notice.

Senator WEST—That is fine. Maybe your New South Wales branch would like to look at the Sinclair report because you might be able to go and pick communities and areas that would benefit very greatly from this. There would appear to be some synergies between what this project is doing and—

Ms Davidson—There has been a lot of follow-up work in New South Wales after doing the advertisement round. They have worked closely now with the state government and have worked out some areas to target, so there is quite a bit of service planning happening.

Senator WEST—I know, I am getting the phone calls from the communities. That is why I am saying that you should go back and talk to that group, because I can only tell them so much. There was a topic called rural communications strategy. What is happening there?

Ms Davidson—Last time, I indicated that the focus of that was really about providing information products to people about the different programs we have operated. We gave you a package of materials that we have developed. The focus is on rural areas and is fairly low key. We are not looking at a high key campaign. We want to try and get information to people about the different initiatives and how they can get more information or how they can apply for them.

Senator WEST—Is that going to be having a bit of an upgrade or change in emphasis? Are you going to go in for electronic media advertising?

Ms Davidson—The electronic media we had really talked about using is possibly rural radio, which is not expensive. We have not ruled out using rural television but we do not have a large budget, so there is no plan for national radio or television campaigns.

Senator WEST—But there might be some regional radio and television.

Ms Davidson—There might be. We have not ruled that out as a possibility.

Senator WEST—When is that decision going to be made?

Ms Davidson—I imagine it would be made next year, Senator.

Senator WEST—As in next financial year or next calendar year?

Ms Davidson—Next financial year, sorry.

Senator WEST—Early in the year?

Ms Davidson—I would only be speculating.

Senator WEST—It is probably something that needs to be asked more in outcome 9 anyway. I think that will keep me out of mischief, thank you.

CHAIR—Is that your swan song, Ms Briggs? On behalf of the committee we would like to say thank you very much. For those of you who do not know, Ms Briggs has been given a promotion to deputy secretary of transport. Congratulations from us but thank you, most importantly, for what you have done for us over 10 years. It has been terrific and we are very grateful. Thank you very much.

Ms Briggs—Thank you, Senator. The minister has just asked me where I am going. I am going to the Department of Transport and Regional Services. My time before this committee over 10 years has been quite considerable, obviously. The thing that I have noticed with both the coalition and the Labor Party in the chair and in the questioning position is that they have always treated me and my officers very fairly. We have greatly appreciated that, so I would like to thank you all.

CHAIR—Thank you. All the best of luck to you. We will move on to outcome 6, hearing services.

[5.07 p.m.]

Senator CHRIS EVANS—I think we have had this discussion a couple of times but I am trying to come to terms with what is happening with hearing services. The government a couple of years ago put a lot of money into an extra budget allocation to cope with the introduction of the voucher system. You and I probably have different interpretations of what occurred there, but I got a sense that the voucher system had opened up competition and therefore maybe an increase in demand. It seems that since then your demand for services has actually been falling, or you seem to be providing less services than previous years, or certainly around the same number of services. I am trying to get a sense of globally what is happening with hearing services and the provision of services to client. It is a very general question but I just want to get a feel, first of all, for where we are at in a macro sense.

Mr DeGraaff—Perhaps I will go through where voucher issue has gone since the first full year of the voucher system, which was 1998-99. In 1998-99, as you said, there was a significant increase over the estimate for that year of voucher issue. What happened in that year was that there were 139,000 vouchers issued. That voucher issue number was used to then project the forward estimates. It resulted in, as you said, the government putting $209.5 million over four years into the 1999-2000 budget. What then happened in 1999-2000 was that 121,000 vouchers were issued, which was against an estimate of 140,000.

What is happening in this year is that against an estimate of 124,000 vouchers we are going to come in almost right on 124,000 vouchers. We believe that our forward estimates now are a lot more accurate and are based on accurate demand. The forward estimates for voucher issue in the forward years of this budget are only based on demographic growth, in the main. They are the sorts of increases, year by year, that are represented, from 121,000 for 1999-2000 to 124,000 for this year.

Senator CHRIS EVANS—You say 124,000. Did you originally estimate 125,000 for 2000-2001, or have I got the wrong figure?

Mr DeGraaff—I believe the estimate was a little bit more than 124,000. I was just using general numbers there.

Senator CHRIS EVANS—Just so I understand, do you say that the larger number in 1998-99 was due to pent-up demand? Or is it fair to say that you have instituted measures that have controlled the explosion in vouchers or the demand for vouchers? Or is it a combination of both?

Mr DeGraaff—I believe, looking back, that the issue of the 139,000 vouchers in that first full year after the introduction of the voucher system was part of the reaction to the introduction of the voucher system and the awareness that came about in terms of those people who were eligible for the system. The voucher take-up in that year was reflected mainly by that effect. What we are seeing now is not so much a reduction in demand as more of a levelling out of demand.

Senator CHRIS EVANS—Would you say that has partly been because of the tightening of rules about access to vouchers? I am not trying to put words in your mouth but is there another end to that equation. I know you changed one of the rules relating to rehab services or repairs. I am trying to get a sense of whether contributing to that is actions you have taken that might have affected the availability of vouchers.

Mr DeGraaff—The budget measure you are talking about from the last budget I think, Senator, is where we increased the life of a voucher from one year to two years. That impacts on return clients in the first instance. They come back in for a voucher and instead of getting a one-year voucher they get a two-year voucher. New clients, of course, when they come in this

year since the implementation of that budget measure, will get a two-year voucher. There is an effect there between this year and next year because the main impact of that budget measure is on this year. For example, in the forward estimates for next year we are looking at issuing 134,000 vouchers as opposed to 124,000 this year.

Senator CHRIS EVANS—Just so I understand it, you are saying that that is a one-off impact from the change in this year. Is that fair?

Mr DeGraaff—Yes, it is. It will mainly impact in this year. There will be a very slight impact for the next two years.

Senator CHRIS EVANS—Do you think a more accurate assessment of voucher demand, the 134,000 next year, allowing for any changes in population, would be a more likely sort of base figure than this year's?

Mr DeGraaff—This year's, we believe, is very accurate because we took into account the impact of that budget measure.

Senator CHRIS EVANS—Yes, but I am saying it is impacted by that budget measure.

Mr DeGraaff—Yes, it is.

Senator CHRIS EVANS—In a sense it is an abnormal year, isn't it?

Mr DeGraaff—It is in that sense. In that sense, though, as you say, the 134,000 for next year is an accurate figure, we believe.

Senator CHRIS EVANS—What can you tell me about the average cost of the vouchers and how that has been changing over time?

Mr DeGraaff—The average cost of the voucher has changed slightly over time in that it has increased slightly. The main reason why the average cost of the voucher has increased slightly is that we have a number of clients, particularly new clients, who get the voucher and come in to have their hearing assessment, then they do not proceed to a fitting. We term that 'assessment only rate'. That rate at the beginning of the program was about 25 per cent and that assessment only rate in this year is running at around 20 per cent. There has been a five per cent decrease in that assessment only rate, so that means that five per cent more clients are being fitted after their assessment. That has been the main contributor to the increase in the average voucher cost.

The other contributor is the portion of the appropriation that is set aside for maintenance. In other words, once a client has been fitted they then go to on successive annual maintenance agreements until they need their next fitting. That number of clients is a large number. In this year about 360,000 adult clients will get a service under the program and of those, as I said, about 124,000 vouchers will be issued. All of those clients out of that 124,000 who are fitted will then go into the maintenance pool. The maintenance pool proportionately increases more than the number of clients coming in with a voucher. That too has an impact on the average cost of the voucher because there is more in the maintenance pool.

Senator CHRIS EVANS—I think I understand that but I will read the *Hansard* to be sure. I think I follow. Can you give me the figures for the average cost of the vouchers? I had a figure of $646 for 1998-99. Is that right?

Mr DeGraaff—I think I have those figures here, Senator. Yes, that number that you have is the average cost for a return client voucher in that year. The average cost for a new client voucher is higher than that. I do not have the figure for the average cost per voucher, so I will take that on notice.

Senator CHRIS EVANS—Take that on notice for the years from 1998 onwards and your estimates for next year for both the new and the return.

Mr DeGraaff—Yes.

Senator CHRIS EVANS—From what I can see, your community service obligation will actually fall next year in terms of dollars spent. Is that right?

Mr DeGraaff—That is correct, as stated in the PBS.

Senator CHRIS EVANS—Can you explain that to me?

Mr DeGraaff—That effect has been created by the fact that in this financial year at additional estimates we brought forward around $600,000 to allow Australian Hearing Services, which delivers community service obligations under the program, to take advantage of a very competitive price for cochlear implant speech processing units that they could purchase. We brought forward at that time, from the forward years of the budget, around $600,000. There is an actual underlying increase in the community service obligation appropriation, or element of the appropriation, of around $300,000 for next year.

Senator CHRIS EVANS—What is that in percentage terms?

Mr DeGraaff—That increase is a straight effect of the indexation on the appropriation.

Senator CHRIS EVANS—If you discount the advance purchase, you are telling me that it is a straight CPI adjustment.

Mr DeGraaff—Yes, by the Treasury index that is used for our appropriation.

Senator CHRIS EVANS—Which one do you use?

Mr DeGraaff—I am not exactly sure.

Senator CHRIS EVANS—It is not a big point. It is just that there are so many of them I like to keep track. What percentage was that for next year?

Mr DeGraaff—I believe it is of the order of 1.5 per cent.

Senator CHRIS EVANS—Perhaps you would like to take on notice which index they use and confirm for me that it is 1.5 per cent.

Mr DeGraaff—We will take that on notice.

Senator CHRIS EVANS—That looks about right if you put it across the figures. Despite the fact that, on comparing this year's with next year's, it looks like there is a drop of $400,000 in expenditure on community service obligations, you are saying to me that that is explained by the advance purchase last year of the implant equipment.

Mr DeGraaff—Yes, in this financial year.

Senator CHRIS EVANS—That was brought in this year but will be providing services next year.

Mr DeGraaff—Yes, there will still be services provided under the cochlear implant speech processor unit upgrade program—part of the community service obligations—in the budget year and in the forward years as well. It is just that that money was brought forward to take advantage of that competitive price, but there is still some money there to take on the ongoing requirement for those upgrades.

Senator CHRIS EVANS—How much is that? The budget measure again is one of these four zero jobs which says, 'placements of speech processors for children with cochlear implants'—you know, zero dollars in the outyears.

Mr DeGraaff—It is the same answer that was given earlier by Dr Wooding. That amount has been put into the base for the forward estimates but the actual amount is around $400,000 a year for the next four years.

Senator CHRIS EVANS—The actual amount is $400,000 per year for that part of the program.

Mr DeGraaff—For the budget period, yes.

Senator CHRIS EVANS—Is the $600,000 you brought forward out of that money?

Mr DeGraaff—No, it is not out of that money. That is net of that money that was brought forward.

Senator CHRIS EVANS—Which budget year did the money that was brought forward come out of?

Mr DeGraaff—It came out of the forward years.

Senator CHRIS EVANS—All forward years, not just the next financial year?

Mr DeGraaff—No, it came out of all forward years.

Senator CHRIS EVANS—How is it that you took $600,000 out of the four forward years and you should have had a $300,000 increase next year, yet you look to be net for $400,000 down? From my very poor arithmetic, that does not work.

Mr DeGraaff—I recall that the yearly amount for that program in the forward years was estimated to be slightly more than $400,000 but I would like to take that on notice because I do not have those detailed figures here. That is my recollection, but I will take that on notice.

Senator CHRIS EVANS—I am not trying to make a case here, but there is a reduction in the community service obligations for next year and, on the explanation you have given me, that does not seem to explain that in total. If there was a $300,000 increase in the expenditure on CSOs, that would get you to $29 million. You actually have $28.3 million, which says you are $700,000 down and that is explained by $600,000 that was allegedly taken over four years. Do you see what I mean? It does not seem to add up.

Mr DeGraaff—Yes, I can see your point, Senator.

Senator CHRIS EVANS—It looks to me as if the figure for the numbers of clients you have been servicing has been steady or falling. I see last year the number of children you were servicing fell. The number of pensioners and veterans you were servicing fell. I just wanted to know what was going on there and how that is explained. You seem to be providing fewer services to fewer clients and then the budget figures say you have a drop in your CSOs as well. It has been raised with me as a concern as to what is happening here.

Mr DeGraaff—Senator, I am not sure which figures you are looking at there but, in the community service obligations, the services that are delivered to children year by year have remained fairly constant at about 40,000 children a year getting a service.

Senator CHRIS EVANS—That is right, but in 1998-99 you serviced 43,866 and in 1999-2000 you serviced 43,321, so it is 500 down. If you have the figure for 2000-01, I would appreciate it. I see the numbers falling and then I see the CSO allocation falling. I am a bit concerned to make sure that we are not reducing our commitment to the CSOs.

Mr DeGraaff—I think with children, the services are delivered to those children that present, and that can fluctuate from year to year. The other underlying effect is that the birth rate over time is decreasing as well. Those two things taken together would indicate that there would be fluctuations year by year with a downward trend over time.

Senator CHRIS EVANS—According to my figures you also serviced 7,000 fewer pensioners and veterans between 1998-99 and 1999-2000. I assume the birth rate does not explain that one. Maybe the death rate does!

Mr DeGraaff—The adults that receive services under the community service obligations are mainly what we term complex clients. The number of complex clients that are receiving services under the program has actually increased over the last three years. I do not have those detailed figures with me but I can certainly provide those to you and take that on notice.

Senator CHRIS EVANS—I am just pulling figures out of your annual report. The figures I have are that you serviced 115,783 pensioners and veteran clients in 1998-99 and 108,000 in 1999-2000, unless I have mucked it up. You serviced fewer veterans and you serviced fewer children. When I look at the 'hearing aids fitted' figures, they seem to be falling as well. I admit my last figures were for 1999-2000, so I am interested in who you serviced in 2000-01 and whether these trends which seem to be reflected in the figures for the last couple of years have continued.

Mr DeGraaff—Senator, I can take on notice getting you the accurate figures for 1999-2000 and also what the year-to-date figures are for this financial year.

Senator CHRIS EVANS—I appreciate that, Mr DeGraaff. I would appreciate it, Dr Graham, if you could perhaps give me an undertaking about getting those in a reasonable period of time. I know there is pressure sometimes with other questions on notice but, to be honest, I think—maybe this should be to you, Mr Borthwick; I am not sure—these are questions that are usually answered at estimates in terms of the services provided and the figures, and I just wanted some sort of reassurance that I would not have to wait three months before I got an answer to that. I am not trying to be smart. It seems to me that it is a reasonably easy figure to get. I just want to know that I am going to get it in a reasonable period of time.

Mr DeGraaff—Senator, we can get to that figure quickly. Can I just clarify that you are asking for those numbers in relation to services provided under the community service obligations?

Senator CHRIS EVANS—Both vouchers and community service obligations, Mr DeGraaff, because all of those figures I look at seem to indicate a reduction in the number of services provided between 1998-99 and 1999-2000 and I want to know what happened in 2000-01. And I then see, in dollar terms, CSOs dropping. You have given me an explanation which, as I say, I accept without question, but it does not then match the maths exactly. I really do want to understand whether or not we are continuing to provide as many services and if not why not. That is why I started with the global. If there is something happening here, I am happy to hear it, but I just do not get a sense from what you have said as to why we would be providing fewer services.

Dr Graham—We will provide that information, Senator.

Senator CHRIS EVANS—Thanks for that. We were going to have a bill that sorted out all the legislative basis of all this, weren't we? Has that been abandoned? It was on the *Notice Paper* for a couple of years.

Ms Murnane—It still is on the *Notice Paper*.

Senator CHRIS EVANS—I am glad I did not hurry up and prepare for it.

Ms Murnane—It is there on the latest *Notice Paper*.

Senator CHRIS EVANS—I have been meaning to prepare for that debate for a couple of years now. I am glad I did not hurry. No doubt when it comes on I will not be ready. I am happy to concede that. I am not trying to get into a policy question, Minister, but it is the intention for that legislation to be proceeded with, is it?

Ms Murnane—It is on the *Notice Paper*, yes.

Senator CHRIS EVANS—I thought that might have been abandoned. What is the current relationship between the department, the government and Australian Hearing Services?

Ms Murnane—Australian Hearing Services is a statutory authority.

Senator CHRIS EVANS—Is it a purchaser provider agreement?

Ms Murnane—We fund the voucher system, we fund the CSOs, and Mr DeGraaff will describe the arrangements.

Mr DeGraaff—Senator, the way that the arrangement works in relation to Australian Hearing Services is that under the voucher system Australian Hearing Services has a service provider contract with the Office of Hearing Services, the same as all of the other private providers that are in the scheme. There are about 133 of those; 134 including Australian Hearing Services. For the community service obligations, Australian Hearing Services is the only provider of those CSOs and we fund Australian Hearing Services on a monthly basis over a year to provide those services.

Senator CHRIS EVANS—Do you say, 'They should get an average of this many clients expected, so we will pay them as a contract for the year,' or is it based on the number of services, CSOs, they provide?

Mr DeGraaff—It is an agreement based on the appropriation that the government provides for that part of the program and there is a reporting regime in place where Australian Hearing Services report to us on a quarterly basis on what services they have actually provided.

Senator CHRIS EVANS—But, effectively, you say you are going to pay them $28 million a year on a monthly basis and they provide the service?

Mr DeGraaff—Yes.

Senator CHRIS EVANS—In terms of the vouchers, though, you do not guarantee Australian Hearing Services a share of the vouchers or a market share?

Mr DeGraaff—No. They are in competition for those vouchers with those other 133 private service providers.

Senator CHRIS EVANS—How much of the market do they have currently?

Mr DeGraaff—The actual figure I do not believe I can give you, Senator.

Senator CHRIS EVANS—Just roughly.

Ms Murnane—Senator, from our point of view we would be prepared to give it to you. AHS themselves have been insistent that that figure is commercial-in-confidence. I know there are issues around in camera presentations at this hearing. We would be prepared to provide it to you but the chair, the board and the managing director of AHS would regard it as detrimental to their interests were we to make that available.

Senator CHRIS EVANS—I have a general view about these things. If I cannot be told in public I do not want to be told, in the sense that it seems to me it is a matter that I can legitimately ask about. It is not a burning issue for me. I do want to get a sense, though, of what share of the market they have. Do they represent 50 per cent of the market or 10 per cent or 90 per cent? It is that sort of thing. I assume someone with any knowledge of the industry could tell me off the top of their head. I am just trying to get a feel for that, but not commercial-in-confidence.

Ms Murnane—It is certainly not 10 per cent. There has been a contestable system in place now since 1997, so it would be unlikely that it was 90 per cent. I think I would like to leave it at that.

Senator CHRIS EVANS—So it is somewhere between 10 per cent and 90 per cent. Thank you very much! Maybe I do feel passionately about this and maybe I will not accept it! Sometimes it seems easier than cooperating. I suppose you can't tell me how much you pay them either? That is secret too, is it? And you cannot tell me how much government money we spend on—

Ms Murnane—What we pay in relation to CSOs is available. We have given you that. What we pay in relation to the voucher system as a whole is public. Were we to give you the funds that were transferred to AHS on the basis of vouchers presented, we would put you in a position where they would regard others—that is, their competitors—as being able to derive what their market share was.

Senator CHRIS EVANS—Yes, I know that.

Senator Vanstone—Can I just offer a suggestion? I do not know if you will regard it as helpful. I understand your view that if you cannot be told publicly you do not want to be told. That is an attractive proposition because then you cannot be blamed for leaking it, which you are an easy mark for if you know something other people do not know. Unless the standing orders and various other arrangements have changed, estimates committees cannot actually take in camera evidence but you could ask for the same committee sitting in another capacity, in a different session, to have an in camera session. It would be not just you but the whole committee and there would be a *Hansard* record of it.

You can get that element of accountability by shifting out of estimates into another committee at another time and giving the department notice that you want to do it. I say that because I have a longstanding interest in the ruse of commercial accountability. Often there are cases where it is perfectly appropriate but there are plenty where it is not. Take the case of a carpenter who makes a table here and has to have the price of the table available so that every other damned carpenter can see how much he charged for his table. In some industries there is a degree of preciousness about the price that they have been paid in the end. They have been paid taxpayers' money for which the government should be accountable.

There will be circumstances where that is not appropriate but I think this has been dealt with by a number of estimates committees. There are a number of reports on it. If departments want to make that claim they have to argue the case as to why it is. This all started back in the eighties. I will not give you the detail of it now but it started with someone asking how much Geraldine Doogue of the ABC was paid—an inquisitive, nosy question for no reason other than a passing interest—only to discover that 'auntie' was writing lots of contracts and putting in every one, 'Your salary is commercial-in-confidence.' Well, I do not think so! There is a long history of reports from that position on that you might like to look at. I offer that as advice.

Senator CHRIS EVANS—I was going to research it actually. Thank you, Minister, for preparation to do battle with you tomorrow about FACS' refusal to hand over some documents.

Senator Vanstone—But, as I say, there will be circumstances but they have to be justified. They cannot just pop out at whim, 'I don't want to tell you, so I'll say it's commercial-in-confidence.'

Senator CHRIS EVANS—I thank you for that intervention.

Senator Vanstone—Can I just make the point that if you do not do that, if you allow someone to do it on the making of pencils, for example, then you allow them to do it on the purchase of an aircraft carrier. What is the difference? You have to get some basic principles in order here.

Senator CHRIS EVANS—Yes, I think that is right. That is why I am reluctant to let it go now. I think the answer, with respect to the officer, is a bit unsatisfactory.

Ms Murnane—Senator, first of all there is the annual report that has some information in it, although my recollection is it is not the sort of information you are seeking. As I have said, what the department is doing is acting in trust, really, for AHS which is now, as Mr DeGraaff says, in competition. Were the chair and the managing director to be comfortable with us giving you this information, from our point of view we would be prepared to give it.

Senator CHRIS EVANS—Thank you for that, Ms Murnane. From my perspective I think you are in trust for the taxpayers of Australia and that is where your obligation falls, as does mine. I am not asking you what a commercial statutory authority view of the world is; I am asking why the taxpayers of Australia, through their elected representatives to the estimates committee, cannot find out how much we are paying somebody who is providing services to the Australian public on contract.

Ms Murnane—In terms of the contract, in terms of the money that only they get, you do know that. But I will follow that through. I would not want to diminish in any way our sense of responsibility to the taxpayer for the moneys and programs we are responsible for. We take that very seriously indeed.

Senator CHRIS EVANS—But having made that statement, you then say you cannot tell me how much you pay somebody with taxpayers' money.

Ms Murnane—I am saying that I know Australian Hearing Services is sensitive about it. The reason I know it is that there is a committee advising the government on hearing services, and we used to provide to that committee the market share of the public provider and the market share of the private providers. The AHS became very uncomfortable with that and indicated to us that they regarded the providing of that information to this committee as something that was very much against their commercial interests. That is why I would prefer to talk to the chair and the managing director. I will certainly put your views to them and they will have *Hansard* to read.

Senator CHRIS EVANS—As I understand it, doesn't this bill on the list affect the status of Australian Hearing Services? Isn't there a change to their status?

Ms Murnane—Insofar as they would become a government owned company, I am not sure how that would translate into the sorts of responses we would give to you in relation to questions you have asked.

Senator CHRIS EVANS—I am just making the point that there is a proposition by the government in a bill before the parliament that they are going to change from a statutory authority to an Australian government owned company. We are going to be asked to do that, not knowing what share of the market they have or how much we pay them a year. It seems to me that you are not going to get away with that in the parliament. Sooner or later someone is going to have to say, 'What are we dealing with here?'

At the start of this estimates process I did say that this is a key issue for me, but I am not going to die in the ditch about it today. I do think that it is reasonable for us to know, as Senator Vanstone pointed out, where the taxpayers' money is going. I understand that they represent somewhere between 10 per cent and 90 per cent of the market; therefore we pay them an awful lot of money. There have been significant changes to the way we work the voucher system in the last couple of years. We ought to be able to assess what impact that has had on the provision of services. We will not be able to do that, or deal with the bill, if there is this sort of secret society attitude to it.

As I say, I am prepared to leave it today but I put you on notice that I am not conceding the ground on that. I would appreciate you taking it on notice and we will come to it another day, I suspect.

Senator Vanstone—Actually, Senator, you have reignited my interest in this issue. I do recall when your government used to have the view that we could not possibly know what was the rate we paid a barrister per day, any particular one, to run a matter for the Commonwealth. That was confidential. It would be a disincentive for them to work for the Commonwealth. I do not think so. They are lining up to get the work and always have been. The guise that was used was that there is a common discount given to the Commonwealth by QCs to do Commonwealth work. It does not sound like they do not want to do it, does it?

Senator CHRIS EVANS—Discount or premium.

Senator Vanstone—This discount was so common that everyone knew what rate it was, which made me beg the question at some stage that, if everyone knows what the discount rate is and you know what their daily rate is, what is the problem with telling us? It took some years and, to his credit, Michael Lavarch changed that and we were able to get the daily rate or at least the maximum paid to the highest barrister, and the number of days, as opposed to just a conglomerate amount. What you could be left with is a $100,000 to one barrister who might have worked 10 days, say 20 days, and $100,000 to another who had worked perhaps 100 days. So the total amount gave you no indication of real value, and you have sufficiently sparked my interest to see if there is any recalcitrance in A-Gs which have crept back to the old system.

Senator CHRIS EVANS—They are all contracted out services now so you would not run into the hourly rate. You would run into the fact that it was a commercial-in-confidence contract probably.

Senator Vanstone—I might have to go through a whole range of departments but I can guarantee that there are certain sections of the community that expect everyone else to be accountable to parliament except themselves.

Senator CHRIS EVANS—I think it is fair to say that it is not a political issue. Generally people in government tend to take a different view to when they are in opposition about that. I do not exclude myself.

Senator Vanstone—I have not lost my keenness about it, but I did want to add the rider that I think you will find there is a Senate report on this, that there will be circumstances when it is not in—I won't say the government's interests—the national interest, so that seems to raise it to too high a level, doesn't it? But you know what I mean. It is not in the interest of good government for certain figures to be released. There will be those circumstances, and under those there should not be.

Senator CHRIS EVANS—I am happy to concede that, and on a couple of occasions on various other matters I have let something go because I thought on balance maybe that is the case, but, quite frankly, when you have a contract between the Commonwealth and a company, be it a statutory authority or a private company, to purchase services on behalf of the taxpayer—

Senator Vanstone—No, let us have a look at what I say.

Senator CHRIS EVANS—I need to be convinced.

Ms Murnane—They say again that the vouchers they get are not actually a contract. They are accredited as are 124 or 125 other providers and they present claims as a result of vouchers fully executed.

Senator CHRIS EVANS—We pay them money, though, for that service, don't we?

Ms Murnane—Yes, as a result of a voucher that shows that they have completed the services, which is the test, the fitting and the supply of the device. So it is a little bit different from a contract. I understand where you are coming from. I will be talking to the people I referred to tomorrow, if not tonight.

Senator CHRIS EVANS—Thanks for that, Ms Murnane. I appreciate your taking it on notice. In terms of the relationship with Australian Hearing Services, we do not know how much we pay them. They are a statutory authority. Do they provide other services for us apart from CSOs and vouchers?

Mr DeGraaff—No, they do not, Senator.

Senator CHRIS EVANS—The research function is not handled by Australian Hearing Services?

Mr DeGraaff—The research function is delivered under the overall umbrella of the community service obligations. The National Acoustics Laboratory, which is an integral part of Australian Hearing Services, carries out that research. That research function is paid for out of that. It is a bit over $28 million a year.

Senator CHRIS EVANS—Is there any sense in which the Australian Hearing Services have been asked to pay a dividend to the department? Are they subject to your efficiency dividend? I know it is the bane of disability service organisations throughout the country. I thought it was supposed to be knocked off in the budget, too, but I do not think it was in the end. Is there an equivalent sort of arrangement with Australian Hearing Services, this efficiency dividend or return to the Commonwealth on investment or anything of that nature?

Ms Murnane—I think I can say that there is an arrangement in relation to a dividend, yes.

Senator CHRIS EVANS—Would you like to describe that to me, Ms Murnane.

Ms Murnane—I would like to take advice on that. It is within the context of a discussion between the shareholder departments and the statutory authority in relation to their corporate plan. It is not finalised yet. The corporate plan will of course be a public document. No, it is

not. I have just confirmed that there will be a public version of the corporate plan. Again, I think I should take that on notice, Senator, to see what we are going to be able to give you.

Senator CHRIS EVANS—All right, but I would like to make a little bit of progress tonight, if we could. Is there or is there not a dividend arrangement currently in place between the Department of Health and Aged Care and Australian Hearing Services?

Ms Murnane—Senator, under the arrangements in place for the development of their corporate plan, there is a provision for a dividend payable to the Commonwealth to be agreed, so I can say that.

Senator CHRIS EVANS—Is there a dividend payable in the financial year 2000-01?

Ms Murnane—I do not believe that there will be. This matter is being discussed currently with the authority by the two shareholder departments, that is, the Department of Finance and Administration and ourselves.

Senator CHRIS EVANS—Does that mean that maybe there is a dividend to be paid this financial year?

Ms Murnane—Yes.

Senator CHRIS EVANS—Yes, there is, or no, there is not?

Ms Murnane—There is consideration given to this in a draft corporate plan for this year, yes.

Senator CHRIS EVANS—For this financial year?

Ms Murnane—Yes.

Senator CHRIS EVANS—So on 29 May you have not decided whether they are going to have to pay a dividend or not for the financial year 2000-01.

Ms Murnane—That has not been finalised yet, no.

Senator CHRIS EVANS—I know I am not very experienced in financial matters but that strikes me as slightly incredible, that a decision about a dividend to be paid by a statutory authority for a financial year will not be determined with only four weeks of the financial year to go.

Ms Murnane—It is a transition to a GBE status for Australian Hearing Services and the corporate plan has been the subject of discussion. Their draft corporate plan has been the subject of discussion between the departments and the authority.

Senator CHRIS EVANS—Yes, I accept that, but what is the answer to the question? It has been put to me that you are asking them to pay $4 million this year. Is that right or is that wrong? Is there somebody here who can help?

Ms Murnane—Senator, these are issues that are clearly very difficult for us to discuss, because they are not issues that are yet resolved. What I can say is, there is not a definitive answer to that question.

Senator CHRIS EVANS—Ms Murnane, you sometimes have a view about what is and what is not appropriate for discussion at estimates committees, and I think you and I maybe disagree on occasions, but it seems perfectly competent for me to ask who we pay taxpayers' money to, and how much. You said that is commercial-in-confidence. Now I ask whether you have an efficiency dividend arrangement whereby that company, statutory authority, has to

pay you money back or meet the dividend, and you do not think it is competent for us to talk about. I just do not think that is right.

Ms Murnane—No, that is not what I have said. I have said it is not finalised.

Senator CHRIS EVANS—We were not sure it was happening a few minutes ago, and now we are sure it is happening but it is not finalised.

CHAIR—Can I help here, or offer to?

Senator CHRIS EVANS—Please.

CHAIR—In addition to what Senator Vanstone was saying a little while ago, would it be possible, once some of these things are finalised, that this committee meet as a legislation committee—so the same committee, just a different time, different place—for a briefing on this issue? Would that be a viable alternative to trying to press the issue now when clearly there is discomfort about where you are at and the ability that you have at the moment to disclose the precise information that Senator Evans is seeking?

Senator CHRIS EVANS—Could I just indicate, Madam Chair, that that will not be acceptable to me.

CHAIR—I am sorry.

Senator CHRIS EVANS—I appreciate the spirit in which it was offered, but it just is not acceptable to me that questions about financial arrangements between the Commonwealth and statutory authorities are not able to be discussed at an estimates committee. I think that is an untenable proposition. If that is the defence then we are going to have a blue about that, because that is just not right, and no estimates committee has ever accepted that. One of the reasons why some people have resisted us going to wholly owned companies as separate from statutory authorities is because that defence is then used. It seems to me perfectly reasonable for me to ask whether or not the Commonwealth, as represented by the officers at the table, has an arrangement where Australian Hearing Services has to pay a dividend this financial year and in the outyears. I assume this is in the budget papers, or has been budgeted for. It seems to me that that is a perfectly competent question and I do not think private hearings or whatever are necessary.

CHAIR—Can we see what Dr Wooding or Ms Murnane might be able to add.

Ms Murnane—As I have said, these issues are not finalised with AHS at this stage. There is published in the portfolio budget statements an estimate of the dividends payable for 2000-01 and 2001-02.

Senator CHRIS EVANS—Where is that?

Ms Murnane—Page 312.

Senator CHRIS EVANS—So we can't talk about it but it is published in your documents?

Dr Wooding—Senator, the actual dividend is obviously not known at this time, but we have these estimates as to what it might be, but there is no certainty that that will be the dividend.

Senator CHRIS EVANS—But I gather from this then that you estimate that you will get $1.9 million this financial year as a dividend payment from Health Services.

Dr Wooding—Sorry, that is Health Services. Hearing Services is further down, Senator—$6.190 million.

Senator CHRIS EVANS—And here's me saying four! I am always too conservative. So for Australian Hearing Services the budgeted dividend for this year is $6.190 million. Is that right?

Dr Wooding—That is correct.

Senator CHRIS EVANS—And was that included in last year's budget papers?

Mr Williams—Certainly it is in the AEs. I was just looking at it. That is where we just saw it. It was in the AEs papers and it was, I think, the same figure.

Senator CHRIS EVANS—What are the AE papers?

Mr Williams—Sorry, the additional estimates document.

Senator CHRIS EVANS—So you have estimated a $6 million dividend from Australian Hearing Services, but I gather from what Ms Murnane has been saying that the final negotiation on the amount is still being negotiated with Australian Hearing Services.

Ms Murnane—That is correct.

Dr Wooding—One other important point I want to make is that, as it says at the top there, it is administered revenue, which means that the money returns to the government; it does not come to the department. I just wanted to clarify something you were asking before.

Senator CHRIS EVANS—So basically Finance get their hands on it if it is paid?

Ms Murnane—Consolidated revenue.

Senator CHRIS EVANS—And are there like amounts in all the outyears, Dr Wooding?

Dr Wooding—Yes.

Senator CHRIS EVANS—So the suggestion that it is going to be $10 million in the outyears is not right?

Dr Wooding—It is not something I am aware of.

Senator CHRIS EVANS—Can you confirm for me that in the four outyears the figure stays at around the $6 million mark, or does it rise to $10 million?

Dr Wooding—We will have to take that on notice as to the precise figures.

Senator CHRIS EVANS—I could not find that in this documentation. We only have this year's and next year's. Is that fair?

Mr Williams—That is correct.

Senator CHRIS EVANS—And where would you find, in the overall budget papers, that figure? Are you saying that it is in the budget papers, or that it would just be in departmental records?

Dr Wooding—It would certainly be in the department's account records. We could look now and see if it is in the budget papers somewhere explicitly. I cannot answer that off the top of my head, Senator.

Senator CHRIS EVANS—No, it was more a question of—and you might simply take on notice what it is for the outyears—whether it was actually published or not, and you are not sure.

Dr Wooding—We will advise you of that.

Senator CHRIS EVANS—All right. So the dividend would be paid to the department of finance into consolidated revenue. What is the dividend for?

Dr Wooding—As in its revenue?

Senator CHRIS EVANS—You contract with Australian Hearing Services for CSOs and vouchers. You work out the rate. You have an agreement. You pay them the money.

Dr Wooding—Yes.

Senator CHRIS EVANS—Now they have to pay you $6 million. Why do they have to pay you $6 million? On what basis do they pay you?

Dr Wooding—As a business, they are paying a dividend to the shareholder. That is the basis.

Senator CHRIS EVANS—This is a general government policy of expecting a dividend from all statutory authorities, is it? I am just trying to understand how it works.

Dr Wooding—It is a bit more complex than that, but certainly it is related to a general government policy in relation to business enterprises owned by the government.

Senator CHRIS EVANS—So on what basis do you strike a rate? I am not saying how do you strike the figure of $6 million, but how do you assess what they will be paying you, and what are they paying you for? Obviously as a shareholder you would like them to pay you a great deal, but—

Dr Wooding—That is something that is a matter between the Department of Finance and Administration and our department—I think it is more accurate to say the ministers, effectively. We need to take that on notice because that is not something I can answer.

Senator CHRIS EVANS—I appreciate you taking that on notice. Are you able to help me with general principles? I know, for instance, in the disability area there is this efficiency dividend concept where each year is increased by a per cent.

Dr Wooding—This is not an efficiency dividend; it is unrelated.

Senator CHRIS EVANS—No, I accept that. I understand the logic, however twisted, of the efficiency dividend and I understand the rationale. What is the rationale behind these dividend payments?

Ms Murnane—We will take that on notice, Senator.

Dr Wooding—I think there are some words we can give you which explicitly set out the government policy on these matters which do not fall into our portfolio, but we can either direct you to where you can find those or provide you with them.

Senator CHRIS EVANS—Did you receive a dividend payment from Australian Hearing Services last financial year?

Ms Murnane—No.

Senator CHRIS EVANS—Have you ever received a dividend from Australian Hearing Services in either previous years?

Ms Murnane—We will check this but, to my knowledge, no.

Senator CHRIS EVANS—Does Australian Hearing Services retain profits?

Ms Murnane—Yes.

Senator CHRIS EVANS—I guess you are not competent to answer it in a sense, I suppose—

Ms Murnane—I cannot say what they are, but I can say, yes, they have a capacity to retain profits.

Senator CHRIS EVANS—Does Australian Hearing Services appear at estimates?

Dr Wooding—They can be if requested.

Senator CHRIS EVANS—Yes, all right.

Ms Murnane—And we received advice that you did not want to call them.

Senator CHRIS EVANS—No, I am not asking why they are not here, I am just trying to understand the relationship.

Ms Murnane—Yes, sure.

Senator CHRIS EVANS—We will ask them next time. And now for something completely different: Mr DeGraaff, I read in your report that you employ audiologists and audiometrists. Is that right?

Mr DeGraaff—In the service provider organisations that have a contract with us there are audiologists and audiometrists, yes.

Senator CHRIS EVANS—This is a question for Australian Hearing Services in the sense that they would be one of the employers and the other contractors would be employers. You would not employ anyone directly. Is that it?

Mr DeGraaff—No, within the Office of Hearing Services there are seven professional audiologists on staff.

Senator CHRIS EVANS—All right. Is that more in terms of the policy development work, et cetera, rather than services for clients?

Mr DeGraaff—It is for program delivery in terms of quality assurance and compliance and also part of policy advice.

Senator CHRIS EVANS—But it is not actually related to direct provision of services to clients.

Mr DeGraaff—No. The direct provision of services is by the contracted service providers and they are qualified practitioners.

Senator CHRIS EVANS—I notice in your annual report you are talking about client surveys. Can you give me a summary of where you are with the client surveys, the reaction and summary of feedback?

Mr DeGraaff—We conduct an annual client satisfaction and hearing aid usage survey. The one for this calendar year has only, in the last couple of weeks, been sent out to the sample group that was selected. The sample group size is about 1,500 clients, who we select each year, to administer that survey to.

Senator CHRIS EVANS—They are clients as in people who have used vouchers?

Mr DeGraaff—Yes. They are clients who have received a voucher and/or been fitted with a hearing aid.

Senator CHRIS EVANS—Do you do that yourselves, or do you get someone professionally to do that for you?

Mr DeGraaff—We administer the survey ourselves and we conduct the analysis ourselves.

Senator CHRIS EVANS—What were the results of the last one?

Mr DeGraaff—The overall results were that around 92 or 93 per cent of the clients were satisfied with the services they received through their voucher, but there are a number of other categories that we look at in terms of that satisfaction. Also, the second part of the survey is around hearing aid usage. Overall the figure is good, but with all such self-reported surveys and with this demographic group you would expect quite a positive result, but even taking that into account the overall result is very good. On hearing aid usage, similarly, the number of clients who use their hearing aids, or report that they use their hearing aids up to eight hours a day, is a high figure. I do not have that figure with me. There is a very low figure there where clients have reported that they either do not use their hearing aids or use their hearing aids for less than two hours a day.

Senator CHRIS EVANS—Can you tell me about top-up arrangements?

Mr DeGraaff—Yes, the top-up arrangements in the program work in this way: the client gets a voucher and they come to a contracted service provider. They can surrender that voucher and receive a package of hearing rehabilitation services, including a quality hearing aid, for free—or essentially for free—if they wish. That rehabilitation package they get almost free through the voucher will give them a satisfactory rehabilitation outcome for their hearing loss. If they choose to purchase features in a hearing aid that are not required for their clinical rehabilitation, they can choose to become a consumer and pay the additional amount over and above the government subsidy that is paid to the service provider. That difference—between the amount that is paid to the service provider by the Office of Hearing Services anyway, and the amount that the consumer pays for the additional features that they do not need for their clinical rehabilitation—is the top-up element. They pay that out of their own pocket.

Senator CHRIS EVANS—Do you have any feedback of concern about people being pressured into top-ups? I gather there has been quite a bit of growth in the top-up services. Does the department have any concerns about what is occurring in terms of practices there?

Mr DeGraaff—We monitor the complaints about top-up very closely. We do receive top-up complaints; complaints about clients or consumers who have chosen to go the top-up route. They are investigated and taken very seriously. We do receive complaints about that. Within those complaints some complaints are about where a consumer may have felt some pressure.

Senator CHRIS EVANS—The figures I have seen showed that between 1997-1998 and 1998-1999 the number of clients fitted with top-ups rose from 2,168 to 5,237, which is a massive increase in the number of services. Is that consistent with the sort of information you have received? As I say, is there any concern about what is occurring there?

Mr DeGraaff—There is certainly no overall concern about the fact that there are a significant number of clients who are being pressured into purchasing top-up. That impression is also backed up by the low overall level of complaints in the program and also the low level of complaints about top-up itself. The top-up rate against other fittings within the program is relatively low.

Senator CHRIS EVANS—But clearly increasing at a rate way beyond other services, if that is the case. I would be interested if you could give me the figures for 1999-2000 and 2000-2001, on the top-ups. It looked like, on those couple of years of figures, that there was an explosion in the top-up services. Is it your impression that that is occurring or not?

Mr DeGraaff—No, it is not my impression at all, Senator. I will certainly take that on notice.

Senator CHRIS EVANS—It might have been a one-off then. Those are the only two years I have the figures for.

Mr DeGraaff—Those years again were 1999-2000?

Senator CHRIS EVANS—The figures I had were for 1997-98 and for 1998-99, but I would appreciate it if you could confirm whether I have got the right figures and whether they are correct, but also for the two years since then. If you could give me the figures for top-ups for those two years.

Mr DeGraaff—Certainly.

Senator CHRIS EVANS—If you think my figures are wrong, please correct them. I think I will leave it there. I think I will pursue some of the other questions with Australian Hearing Services next time.

[6.10 p.m.]

CHAIR—Thank you, Senator. We will move on to outcome 7, Aboriginal and Torres Strait Islander health.

Senator WEST—I wanted to start with the Aboriginal coordinated care trials. What is the current situation with those, particularly in the Northern Territory.

Ms McDonald—The evaluation of the trials has now been completed. The national summary report of the evaluation is now publicly available. The full evaluation reports are being printed at the moment and should be released soon. Once the evaluation was completed, the trials were moved on to interim arrangements so we could spend some time working with the trials and the other partners—the state governments—in terms of working out long-term arrangements to move their services from what were trials to ongoing service delivery arrangements. There were things that were not part of a trial structure that needed to be taken into account—for example, longer-term arrangements for things like capital upgrade and replacement, repairs and maintenance, things that were not part of an ongoing service delivery arrangements and did not need to be thought of in the short-term, and also some of the lessons from the trials and how they are then implemented into the changes that happen in the longer-term.

Senator WEST—Are you able to tell us the outcome of the trials or is too early yet because it is not public?

Ms McDonald—No, the summary evaluation report is available and we can certainly get committee members a copy of that. I just don't have one with me at the moment.

Senator WEST—Yes, thank you. The trial has had a positive outcome, from the way you are talking.

Ms McDonald—Certainly, the results of the trials were very positive. As you can imagine, they were not over a very long period so they were progress along the way, but certainly they did show improvements in terms of health service and health system delivery within the areas that the trials were undertaken. They showed improved community participation and involvement in terms of health service access and programs to improve the health of the communities and also greater client empowerment in relation to health services. I was hoping I had some more information here in terms of the outcomes but I will give you a copy of that report. The longer-term arrangements are currently being sorted for each of the trials. What

we did was put in place interim arrangements with both the state and Commonwealth governments committing continued resources at the level they had previously. The longer-term arrangements are now being finalised and we are hopefully, for the NT trials anyway, getting close to finalising those arrangements.

Senator WEST—What modifications have been necessary for the long-term funding of these as a general program, not as a trial?

Ms McDonald—Each site has its own experiences—certainly the pooling arrangements and the flexibility to provide a broader range of services. In terms of the ability to have a more bottom up approach in terms of health service delivery and priority setting, it has been seen to be very positive. In terms of lessons for the longer-term, certainly some of those structural changes around flexibility were seen to be important. There were issues around some of the pooling where there were purchase-back arrangements which were not as flexible, but some of those moved over time and certainly those greater flexibilities were seen to be something that was needed in the longer-term.

Senator WEST—I suppose there is always a very important element of money. Where, in the budget for this year, is there an allocation for funding?

Ms McDonald—For the trials?

Senator WEST—Are they going to continue to be trials or are they going to be full blown programs now?

Ms McDonald—The ongoing funding for the former trial sites was agreed in the 1999-2000 budget. It was the first stage of the Primary Health Care Access Program funding. There is an ongoing funding base as part of that money and that money grows across the period of the forward estimates.

Senator WEST—It has a four-year forward estimate funding proposal, has it?

Ms McDonald—The funding for the trials and also for new services based on the lessons from the trials in the 1999-2000 budget, the figures for the Primary Health Care Access Program—and I can table this—were $6.8 million in 1999-2000. That grows to $16 million in 2000-2001, $22.5 million in 2001-2002, then up to a base of $33.5 million from 2002-2003. Then there was another step given in this next budget which took the base level up from 2003-2004 by an additional $20 million, which means that the whole base for that new service development is about $55 million ongoing recurrent by 2003-2004.

Senator CHRIS EVANS—So that is $55 million per annum, as ongoing.

Ms McDonald—Yes.

Senator WEST—What is the roll-out of new programs going to be? Have you worked through that yet or have you in fact started with the new programs?

Ms McDonald—The process is very much based on the outcomes of regional planning that is happening jointly with the community controlled sector, ATSIC, state government and Commonwealth. It is happening through the planning forums in each state and territory. The rate of completion of planning has been at different rates in different places. The first states to finish were South Australia, the Northern Territory Central Australian region and Queensland. In those areas, there has been work done in terms of looking at the first areas for implementation of new services, based on the findings of those studies plus the lessons learned from the coordinated care trials and other service development.

South Australia and the Northern Territory Central Australian region have moved forward the fastest. We have integrated funding arrangements being finalised with the Northern Territory government at the moment. We have a joint working group involving all the four partners working on program design and implementation in the NT. There have been five regions selected already and that group are working with the local communities around improving health services in those areas. In South Australia, we also have a number of regions that have been selected. If you are interested in the regions, we would be happy to provide you details of those.

Senator WEST—On notice, is fine.

Ms McDonald—The Queensland working group has picked what they think are the priority regions for increased service development. They have yet to take that to the health forum for endorsement but that is expected to happen soon. The money that is being provided in this year's budget will enable this program to be extended now to those states that have finished regional planning more recently. They will be able to start looking at some regions to improve health service delivery.

Senator WEST—Thank you. Can I have a progress report on what is happening with the Broome and Cape York dialysis programs. You gave us a report in February. What is the latest?

Ms Evans—My understanding is that the Weipa dialysis unit is being built at the moment. The funds have been handed across. The funds have also been handed across for the Broome one and work is just about to commence.

Senator WEST—When do they expect to have the Weipa project up and running?

Ms Evans—I will have to take that on notice, Senator.

Senator WEST—And the same for the Broome project.

Ms Evans—Yes, the same for the Broome one.

Senator WEST—What has been the impact on the program that was operating with the ADF in providing facilities for Aboriginal rural and remote communities? Given that we have had a fair number of ADF personnel in East Timor, Bougainville and now currently just finishing Tandem Thrust, what has been the impact of those exercises?

Ms McDonald—As you are aware, the first stage of AACAP has been completed. The second stage was affected, especially by the East Timor activity. There has been a rephasing of the funding, so the program that was going to run over four years is now going to run over six years. The first few communities have been started there and we are looking as though we are on track now for that program under the revised time lines.

Senator WEST—Is there recurrent funding for the work they have done on those, particularly the construction type work?

Ms McDonald—It is one-off capital funding in those communities. It is not putting health personnel and people like that on the ground long term; that is coming out of other programs.

Senator CHRIS EVANS—What about the maintenance?

Senator WEST—If they put in a sewerage system, say?

Ms McDonald—That would be funded through the normal arrangements for that sort of thing. A lot of the projects that are being picked up are bringing forward projects that were on priority lists for NAHS and other programs like that. The ongoing maintenance of those is

picked up on those programs. Some of the work also involves health clinics and fixing up health infrastructure as well within communities. Where we have responsibility for those clinics we pick up the recurrent costs: if state governments do, they pick up those costs.

Senator CHRIS EVANS—I hope it has not all been left to ATSIC. One of the problems with some of those communities is that normal services that every other community expects are not maintained. ATSIC is then required to fund things.

Senator WEST—In a normal community, the local government would be funding it.

Senator CHRIS EVANS—Or the state government would be funding it. I am just concerned to make sure that the investment the Commonwealth is making in the infrastructure, which is a good thing, is not then lost, or the value lost, because those maintenance programs are not in place. You are saying basically the Commonwealth is not taking responsibility for that in an ongoing sense; it falls back to the relevant authority to maintain that.

Ms McDonald—That is right. Those issues are looked at as part of the scoping work that is done, and also where other funders are involved—for example, a state government might contribute to some of the work. We have contributions, say, to state governments to pay for clinic buildings and part of the capital infrastructure if that is their responsibility but it is better to fund it all as one project. The agency responsible would then take recurrent funding responsibility. From a Commonwealth point of view, if it is a health service responsibility, we would pick that up in our normal programs. It is not funded from the AACAP share. If ATSIC were responsible, they would pick it up under their normal programs. If it was a state government issue or local government issue, they would pick it up.

Senator CHRIS EVANS—Okay, thanks.

Senator WEST—Thank you.

CHAIR—Thank you very much.

Proceedings suspended from 6.26 p.m. to 7.37 p.m.

CHAIR—Senator Evans will continue with outcome 8.

Senator CHRIS EVANS—I will start by asking about private health insurance. Can I get an update of where we are at with the advertising campaign to sell gap-free cover?

Mr Wells—The ministerial committee has approved a campaign which we expect to start in late June. The purpose of the campaign is to inform the public of the gaps or no gaps, or fixed gaps or whatever around the gaps issues. As I say, that will be running in the media from about 17 June.

Senator CHRIS EVANS—This committee you refer to, is this ministerial—

Mr Wells—It is the ministerial committee on government communications.

Senator CHRIS EVANS—Thank you for that. Is the budget still $10 million?

Mr Wells—The total budget on current estimates for the campaign will be $14.4 million.

Senator CHRIS EVANS—You had $5 million rescheduled or something as well, didn't you? I thought you had approval for $10 million and you found $5 million from somewhere as well, did you?

Mr Wells—Yes, I think that is correct.

Ms Sperling—There was a series of money. I think you recall we explained to you last time that it had originally been allocated for simplified billing and we are now progressing the simplified billing agenda through increasing no-gap arrangements.

Senator CHRIS EVANS—You have $10 million from the last budget and $5 million from simplified billing to give you a budget of $15 million for gap cover advertising, is that right?

Mr Wells—That is right, yes.

Senator CHRIS EVANS—The campaign starts on 17 June. How long will it go for?

Ms Sperling—The actual TV advertisements are planned to go to air for about six weeks. The campaign, though, has a number of other components working with the industry, and that will continue. It will start before that and it will continue after that period. The TV advertisements are at the moment scheduled for about six weeks of air time.

Senator CHRIS EVANS—Is there a radio campaign as well?

Ms Sperling—No, not at this stage.

Mr Wells—I do not think so, Senator; it is for the posters and public relations.

Senator CHRIS EVANS—TV, posters and PR?

Mr Wells—Yes.

Ms Sperling—There are also newspaper advertisements.

Ms Dove—There is also a component of outdoor advertising.

Senator CHRIS EVANS—Billboards?

Ms Dove—Billboards, yes.

Senator WEST—Is this going to take a similar format to the umbrella ads of last year, whereby the companies themselves can pack in and get a bite of the cherry too?

Mr Wells—Sorry, I missed the bit about the cherries, Senator.

Senator WEST—They are getting a bite of the cherry?

Senator CHRIS EVANS—It was a mixed metaphor—the umbrella and the cherries.

Senator WEST—Yes, it is too late in the night. Is it going to be like those umbrella ads last year, for which you provided some money for the use of the logo and stuff?

Mr Wells—It is the same advertising company, its own creative company, and there will certainly be similarities between the two.

Senator CHRIS EVANS—I think Senator West is asking whether you are allowing the branding and the logo of that to be used by companies as part of their advertising, and whether the gap-free cover is a—

Mr Wells— We will, but just how that will pan out has not been settled yet. But yes, we will.

Senator WEST—Maybe you would like to take on notice how much the private companies used in terms of value in the last campaign.

Mr Wells—We will see what we can do on that. I am not sure how big a job that would be to come to an accurate figure. I will take it on notice.

Ms Sperling—Could we get clarification of exactly what sort of information you want?

Senator WEST—They used some of your artwork and stuff. What was the value of that to them?

Mr Wells—To them?

Senator WEST—Yes.

Mr Borthwick—I doubt very much if we have got an estimate of that. What we did encourage them to do was use the umbrella when they ran their advertisements, but the costs of their individual campaigns will not be known to us.

Mr Wells—It is difficult to put a value on that umbrella. We could probably get some rough figures about how much advertising spend they had using that umbrella.

Senator WEST—And with the staff.

Mr Wells—But that does not put a value on the umbrella itself.

Ms Dove—They also used the umbrella logo on a variety of printed material as well as advertising.

Senator CHRIS EVANS—You are using the same company. Which company is that, Mr Wells?

Mr Wells—It is Whybin TBWA and Partners.

Senator CHRIS EVANS—They had to win that contract separately again, did they?

Mr Wells—No, it was treated as a follow-on.

Senator CHRIS EVANS—From the umbrella thing?

Mr Wells—Yes.

Senator CHRIS EVANS—So that did not go out to tender?

Mr Wells—No, but it was approved through that ministerial committee process.

Senator CHRIS EVANS—I presume if they are going to air that this financial year, then this is money out of the 2000-01 budget, is it?

Mr Wells—No, it will cross over. In fact, most of the expenditure will be in the next financial year.

Senator CHRIS EVANS—So what do you expect to spend this financial year?

Mr Wells—I am not sure how much on advertising, but this financial year so far, in terms of developing the creative materials, et cetera, we spent about $1.5 million.

Senator CHRIS EVANS—Presuming you will get some of the bills for buying space, et cetera, before the end of the financial year?

Ms Sperling—Yes, although the normal arrangements now are to actually pay for advertisements after they have been screened. Certainly, some of those advertisements will be screened this financial year. The majority of them will be in the next financial year.

Mr Wells—Most of the accounts will probably come in too late for expenditure this financial year.

Senator CHRIS EVANS—How much of that $14.8 million is going to be spent on the TV buy?

Mr Wells—About $9.5 million.

Senator CHRIS EVANS—Is that production as well, or is that just the buy?

Mr Wells—No, production is $4.3 million.

Senator CHRIS EVANS—So the great bulk of the funds is going to the TV campaign?

Mr Wells—Yes. Sorry, that is the media buy. I assume that includes the press advertising and the posters—the hiring of the sites for the posters.

Senator CHRIS EVANS—The $9.5 million?

Mr Wells—Yes.

Senator CHRIS EVANS—So it is not just the TV buy?

Mr Wells—No, I do not have a breakdown of those components.

Senator CHRIS EVANS—I would not mind if you would take that on notice.

Mr Wells—Yes.

Senator CHRIS EVANS—And the $2.3 million then is all production?

Mr Wells—It is production and agency fees.

Senator CHRIS EVANS—Yes, but that includes billboard production as well as TV, pamphlets, et cetera?

Mr Wells—Yes.

Senator CHRIS EVANS—What are the other large items in the cost?

Mr Wells—I can give them to you if you like.

Senator CHRIS EVANS—I am only interested in the larger ones.

Mr Wells—The public relations is $1.3 million and advertising is $2.3 million. That is the production and agency fees. The media buy is $9.5 million, research is $0.7 million and miscellaneous costs are $1 million, which includes some departmental costs and administrative type costs.

Senator CHRIS EVANS—Is there an objective for the campaign?

Mr Wells—It is consumer oriented, the objective being to inform consumers about the fact that there is no gap cover available and with the message that they go and talk to their funds about it with a view to finding out what it means for them in that fund.

Ms Dove—Also the fact that legislation passed last year changed the situation and the objective is to make sure that they are aware of the implications of that change.

Senator CHRIS EVANS—You would measure success or otherwise by the take-up of gap cover, would you? Do you set yourself as a benchmarking measure for—

Mr Wells—It is directed at people who already have private health insurance and most of those would inherently have gap cover. The successful outcome would be those people then going to their funds and exercising their rights, or finding out which product best suits them, that sort of thing. It is not directed at recruiting people into funds so much as to at people already in funds to encourage them to exercise their full entitlements and that sort of thing.

Senator CHRIS EVANS—Thank you for that. Could I ask a couple of questions about expenditure on the health insurance rebate?

Mr Wells—Yes. Would it help if we were to actually table the current estimates out of the budget?

Senator CHRIS EVANS—Yes. Could you take me through this?

Mr Wells—The first column is the estimates as at now—the current fund investments.

Senator CHRIS EVANS—Yes, this budget's estimates.

Mr Wells—The second column is the estimate that we had last time at the additional estimates. The last two columns are the actual variations and the percentage variations between those two figures, and then we show them for the full budget period.

Senator CHRIS EVANS—Thank you for that, that is very helpful. It takes me to the question I was going to ask. What happened to revise downwards your estimates from the additional estimates process and is there some explanation for it?

Mr Wells—There are four main factors. First of all, the participation rate is stabilised.

Senator CHRIS EVANS—Your original estimate was based on a growth, was it?

Mr Wells—Yes. The second is the change in the base year estimates in the model due to a lower than expected ancillary cover amongst new members. The proportion of ancillary cover that new members are taking out was lower than had previously been estimated. In other words, there was a predominance of hospital only cover being taken out, which reduces the premium and therefore reduces the rebate.

Senator CHRIS EVANS—Yes, I will come back to that.

Mr Wells—We have made some changes in assumptions regarding the premium increases, particularly in the light of the outcome for 2001, which was an overall increase of 0.1 per cent. That has a flow-on effect into the outyears.

Senator CHRIS EVANS—Just so I understand what you seem to be implying, do you think they will ask for more in the outyears because they had a small increase this year, or that overall it will be less?

Mr Wells—No, I am not saying what we are predicting for the future years; we would rather not flag that. What I am saying is that, because there was only a 0.1 per cent increase this year, that carries through. It is different from what we previously estimated.

Senator CHRIS EVANS—Yes. You assume they do not catch up next year?

Mr Wells—It would not affect our current estimate, it would only affect the estimate in future years.

Senator CHRIS EVANS—Yes. But you basically pull back on all the future years as well as a result as one of four considerations?

Mr Wells—With respect to the actual outcome for this year, that has pulled the whole structure down in the RTS, yes. The final change was in the mix of those who take it as a tax refund and those who take it as a ongoing rebate or premium reduction.

Senator CHRIS EVANS—Thank you for that. Can you take me through each of those assumptions? You have basically revised downwards your anticipation of the growth in anticipation?

Mr Wells—We have assumed a stable participation rate of around 45 per cent.

Senator CHRIS EVANS—That is for all the outyears?

Mr Wells—Yes.

Senator CHRIS EVANS—What was it before? You had it growing slightly over that, did you?

Mr Wells—I do not have the actual figures with me.

Senator CHRIS EVANS—What figures have you got then on the take-up of hospital only cover? I think I have pursued this with you for a couple of years now to try and nail this.

Ms Sperling—The change from March last year to December this year is really where the growth in participation occurred due to lifetime health cover. There was approximately a 42 per cent increase in the proportion of people taking out hospital cover compared with the 24 per cent increase in the proportion of people taking out ancillary cover.

Senator CHRIS EVANS—So 42 per cent of them taking out cover were taking out hospital only, is that right?

Mr Wells—It is 42 per cent of the increase.

Ms Sperling—It is 42 per cent hospital, but only 24 per cent ancillary; so the difference between the two would be people taking out hospital only.

Senator CHRIS EVANS—Could you say that to me again, Ms Sperling? I am sure you are right, I just want to make sure I understood that properly.

Mr Maskell-Knight—I think what my colleague is trying to say is that the number of people with hospital cover increased by 42 per cent, whereas the number of people with ancillary cover only increased by 24 per cent.

Mr Wells—That is right.

Senator CHRIS EVANS—Is there a third group?

Mr Maskell-Knight—No, I think we are getting into abstract set theory here. Some people take out only ancillary, but when we look at the headline figure, it is of the people who take hospital cover either alone or with ancillary. So the 42 per cent represents a change from six million people to 8.5 million, but a much lower proportion than previously of that increase took out ancillary cover only.

Senator CHRIS EVANS—I think I would be happy if we went back to base numbers, I think. Just so I make sure that I have understood this, have you got the base numbers there? We are talking about a percentage of the increase. I am just beginning to think I am losing perspective.

Ms Ginnane—The membership at 31 March 2000 for hospital cover was 32.2 per cent of the population and at 31 March 2001 that had increased to 45.1 per cent of the population. The ancillary comparisons—

Senator CHRIS EVANS—Sorry, the second date was?

Ms Ginnane—It was 31 March this year. These are the quarterly figures released last week. The ancillary cover over the same period in March 2000 was 32.9 per cent of the population, and that had increased to 40.5 per cent of the population with ancillary cover at 31 March 2001.

Senator CHRIS EVANS—So there is a growth in both obviously in terms of total numbers and percentage of population, but there was a greater growth in hospital only cover?

Ms Ginnane—That is correct.

Senator CHRIS EVANS—What does that represent of the population who have private health insurance? What does the hospital only proportion represent?

Ms Ginnane—It is difficult to actually ascertain that. There will be a proportion of those people that have hospital only and there will be a proportion of people with ancillary only, but most people have both. The maximum number, if you like, that can have both is only 40.5 per cent of the population by definition because that is the ancillary cover.

Senator CROWLEY—Was there not an understanding for a time, though, that people bought ancillary cover and then discovered that did not exempt them from liability for the one per cent?

Ms Ginnane—I am not sure, that is a matter for the department, I think.

Senator CHRIS EVANS—I think that was the debate about hospital-only, was not it?

Senator CROWLEY—Remind us on these rules about what you had to do by way of private insurance so as to be exempt from the tax penalty? I understood you could not have a front-end deductible greater than $500—is that right?

Ms Ginnane—That is correct.

Mr Wells—That is now $500 for a single family.

Senator CHRIS EVANS—That is a new regulation though, isn't it?

Senator CROWLEY—That is right, to catch them coming or going. But I wondered about people who took out ancillary cover?

Mr Wells—Ancillary only?

Senator CROWLEY—Ancillary only.

Ms Sperling—That does not count, it has to be hospital.

Senator CROWLEY—That did not count?

Ms Sperling—That is correct.

Senator CROWLEY—They discovered very quickly that ancillary-only might have covered them for health insurance but it was not going to protect them against the penalty?

Mr Wells—Yes.

Senator CROWLEY—Ergo, why ancillary cover did not increase much. They were still going to be hit for the one per cent tax liability.

Ms Ginnane—They needed to have hospital insurance I think is the answer to that.

Senator CHRIS EVANS—Yes, they needed to have both.

Mr Wells—They had to have at least hospital?

Senator CROWLEY—They had to have hospital only; they can have ancillary if they want to?

Senator CHRIS EVANS—No, they had to have hospital or hospital and ancillary, but they could not have ancillary only.

Mr Wells—No, that is right.

Senator CHRIS EVANS—I understand.

Senator CROWLEY—But for a while, I think, some of them had ancillary only, didn't they?

Senator CHRIS EVANS—There would still be some people who probably have ancillary only, but it does not exclude them from the one per cent surcharge.

Ms Sperling—That is correct, yes.

Senator CHRIS EVANS—You can tell me the percentage increase in the percentage of the population who have got hospital only, but you cannot tell me what they represent of the total number of people insured. It seems a bit odd.

Ms Ginnane—Sorry, what I am saying is that we do not know how many of them just have hospital or just have ancillary. There will be an overlap between the hospital and the ancillary figures. Most people actually have both.

Senator CHRIS EVANS—Regarding the figure of 32 per cent from March last year to 45.1 per cent now that you have given me, are we talking about people in hospital only?

Ms Ginnane—That is hospital only.

Senator CHRIS EVANS—You must know who has hospital only?

Ms Ginnane—That is right. Sorry, that is people with hospital cover. What we do not know and cannot separate out, is how many of those also have ancillary. We suspect most of them do, but we do not ask, 'Do you have hospital only, do you have hospital and ancillary, or do you have ancillary only?'

Senator CHRIS EVANS—I must be getting confused—I thought the definition of hospital only meant you did not have ancillary?

Ms Ginnane—I am sorry, I misled you, Senator. What I am saying is that they are people that have hospital cover insurance in total, not hospital only.

Senator CHRIS EVANS—Let us go back to stage one then, I think, because there are two goes and I accept it may be me, but I was after the hospital only figures— those persons who have hospital only cover.

Mr Maskell-Knight—I think we are in a logical sort of twist here; we do not know that. You can sort of subtract from the 45 per cent of the population who have hospital cover the 40.5 per cent who have ancillary, and deduce that 4½ per cent there have hospital only. The trouble is that we do not know that all the people with ancillary cover have hospital cover. Indeed, there are people I know of who have hospital cover with one fund and ancillary cover with a completely different one. I think we are groping towards the unknown here.

Senator CHRIS EVANS—You are saying to me that the best you can do in terms of identifying hospital only cover is to subtract the general—

Mr Maskell-Knight—Subtract the ancillary from the hospital and that gives you a number which is not dramatically wrong, but we do not know how much it is wrong by.

Senator CHRIS EVANS—You would say there would only be, at most, 4½ per cent or so who have hospital only cover?

Mr Maskell-Knight—No, it could be more. If half of the people with ancillary cover only have ancillary cover, then you could have 25 percentage points of the people with hospital cover who only have hospital.

Senator CHRIS EVANS—We do not have any better figures from the insurers or from your department which tells us about that? Surely, now when you are paying the rebate, you know what you are paying the rebate on, don't you?

Ms Sperling—We pay the rebate on the premiums.

Mr Wells—We pay on the premium.

Senator CHRIS EVANS—You do not inquire what the premium is for?

Ms Ginnane—Yes, because they—

Mr Wells—It has to be the hospital component.

Senator CHRIS EVANS—My point exactly. You have to, when paying the premium, assess what you are paying it for.

Ms Ginnane—Right.

Senator CHRIS EVANS— Do you pay the premium on the ancillary?

Ms Ginnane—Yes.

Senator CHRIS EVANS—So you pay on everything, do you?

Ms Sperling—That is correct.

Senator CHRIS EVANS—So as long as they say to you that it is a bill from their private health insurance you pay 30 per cent of it?

Ms Sperling—For a private health insurance product, yes.

Senator CHRIS EVANS—And provided they assure you it is for a private health insurance product, you have no information as to what services you are subsidising?

Ms Sperling—There is quite a deal of comprehensive information collected through PHIAC, but it is obviously not collected in such a way as to answer the exact question that you originally asked, but there is quite a lot of comprehensive information available.

Senator CHRIS EVANS—I am a bit frustrated, because we have been having this debate, and we had it when the legislation went through, about whether we were appropriately subsidising 30 per cent of ancillary cover—for instance, running shoes and gym membership and that sort of thing. We also had a debate about whether or not it would lead to a change in the market, about people buying minimum health insurance cover, products deliberately designed to, if you like, get them out of the one per cent surcharge but not necessarily to provide genuine, comprehensive private health insurance as envisaged by the government's ideas on the issue.

Now you are saying to me that we are not able to find out what is happening out there, or what we are paying for, and you cannot help me about whether there have been changes in the market, et cetera. I thought we had debates before about how we all accepted this was part of the legitimate public debate that we needed to know. I think the government on previous occasions has said that they were concerned about those products being offered and we had the regulation moved, as some sort of response to that concern, about front-end deductibles. If what you are saying to me is right, we actually do not know what we are funding almost.

Ms Sperling—We do have comprehensive information on the number of hospital products that people have purchased and the number of ancillary products as well as some breakdown of those ancillary products and what benefits are paid according to those ancillary products. We also have information, which we have provided to you previously on notice, about the

number of people who have products with front-end deductibles and the number of people who have products with excesses.

Senator CHRIS EVANS—That is right, and that is why when I asked you to tell me how many had hospital only, I just thought Mr Wells would turn a page and say, 'That's the answer'.

Ms Sperling—Yes, I guess what we are indicating is that we do not collect the data in that way, but there is fairly comprehensive information about private health insurance and the products that people take out just collected statistically in another way.

Ms Ginnane—If I could add to that, all health insurance products are effectively approved before they can be sold by the department and those approved products are only what can be offered. So they are effectively approved either as a hospital product or an ancillary product.

Senator CHRIS EVANS—I accept that; I am just trying to find out what we are paying 30 per cent of, and get a breakdown within that general approval process. I accept they have to be approved and if they are not, you would not be funding them.

Mr Wells—So you want to find out how many are hospital only?

Senator CHRIS EVANS—I guess I was interested in the information about how many were hospital only. I am interested in what we are getting for the $2 billion and what changes that is driving in the services that are being delivered and subsidised. One of the key questions for that is: how many people are purchasing hospital only cover and how many are buying just front-end deductibles?

Ms Sperling—I can give you information about front-end deductibles and excesses. I think we have previously given you comparative information over time. I can update that information and tell you that the March 2001 quarter statistics show no change, so it is 53 per cent of people with front-end deductibles and a continuation of the number of people with excesses as well.

Senator CHRIS EVANS—It will be helpful if you can you table those for me, Ms Sperling, rather than me ask you for the individual figures.

Ms Sperling—Yes.

Senator CHRIS EVANS—When you said about going back to base year estimates, you were not actually saying hospital only cover, you were saying hospital cover, were you? I wrote it down as hospital only cover, Mr Wells, I might have misheard you. That is what prompted my interest and led us down this barren path.

Mr Wells—Hospital cover?

Senator CHRIS EVANS—Yes, I wrote it down as hospital only cover and that is why I then was inquiring with you about the assumptions you said had changed, but it was actually hospital cover.

Mr Wells—Hospital cover is what I hope I said.

Senator CHRIS EVANS—I think you have told me about your change in assumptions for the premiums. The other assumption you said had changed was the change in the tax versus the rebate mix. Can you tell me what has happened there?

Mr Wells—Yes. The current assumption is now that 88 per cent will claim through the outlay system and 12 per cent through the tax system.

Senator CHRIS EVANS—What were your previous assumptions?

Ms Sperling—It was 87 per cent and 13 per cent. But it does make a difference to the—

Senator CHRIS EVANS—Is that based on the experience from last financial year, is it?

Mr Wells—As we build up experience we are changing that in the model.

Ms Sperling—That particular tax information is because the tax office has now just about finished processing the last financial year's tax statements. As my colleague said, one per cent of $2 billion actually does have a significant flow-on effect, which has shown up in these figures here.

Senator CHRIS EVANS—Just so I understand, what is that effect? That you pay the money out faster if—

Mr Wells—It affects the end of the period, because in the final year, with those who claim it through the tax system, that is not an outlay until the next financial year because it is a refund. You put your tax return in as at 30 June 2005 and you have a claim for a rebate of 30 per cent—whatever the figure is—but that is not paid until 2005-06 and it therefore does not show up in this period of estimates.

Ms Sperling—It is a lagged impact.

Mr Wells—It is a lagged issue, Senator.

Senator CHRIS EVANS—Why does it lag that long, though?

Mr Wells—It is only in the final year that it lags.

Senator CHRIS EVANS—I see, in the sense of your estimates. I thought it might have been when you actually pay the money out in a sense, but no.

Mr Wells—If you claim it through the tax system it is paid in arrears—this financial year for last financial year.

Senator CHRIS EVANS—So are you predicting that the rebate per annum will only rise very slightly over the next couple of years? I got caught looking at the percentage, but they are the variations from your original estimates to your current—

Mr Wells—In the second last column, they are actual figures. It is minus 136—

Senator CHRIS EVANS—They are the differences, though, between your budget estimate and your additional estimates, and I am talking now about your predictions for the outyears. The prediction is that the cost of the rebate will grow by what looks like about two per cent per annum.

Mr Maskell-Knight—I am just doing a calculation, Senator. I think next year works out at 4.956 per cent.

Senator CHRIS EVANS—That is $100 million over the base?

Mr Maskell-Knight—Yes, and it is about five per cent in the following year.

Senator CHRIS EVANS—Is it? You are predicting cost increases in the order of five per cent for the next couple of years?

Mr Wells—We do not normally do the sum that way. We focus on how we are revising the estimate. We need to do those calculations.

Mr Maskell-Knight—It is between five and six per cent.

Senator CHRIS EVANS—I accept what you say about the changes, the variations. I am just trying to get a feel now for your predictions about the cost to the budget of the program over the next few years.

Ms Sperling—Yes. That is what is being projected.

Senator CHRIS EVANS—You are saying another five per cent per annum increase.

Ms Sperling—Yes.

Mr Wells—Roughly.

Senator CHRIS EVANS—I will leave it at that. Thank you for that.

Senator CROWLEY—Mr Wells, do you have any tick-tacking with the tax office about how many people are picking up the tax liability for being over $50,000? Do you tick-tack with the tax office about how many people are actually paying the penalty rather than buying insurance?

Ms Sperling—No, we do not get that information.

Senator WEST—I have some questions for the Private Health Insurance Ombudsman. Am I right in saying that there has been a rise in the number of complaints in the last nine months? This year it has gone up to something like 2,557 as opposed to 1,172 in the same period of 1999-2000?

Ms Gavel—That is correct.

Senator WEST—Can you explain what you think the underlying factors are that have produced such a substantial increase?

Ms Gavel—Basically, with the large number of people who have come into private health insurance since the advent of Lifetime Health—I think the figure is around 2.7 million—so we do not see that rise as unexpected.

Senator WEST—Are you taking any steps to reduce those complaints?

Ms Gavel—We are working with the department in a lot of areas about which we have had a lot of complaints, such as pre-existing ailments. Other areas that have the potential to cause problems to consumers are portability, transferring between funds and informed financial consent. Yes, we are doing a lot of work on some of these underlying issues that are causing complaint.

Senator WEST—What would you say was the most common complaint? Can you give us a list of what the complaints are in a descending order?

Ms Gavel—Yes. We break them down into about six main areas. They include: complaints about benefits, and that that can include complaints about the amount that you get back; complaints about waiting periods, which are the waiting periods in the legislation; complaints about membership issues, such as arrears; and complaints about information that is given to people when they contact the branch or in the literature that they are given. Then we have the category of 'other' that includes a lot of other things. Cost, which used to be quite a large issue, has dropped off significantly since the rebate came in.

Senator WEST—Are pre-existing ailments another area of complaint?

Ms Gavel—Yes, it is. That has gone up in the last year, as you would expect, with a lot of new people coming in because it only affects people in the first year of membership.

Senator WEST—How have you been able to resolve those?

Ms Gavel—We are part of the working party with the department of health that is looking at some of the underlying issues there. We have got a number of strategies on that so that people are given the correct information when they join, or when they ring the fund because they are planning a hospitalisation they then get given the correct information. If that does not solve the problem when they go to hospital, the hospital checks with the fund and they are advised then. We have got a number of strategies in place.

Senator WEST—There was a process that was being adopted, an industry wide one, called the key feature statement policy. Is that correct?

Ms Gavel—Yes. We have input into that.

Senator WEST—You have input into that. What has happened to that? Is it actually out there in the real world or is it still being worked on?

Ms Sperling—I think that might be something that is better for me to answer, Senator. The department is working with the private health insurance industry on developing the key feature statement. The purpose of that statement is to provide consumers with clear definitions of health insurance entitlements and to standardise present product attributes to allow consumers to broadly compare the relative costs and level of health fund benefits between products and funds. To date where we are at is that the key features document has been revised to take into account recent changes in private health insurance. It is in the process of being consumer tested using information from two health insurance funds. The document is scheduled to be implemented by health insurance funds within the next couple of months.

Senator WEST—How long has this policy statement been in the making?

Ms Sperling—It has been in consultation with the industry since October 1999.

Senator WEST—It is not exactly moving speedily, is it? When do you expect it to be out there for the consumers to actually consume?

Ms Sperling—We are expecting, as I said, health insurers to be implementing it by about August or September this year.

Senator WEST—It has taken two years to do it? What is happening with the working group to clarify the rules on transfers between funds to minimise the impact on members being forced to re-serve waiting periods?

Ms Gavel—We released a discussion paper last year and out of that came a number of recommendations, one of which is the consumer brochure that should be going out to funds by the end of June, to explain to people what they are entitled to under the transfer provisions.

Ms Sperling—Just taking that process back one step to the Private Health Insurance Ombudsman in consultation with the health funds, consumer groups and the department conducted a review of portability arrangements and prepared a paper on the issue. The industry has agreed to implement standard arrangements in relation to portability across all health funds. That is now in practice and being implemented and those common approaches are actually being implemented by all health insurance funds. As part of that review, as the ombudsman mentioned, it was agreed that the ombudsman's office would develop a brochure that would be made available to all health fund members who are seeking to transfer within a health fund from one table to another; also health fund members who are seeking to transfer between health funds. That brochure is actually at the printer at the moment and should be available for distribution to those people through health insurance funds at the end of June.

Senator WEST—It will be written in simple English?

Ms Gavel—Yes, as simple as we have been able to make it.

Senator WEST—What happened about standardising the exclusions of certain treatments from some policies?

Ms Sperling—As I think I mentioned last time, the department is planning to hold an industry roundtable discussion in August this year to discuss with the industry issues relating to exclusion products and other products that have recently emerged on the market and whether they are appropriate and beneficial for members. It is important to note that the number of people who currently are on products which have specific inclusions has reduced significantly and is now only 3.9 per cent of all people with private health insurance.

Senator WEST—People are actually making a choice not to—

Ms Sperling—It is partly that, and also that those private health insurers who did have those products have voluntarily withdrawn them from the market. Most of the people who are now on products are on products that were older products and they still wanted to keep their membership. Most of those products are being withdrawn voluntarily by insurers from the market.

Senator WEST—Has the ombudsman's office undertaken any further work to look at the consistency and accuracy of the advice provided to members by fund call centres?

Ms Gavel—We are looking at a number of issues to do with the information given to members. Basically, when we get a complaint about that sort of issue we see if there are any underlying problems that we can help to solve. I think that issue is something we have taken up in our quarterly bulletin that goes out to the funds. Where we have had problems from consumers we refer that back to the fund and hopefully get the individual problem fixed as well.

Senator WEST—This question arises from a *Choice* magazine survey last year that found many call centre staff were temporary and had only a limited knowledge of the fund policies and as a result were giving incorrect and misleading advice. What measures should be taken to ensure that the policy given by the fund is accurate and understandable?

Ms Sperling—Certainly, one of the things that is in place is that under Lifetime Health Cover, health fund members will be receiving and health funds have to distribute an annual statement issued by the fund outlining clearly what the details are of their hospital cover. These details must include the type of cover that they hold and the level of front-end deductibles, exclusions, co-payments and benefit limitations. The first of these statements is scheduled to be released and actually must be released according to the legislation before the end of July 2001.

Senator WEST—How is the work progressing? Will that date be met?

Ms Sperling—Yes, it will. Individual health funds have been reminded and are aware of this legislative obligation, and they have processes in place to assure that those statements are sent out.

Senator WEST—You have no doubt that they will meet that 1 July date?

Ms Sperling—That is correct.

Senator WEST—What needs to be done about informed financial consent? Should all funds offering gap cover advertise the names of doctors working on this basis so that patients can shop around and find a doctor prepared to treat them at an affordable price?

Mr Wells—That would be a desirable objective, that as much information is available from the funds to their members as possible. Some funds are working towards that and we hope imminently will release that information. Others are not quite as advanced. That is a thumbnail sketch of where it is at. That would be an objective we would like to work to.

Senator WEST—That is an objective. What needs to be done to get more informed financial consent beyond that? Do some of the funds need a reminder of some sort or a bit more stick to go with the carrots?

Ms Sperling—I think the health funds also want to make that information available. The process that needs to happen at the moment is to ensure that, in accordance with privacy legislation, health funds confirm with medical practitioners that they are prepared to have that information released more publicly. At the moment, what happens is that, when health fund members contact their health fund, most health funds are able to provide them with one-off information about whether a particular doctor has agreed to participate in a gap scheme. Health funds do want to make information more widely available and at the moment they are going back and confirming, in accordance with privacy legislation, with medical practitioners who have agreed to participate in gap schemes that they are happy to have their information released more publicly.

Senator WEST—It is amazing the ACCC can make all the airlines put their fares and costs out on public perusal. What is the ACCC doing to ensure that there is a bit of competition here that is publicly available? Anything?

Ms Sperling—I know that the ACCC also supports this information being made available, so it is a process of making sure that the information is made available in accordance with other processes. These are at the moment the implications of privacy legislation.

Senator WEST—Do they look like they are going to take a fairly aggressive stand on it, or are they just going to mouth some words?

Mr Wells—Who, the ACCC?

Senator WEST—Yes.

Mr Wells—I could not answer that, Senator. You would have to ask them, I think.

Senator WEST—They are not flavour of the month with me at present, because they said they did not care if Impulse Airlines went belly up as long as there was competition. They have now got an opportunity to have competition but they do not seem to be moving down that path as vociferously. Thank you; that will do for that. Can I turn to rural private hospitals? I am wanting to know what has happened to the funding provided in last year's budget for the funding of small rural private hospitals and bush nursing hospitals. How much was actually spent and on which projects?

Ms Sperling—The cumulative expenditure to April 2001 for this program is $1.2 million, and it is expected that the expenditure by the end of this financial year will be equal to the budgeted amount of $2.7 million. There have been processes put in place to undertake service planning in most states—in fact, all states with eligible rural private hospitals to date. I can work through those in more detail for you if that would be helpful.

Senator WEST—Last year's budget showed an allocation of $4.1 million for 2000-2001—that is this financial year—now you are telling me the budget is $2.7 million. What has happened along the way? The budget for this year also shows the actual spending for last year as zero?

Ms Sperling—I would have to take that on notice and get back to you on that.

Senator WEST—I want to know why there was no expenditure. When the original was allocation made, what plans existed for spending this money? What action has the Commonwealth taken to assist struggling rural private hospitals that face closure?

Ms Sperling—Would it be helpful if I worked through what we have been doing in each of the states?

Senator CHRIS EVANS—It might be, because I think Senator West wanted to be clear what the broader thing was first?

Senator WEST—Last year's budget showed an allocation of $4.1 million for this current financial year?

Mr Wells—I think some of that figure was departmental funds to employ staff to administer the program, because we have been talking about the funds that we are giving out through the program to assist the hospitals—that is, the $2.7 million for this year. We will clarify that on notice.

Senator WEST—This is the administrative and the departmentals, okay. So to April, which is nine months into the year, we have only spent $1.2 million and in five weeks—that is, four weeks and how many days—we will have spent $2.7 million?

Ms Sperling—That is correct

Senator WEST—What is the big rush?

Ms Sperling—It is more an indication of where we are in terms of the process in each of the states. At the moment, we have had to stagger the implementation of this program across the states to make sure that we properly resourced the assistance that we provided and the service planning that we have been funding. There will be a culmination of the first series of service planning which will be coming to conclusion within the next few weeks, so that explains where we are at this point in time with this program.

Senator WEST—How many state ones are there? Can you run through that quickly?

Ms Sperling—Yes. What you want to know is how many hospitals in each state?

Senator WEST—Yes, and how much they are getting? And how well they are managing up until they get some money.

Senator CHRIS EVANS—This is different from the MPS?

Ms Sperling—Yes, it is.

Senator CHRIS EVANS—So many programs that seem to be going along similar lines, but this is different from the MPS and this is different from the aged care grants to struggling rural facilities?

Mr Wells—This program is not so much about giving the money, in a sense, to subsidise their operations, it is to give them assistance in doing planning, to work out what they need to do to remain viable or to become viable.

Senator CHRIS EVANS—Or how to work out how to get you to subsidise their ongoing operation.

Ms Sperling—We certainly have a comprehensive table which lists each of the hospitals and what funding has been paid to date in this financial year and is yet to be paid between now and the end of financial year, which I would be happy to table for them.

Senator WEST—That would be very helpful.

Senator CHRIS EVANS—Are you paying for consultants that they hire to help them and that sort of thing, is it?

Ms Sperling—That is correct. We are paying for service planning which gives an indication of what the needs are for those particular facilities.

Senator CHRIS EVANS—So you are not buying any services for clients or patients?

Ms Sperling—We are certainly not buying any services for patients and that is where this program does differ from the other programs that you mentioned, because the services are paid for by private health insurers.

Senator WEST—When you look at the PBS on page 206, outcome 8, administered item No. 2, both appropriation bills, one and two, there is zero for this year.

Ms Sperling—There is zero this year and $4.6 million as a budget estimate for next year. This program has two funding components. One is departmental funding and one is administered funding. The departmental funding commenced in the first year of the program, which was this financial year, 2000-2001.

Senator WEST—Where do I find that?

Ms Sperling—It is included in the total $15.620 million, total price for departmental outputs in outcome 8. Most of it would probably be in output group 1 and output group 2, but it is not separately identified. The adminstered funding for this program starts next financial year which is the amount that you can see in the grey box under administered which is $4.623 million starting next financial year. That money will be used to provide assistance to hospitals to implement some of the service planning recommendations that arise from the service planning consultancies that we are currently funding.

Senator WEST—This is where they are getting their sticky fingers on the money!

Ms Sperling—Most of the money but, as I said, it is not to provide actual services for patients.

Senator CHRIS EVANS—I am going to regret asking this but why is some under administered and one under departmental adequates when they are both basically buying advisory services?

Ms Sperling—That is the way the budget measure was originally structured. The service planning money buys consultancies for the department to advise us on what the needs of the hospitals are and the administered funding, which will be provided after the service planning, provides money to the hospital to implement agreed action arising from those service plans.

Senator CHRIS EVANS—Yes, I guess I was wondering why one is represented as administered and one is represented as a departmental appropriation. It is probably not a question for you, Ms Sperling, I guess it is a financial question. I just could not understand why.

Dr Wooding—It is simply that departmental appropriations are where something has been purchased by the department—as Ms Sperling described. Where we were purchasing consultancy services that will be a departmental expense. The second part of the program is more in the nature of a payment of a subsidy to the hospitals to help them with the activities that Ms Sperling describes—therefore, that is an administered expense in that we are not buying something for ourselves with the money.

Senator WEST—Designed to all be hidden from us! I suppose when senators get their heads around this, you will change the accounting method. Is the Commonwealth doing anything to assist those hospitals that are in trouble, face closure?

Ms Sperling—That is what this program is designed to do.

Senator WEST—What has happened with Nagambie Bush Nursing Hospital, because I understand that has been forced to close because it could not get any assistance?

Ms Sperling—Nagambie Hospital has suspended its acute services at the moment. It was a business decision that was taken by the board of the hospital and it was basically taken to ensure they are able to meet their financial liabilities. The Commonwealth and the state government have both put in several hundred thousand dollars over the past couple of years. The hospital does not have demand for significant acute services and so the money that has been funded over a range of programs, both by the state government and the Commonwealth government, have been used to support the financial situation at that hospital, but it has continued to be in a position of going backwards. The Commonwealth, under this program, is still committed and we have made that very clear to the board of the hospital to provide service planning to assist and to expand the range of services that they offer beyond acute care, much more in keeping with what the Commonwealth and the states are trying to do with rural health service provision, both in the public and the private sector, right around Australia. We are continuing to work with the board of that hospital to provide them with financial support both for service planning and the implementation of recommendations coming out of that service planning.

Senator WEST—I am getting the impression that there is a claim that the consultancy is being offered for future health needs rather than the continuation of services.

Ms Sperling—Certainly this program is designed to help, where necessary, reconfigure services and because they are private hospitals, where the traditional acute services are to be provided by private health insurers, it is not to provide for ongoing service provision. The state government has provided some assistance over the last couple of years to treat public patients in that hospital but it is still not in a very viable position if it continues to only treat acute patients. The exercise that we are hoping to assist with will look at expanding the range of services to make it a more viable ongoing proposition.

Senator WEST—Thank you. I think we have have 8 finished.

[8.39 p.m.]

CHAIR—We will move on to outcome 9, health investment. I have a question about Health*Connect*. I am aware that Health*Connect* is a way forward for implementing a national approach for electronic health records but could you bring the committee up to date with the detail of it, what it aims to do in particular. The most important aspect, I suppose, is the privacy question. I know that some people have made allegations about the questionable privacy protection and I would like to know what privacy initiatives have been put in place.

Dr Wooding—Health*Connect* has its origins in the national electronic health records task force, which was established in November 1999 by Australian health ministers looking for a way forward to implement a national approach for electronic health records. The work of the task force was endorsed by health ministers in July 2000, and later in 2000 they agreed that they would like to see development work on Health*Connect*, which would be the way forward in implementing the work of the task force and establishing the National Health Information Network. The states and territories and the Commonwealth agreed that they would seek

funding, and the budget measure announced in the budget provides $15.8 million of funding from the Commonwealth's point of view.

In fact, in total, the Commonwealth is seeking to provide $18.5 million, which we would be hoping the states and territories would match. At this stage, it is to be a research and conceptual exercise. We are basically going to trial the number of approaches and research a number of issues in relation to Health*Connect*, in partnership with the states and territories. There is a joint program office situated in Canberra and headed up by Paul Fitzgerald, who is sitting next to me. We are going to be doing some research and we are going to be doing on the ground testing and pilot exercises.

As you said, Senator, privacy is a very important part of the issue and, basically, we will be working all the way through on a robust privacy framework for Health*Connect*. The Commonwealth has the privacy amendment, private sector legislation, which provides a basis for that. We are developing a national health privacy code within that framework in consultation with the states, and we are hoping to release a draft version of that code for public comment shortly. Finally, when and if there is a Health*Connect* network established there will be specific legislation governing that which will have very stringent privacy requirements about the data within Health*Connect*.

CHAIR—What sort of stringent privacy requirements do you envisage?

Mr Fitzgerald—As Dr Wooding was saying, the intention is to build on the existing Privacy Act, the amendments which were passed to that, to cover the private sector, in December last year. What we are currently working on is the development of a health privacy code. The intention is for that to sit under the Privacy Act and to cover, specifically, personal health information. In a sense what it is doing is translating the provisions of the Privacy Act, the national privacy principles, to specifically cover the collection, transfer and storage of personal health information.

CHAIR—So how will someone and on what basis will someone be able to access the information?

Mr Fitzgerald—You mean the information that is intended to be held in Health*Connect*?

CHAIR—Yes, that is right.

Mr Fitzgerald—Perhaps if I can answer that in two ways. In addition to the general privacy arrangements that I was describing, if Health*Connect* were to be developed in full and rolled out on a national basis, the intention is to develop a set of legislative arrangements that would specifically cover Health*Connect*. In the two years of research and development, which is basically what the budget provides the resources for, part of the activity during that time will be to investigate further some of the provisions that will be necessary to be put in place for a national roll-out. More specifically, though, and this is the second way of answering your question, during the research and development phase of the project, it is intended that at some stage along the way a Health*Connect* implementation site or sites will be set up so there will be live Health*Connect* sites. In those circumstances, the intention would be to seek individuals' consent to both collect and store information on the network.

Dr Wooding—To add to that, basically, we are trying to establish an environment in which individuals will exercise a lot of control over how their information is used and accessed in Health*Connect*—similarly, other participants, including medical practitioners and medical service providers, so that there will be a very secure and controlled environment which people will feel confident in.

CHAIR—How will consumers be involved in the process?

Mr Fitzgerald—In a number of ways. In fact, consumers already have been involved in the development cycle of Health*Connect*. I do not want to go too far back in history but the concept of Health*Connect* was developed in an electronic health records task force which was a committee of the National Health Information Management Advisory Council, which reports directly to Australian health ministers. At each of those forums, both the council and the task force, there were consumer representatives involved so there has already been, in a very direct way, in shaping the nature of the concept of Health*Connect*, the involvement of consumers.

Subsequent to the report being presented to ministers in July last year and again in November last year, the Consumers Health Forum has acted on behalf of the department to undertake a series of public discussions about Health*Connect* and other information initiatives in the department. We are only talking about early days, I suppose, but that has been an involvement of the consumers group up to this time. Looking into the future, though, the intention would be to involve consumers in a number of ways, and in particular we would anticipate establishing a consumer reference group to be able to advise the project development through the course of the next two years.

CHAIR—Is the consumer group satisfied with the privacy provisions that are so far in place through the act and proposed through the additional material that is to be added to it?

Mr Stuart—It is a bit difficult to answer that question as there is no one consumer group.

CHAIR—No, but are those with whom you have been consulting relatively relaxed about what you are putting to them in relation to privacy?

Mr Fitzgerald—I think it is fair to say that privacy is an issue of concern. During the discussions that I was alluding to that were run for us by the consumer health forum, where they assembled a group of consumers and consumer representatives in every state and territory, the issue of privacy was raised by people participating. Without wanting to put words in their mouths, I think there was a level of reassurance that the framework that we are offering through the act, the code and specific legislation, if we were to get to the stage of a national roll-out, was something that people thought would create a level of privacy reassurance.

CHAIR—Thank you.

Senator CROWLEY—First of all, where in this book can I find HealthConnect? I have got it on page 226; is that the only place?

Dr Wooding—That is where there is the measures description. It is also incorporated into the funding resource summary for outcome 9 on pages 32 to 33. That is where the financial information is, but the measures description is on page 226.

Senator CROWLEY—This got a mention in budget paper whichever and I think I have turned every page in this book until I got to page 226, where there is a brief reference that says:

> See also the related expense measure *HealthConnect: A Health Information Network for Australia—Development Phase* in the Health and Aged Care portfolio.

There are no pages, no clues and no assistance. Where would I find HealthConnect, a health information network?

Dr Wooding—It is on page 225.

Senator CROWLEY—I see, so you footnoted the bottom of the bit that says, 'Go back to the start'? I have offered some criticisms by way, I hope, of constructive comment. But if you actually give me a 'see also' I would really love a page or a paragraph. 'See also, go back to the beginning' is not helpful. That is just by way of comment about HealthConnect. It is interesting; it is new money, or prospectively it is $15 million on top of a couple of million dollars, so I would like to have found it somewhere else besides on page 226. Will there be one mainframe for this?

Dr Wooding—It is far too early to say. It is the network and a network could be, in some sense, something like the Internet, where there is no single point. We think there might be a storage point, but whether that is a single mainframe, or a series of storage points, these are all things we will need to research and investigate.

Senator CROWLEY—Indeed. Where do you envisage it will be?

Dr Wooding—You mean where will it, the trial site, be for HealthConnect?

Senator CROWLEY—What is this HealthConnect? Where are you doing anything about it? Is it in general practices in a trial position, or is it still in the research laboratory somewhere?

Mr Fitzgerald—It has not really even reached the research laboratory. At this stage HealthConnect is still really a concept and there is further work that needs to be done in developing the concept to a stage where there can be an accurate description of, I suppose, a HealthConnect architecture. At that point we would, as I was indicating before, hope to involve other stakeholder groups in providing comment on that. I would say that it is still some way off before we would actually hope to have something like a live site that would be able to test HealthConnect on the ground.

Senator CROWLEY—Is it about patients' records and general practitioners being able to buzz a message to the specialist: herewith this patient arriving next week; see gall bladder x-ray pictures; press button X? Or is it about general information about diabetes, heart attacks, et cetera?

Mr Fitzgerald—No, it is something that builds on your first option, really. It is just not intended to be something that simply sends messages around. In a sense we already have that facility in that we can send messages by phone, fax or email. The concept of HealthConnect is to be able to collect information about individual contacts that people will have with the health system, wherever they are, whether it is with a general practitioner, a hospital or a pathology laboratory. As a result of each of those contacts, a summary of the contact would be recorded and that information would be stored in some way. Then, clearly with the consumer's permission both at the point of storage and at the point of retrieval, at a later date, when the person were to see a general practitioner or be admitted to hospital, the entire suite of information could be assembled to be viewed by the practitioner or indeed by the consumer themselves. The intention here is to be able to reconstruct a history of the person's contact with the health system which would build up over time.

Senator CROWLEY—So it is really like an exotic patient record?

Mr Fitzgerald—I do not know about exotic, but a patient record, yes.

Senator CROWLEY—You are including in it things that previously have not been on the record, like visits to a physio or visits to an immunisation centre, non-medical, et cetera? That is to say, it is not just: see your GP or see your medical specialist.

Dr Wooding—Yes, Senator, but also it is going to, for example, combine visits to a public hospital and then visits to a community based physician. The idea is to combine as much as possible—

Senator CROWLEY—I do not dispute it, exotic meaning only that it is outside the current parameters. Have you visited the Kaiser scheme in Denver?

Dr Wooding—I visited the Kaiser scheme in California, but not in Denver.

Senator CROWLEY—I visited the Kaiser scheme in Denver because I heard at a conference about 12 months ago that they have now gone onto completely computerised patient records. There is no paper in the whole of the Kaiser scheme in Denver. If you have not had a look, I might suggest you do. I know it is entirely dissimilar to ours because their primary care out of hospital and their patient care in hospital is all the one system. It is Kaiser and you are in it.

There are a couple of things that I will pass onto you that I found extremely interesting. Every time anything is entered into that computer on behalf of a patient, it is automatically backed up and then at night everything is backed up again. They do not wish to find that all the records have gone and they also have a very significant firewall, or security system, around it. Again, that is a major challenge for you, I should have thought, because you are in hospital, out of hospital, between states, wherever.

Mr Fitzgerald—Indeed, the security side of this research and development phase is going to be a key component.

Senator CROWLEY—I will pass that on, but I suppose I am interested in what you anticipate spending $15 million on.

Senator CHRIS EVANS—It would be nice if you could convince doctors to sign the same piece of paper as nurses. That would be a big step forward.

Dr Wooding—Senator Crowley, are you asking for a breakdown of how we are spending the $15 million? Is that correct?

Senator CROWLEY—How you propose to; or have you got this already on a page here so that I can save everyone some time? It is a pretty expensive concept at this time, is it not, given what it cost for Denver?

Mr Fitzgerald—In the scheme of things, given the history of IT projects, I gather it is a reasonably modest proposal. As Dr Wooding was saying, this really is the research and development phase and—

Senator CROWLEY—There are some Young Turks out there that are a fair way along a similar kind of line, are there not?

Mr Fitzgerald—The development of an electronic record along the lines we are describing here is something that is often referred to as the Holy Grail of health information. This is something that is a world project, without really wanting to overstate it. It is something that all developed countries are really struggling with at the moment. We have been in contact with the UK, the United States and other countries and they are all trying to work out how to deal with this issue in a way that works, that meets people's needs and that is generally effective. It is an important project.

Senator CROWLEY—Are you dealing with any particular company?

Mr Fitzgerald—We are not dealing with any particular companies. I was really just referring to the work that we are aware of going on in—

Senator CROWLEY—Sure, but who are you working with? Or are you just working with yourselves?

Mr Fitzgerald—We really are not at the stage when we would be wanting to engage any particular software companies in the development of products. As I was indicating before, we really are still at a design stage of the project. One thing that is probably worth emphasising, though, is that we are working in partnership with the states and territories on this, because one of the underlying advantages of this scheme, if it were to prove itself, is that it is intended to be a national scheme. Having the states and territories committed to it means that we can possibly avoid the railway gauges of health information.

Dr Wooding—It is an important point. The key priority is to actually get people to agree to participate and work together in this. It is that side of it which is our major task. The technology is there in a sense. What we need to do is work out how to build a series of linkages that we can then actually use the technology to enable. If we go to the $18.5 million, which includes the existing funding—this is only the Commonwealth share of the money we are talking about, not the state share—governance and administration would be $2.7 million. The privacy work, which we have mentioned before, is about $300,000. Security and authentication, including work on public key infrastructure, will be about $5.1 million. Work on standards will be about $875,000. Telecommunications infrastructure will be $125,000. We have some work on implementation sites we expect will cost about $4.5 million.

Senator CROWLEY—What was that one?

Dr Wooding—It is actually $4.325 million if you like.

Senator CROWLEY—For implementation sites?

Dr Wooding—Yes. We are going to have some implementation sites or pilots, I suppose you might say. Uptake of some work on education and training tools for IT in this area will be about $325,000. Then we have an amount of $2.5 million, which will include $1.25 million for community liaison. Is that right Paul? In the $2.5 million there will be an amount for a communications strategy, which I am sure will interest the senators. Is it $1.25 million?

Mr Fitzgerald—Yes.

Dr Wooding—So $1.25 million will be for a public communications strategy. I think the remainder—

Mr Fitzgerald—The other component that we have described in this table is implementation costs, and they are really the telecommunications recurrent costs that we would incur in the actual implementation sites. We would expose the concept to live testing.

Senator CROWLEY—Can I just be clear? This means that, theoretically, what you are hoping is that anybody who provides some kind of health service for a patient would be able to access that person's record and add to that. So, for example, a diabetes nurse or a visiting district nurse could also add information to that system.

Mr Fitzgerald—Yes, that is correct. If HealthConnect were to be developed on a national basis, I was indicating before that we thought it would probably need some legislative framework. The legislative framework may need to define the limits of health. Some of the examples you are giving are starting to get towards the boundaries of the health sector. During

the course of our implementation site testing of HealthConnect, what we are anticipating is that this will be simply a matter of the consent of those who choose to participate.

Senator CROWLEY—Thank you.

Senator WEST—I have a couple of questions on RAMUS. What is the progress? How many scholarships have been offered this current year? Have they been offered? Have they been paid?

Mr Wells—Senator, that is outcome 5. Could we take those on notice? I think our colleagues have left.

Senator WEST—What I want to know is what progress is going on. I want to know how many offers there have been. I want to know the number that have been accepted. I want to know the date that they have been paid their scholarship. I also want to know the date on which last year's recipients were paid their scholarships as well.

Mr Wells—That is the RAMUS scheme, not the bonded scholarship scheme, isn't it?

Senator WEST—Yes. You can give me the same information for the bonded scholarships as well, please, while you are at it.

Mr Wells—We can give you information on that.

Senator WEST—I am quite happy for it to go on notice. I think you gave it to me on notice last time. There is a question I forewarned you of yesterday about grants and advertising. I think Dr Wooding knows what I am talking about.

Dr Wooding—Can we start with grants? Are they related questions?

Senator WEST—We have had a few questions in relation to grants and advertising with regard to this area because some of them are apparently administered in this area, is that correct?

Dr Wooding—There is a grant scheme. I think earlier yesterday Ms Murnane was referring to a grant scheme.

Senator WEST—On page 260.

Dr Wooding—Yes, the Community Sector Support Scheme is mentioned on page 237 of the PBS, under outcome 9. That gives you a total cost for the administered item. I think that administered item includes things other than the Community Sector Support Scheme. It does because it is $26.3 million, but the Community Sector Support Scheme is $2.9 million, I think.

Ms Feneley—There is $2.9 million for the 2001-02 year.

Senator WEST—That is only one set of grants of course. How much of that was allocated to it last year and how much was spent?

Dr Wooding—It is virtually all spent every year.

Ms Feneley—It is fully committed to 12 organisations which receive that funding.

Senator WEST—You are not increasing the number of organisations or anything, are you?

Ms Feneley—No. We have no intention of doing that at this point.

Senator WEST—When will the funding for those be decided, or has it already been decided for this coming financial year?

Ms Feneley—It has already been decided. The 12 organisations continue from year to year with their funding after a 12-month review.

Senator WEST—Does the 12-month review take place regularly?

Ms Feneley—Yes it does. There is a six-month review as well, but we have just had the 12-month review a few weeks ago.

Senator WEST—But that is not the only grant program that Health and Aged Care has got?

Dr Wooding—No.. There are a large number of grant programs in the department. I am not even sure I could tell you how many, but there are lots.

Senator WEST—Somewhere in there one area said 700.

Dr Wooding—I think it depends on how you define grants, Senator. One of the problems is that there are accounting mechanism ways of defining grants; there is legal; there are lots of different ways of defining a grant program.

Senator WEST—That is the problem I am having with this department because there are grants that go each year to the states for the running of the private hospitals and the public hospital system, and they are embedded in legislation. I am interested more in discretionary grants, ad hoc grants, one-off grants.

Dr Wooding—I suppose the question really is: are you looking for information on these in general? We could give you a table of all the grant programs that are not defined in legislation or any that are in a sense—ad hoc is not quite the right word, but I see what you are saying.

Senator WEST—You know what I mean.

Dr Wooding—They are not specified as such. We could give you a table of the grant programs and how much is spent on them. It may take some time to prepare but we can take it on notice and do that.

Senator WEST—I had hoped that some of us would not let you take it on notice because I did give some warning yesterday that I was going to ask questions about this. I wanted to know how much has been allocated to the various programs in this financial year. How much money was left in those programs as of 1 January and what disbursements have been in those programs from then until now?

Dr Wooding—That is something that would take a little bit of work to do. We will take that on notice and see what we can give you.

Senator WEST—What is the timetable for the application and assessment process for the current financial year and for the next financial year?

Dr Wooding—We will take that on notice as well, Senator.

Senator WEST—In some areas there have been one-off grants under the budget appropriations. Have you got any of those?

Dr Wooding—I suppose it depends on what you mean. Do you mean a one-off grant to an organisation?

Senator WEST—Recently, for example, the Commonwealth contributed $2 million for the construction of a basketball stadium in Maitland which came out of the sport budget. That

was actually through a specific purpose appropriation. Do you have them going for any of those?

Dr Wooding—There are a lot of appropriations when we are making grants to organisations for various purposes, Senator. I guess what is one-off in the definition is probably a bit difficult to say. Once again where we have given grants we can get some information on that too.

Senator WEST—How long is this going to take, knowing Health's ability to answer questions and get the answers back speedily. I would like it before the end of June. I am also wanting to know whether the department is aware of the caretaker conventions and their application to the operation of grant programs during an election campaign.

Dr Wooding—I am not certain there has been that election.

Senator WEST—What do you think it means?

Ms Murnane—What I think it means is that there is no initiation of an expenditure that is not currently within a framework of policy or program administration. For example, payments to aged care homes continue; payments to Aboriginal medical services would continue right through the caretaker period because those payments are flowing from an earlier policy decision. But for payments or a policy or decision that are initiated during the caretaker period, the convention would be that they would not take those, that those payments would not be made.

Senator WEST—The caretaker conventions will be honoured during the forthcoming election campaign?

Ms Murnane—They always have been in my experience, Senator.

Senator WEST—When you are doing those grants, there were certainly some discretionary grants here.

Dr Wooding—There are some listed in the earlier report. Actually with those ones, Senator, I have already mentioned the community sector support scheme. The National Mental Health Strategy project funding is only $43,000 in total. Very small grants are given out under that program. The general practice innovation pool existed last year. I am not sure that there is a new round of grants under that pool this year. My advice is that there has not been a new round of grants. However, there are many other grants in the category. You were talking about where we make grants to organisations and they are not enshrined in legislation or other very explicit sort of rules. We will give you information that goes beyond the list that we have here.

Senator WEST—Can I also ask about rural clinical schools, about the progress that has been made in the establishment of these.

Mr Wells—The current situation is that, as you are aware, it was announced earlier this year where the clinical schools would be located. In terms of our negotiations with universities, we have a funding agreement signed with the University of Adelaide. We have agreements with Flinders, Melbourne, Monash, Tasmania, New South Wales and Queensland universities, and we are still negotiating with the universities of Sydney and Western Australia.

Senator WEST—Have I seen a map of A5 size?

Mr Wells—Yes, I can give you a copy of that.

Senator WEST—That would be wonderful, please. Somebody asked me for one and I have got one copy and I was not going to let that out of my sight, but I was not sure whether it was the same copy. When do you expect the dates for commencement of operations on these sites?

Ms Cobbold—It varies across the universities. They are at different stages of development. For example, with those like the University of Adelaide which is well advanced and in fact has already commenced the building work at their site in Whyalla, we have already had the first community advisory board meeting. They will have students commencing and placements next year. Some other universities that are not able to start with the same base of infrastructure will take a little longer. Essentially, the agreements we have in place with all the universities are to provide the initial start-up funding and development funding to enable them to substantially progress their planning and initial infrastructure development. We expect there will be students at virtually all of the schools some time through the following year.

Senator WEST—That is 2003.

Mr Wells—Yes.

[9.16 p.m.]

Senator WEST—I have only got about 10 minutes all up, Madam Chair, so if I can just have a run at this. On NHMRC funding, I want to know what the actual amount was that was paid out in research grants in 2000-2001 and how this compared with the previous year?

Prof. McLachlan—The amount for 2000-2001 of course is not completely finalised. We will finish that in the middle of June. So far, we have committed, offered grants, to the extent of $265 million approximately for this year and I think all but about $10 million of that has been accepted but not yet paid because we are waiting for clearances.

Senator WEST—So how much at the end of this financial year do you expect to be rolling over?

Prof. McLachlan—We have estimated $34 million.

Senator WEST—What was the rollover of funds at the beginning of last July?

Prof. McLachlan—About $31 million, I think. It is a very similar amount.

Senator WEST—Is spending on track to result in an actual doubling of spending on medical research by 2004-05?

Prof. McLachlan—Yes. We have planned our expenditure in a staged way because additional funding is increasing in a staged way. Every year we have been spending all the increments that we have received. So far we are on track. Because of the commitment on all of the grants—they are three- to five-year funding—we have to plan this rather carefully to make sure that the amounts are not overexpended in the future years.

Senator WEST—So you are on track?

Prof. McLachlan—Yes.

Senator WEST—Thank you. That is all on the NHMRC.

CHAIR—Just a moment. I do not know whether that is all for NHMRC.

[9.19 p.m.]

Senator WEST—Sorry. It is all from me. I have finished with NHRMC. Is there a program out yet for advertising that the department is going to undertake for the next financial year, across all programs?

Ms Feneley—As you would have noted, there are several major initiatives in the budget this year that include communications. There are also other initiatives that will have a communications component and we have not done a total of what those dollars are yet. We can certainly provide you with that if that is what you are seeking.

Senator WEST—Yes. I am seeking the dollar amounts. I am also looking at the timetabling of when those advertising campaigns are likely to be undertaken.

Ms Murnane—We would not have all those yet, Senator. At the end of each financial year we publish all expenditure on advertising and market research in the annual report. That is there in the last annual report. This financial year's will be there in this year's annual report. The report gives the name of the company or individual that actually received payment for the work.

Senator WEST—Yes. I am quite aware of that, Ms Murnane. I am wondering whether the department has done any work on a program—not as detailed as that, but an outline program—of what advertising is going to be done or what community strategies are going to be undertaken and when.

Ms Murnane—That would be done program by program and some programs are more advanced than others. In aged care, for example, there is an appropriation of $2 million; $500,000 in the coming financial year. I can tell you broadly what that is for. But all areas are not that advanced yet. Ms Feneley does have some information but a lot of it is retrospective rather than prospective.

Ms Feneley—We work with the individual program used to develop communication strategies, so, as Ms Murnane indicates, many of those are not yet progressed. But with the aged care communications program, the indicative initiatives under that strategy are likely to be fairly low key communications such as pamphlets on how to access aged care, a legal guide on people's rights, articles in seniors publications and that sort of thing.

Ms Murnane—Following up on a recommendation of Professor Gray in his two-year review report that we should heighten awareness of people of the program and what the program offers.

Senator WEST—I am not wanting to revisit Professor Gray's report; we did that last night. I just misunderstood something that was told to me yesterday. My final questions are on behalf of Senator Lundy who I think if she had stayed here would have produced a baby for us. It relates to some answers that she got back from questions on notice last time. It is a question Senator Denman put on notice. It is volume 2, page 5, question E0100003. It relates to the Humphry report at page 95. It says, 'OASITO's responsibilities in the IT initiative include the following' and it ends up saying:

> The evaluation report was jointly produced by OASITO, DHAC, MPL and the HIC and contains information confidential to each of these organisations. The HIC is therefore unable to release the full Report without the authority of the organisations. The HIC did, however, provide written authority to OASITO to release the Report to the Committee in full.

That appears not to have happened. Senator Denman had also asked question E01000014, in the same bundle of answers, on page 26, in relation to OASITO's responsibilities. That final answer there about developing tender evaluation reports says:

In the context of the possible release of the evaluation reports, Medibank Private has expressed its concerns to OASITO about the release of commercial-in-confidence information and information that may prejudice the security of Medibank Private systems.

What I want to know follows on from the Audit Office report No. 38 about the use of confidentiality provisions where it says:

1.31 Generally, the kinds of information which could form the basis of a public interest immunity claim could include documents or information obtained in confidence from other governments, material ...

I want details of precisely what departments and organisations are claiming commercial-in-confidence over; why and on what grounds?

Mr Moran—I did have a little trouble following that question, Senator.

Senator WEST—Well, you gave us the answer.

Mr Moran—Can I clarify that you are asking, in respect of the department of health, and separately I guess for HIC, for us to describe in our view what in our contract would constitute commercial-in-confidence information and why?

Senator WEST—I am wanting to know why in these two answers confidential reasons appear to be used to not provide copies of reports and information.

Mr Moran—I cannot comment on behalf of Medibank Private at all, which seems to be the thrust of your question.

Senator WEST—They are answers from the department. You have given us the answer.

Mr Moran—I am not sure that I gave you those answers. They sound like something OASITO may have provided on our behalf. As I say, I do not have the documents in front of me.

Senator WEST—I have only got one here.

Mr Moran—Could I take on notice the specific references that you read in then.

Senator WEST—Yes. It is volume 2 of additional information received, outcomes 1 to 2, Health and Aged Care portfolio, May 2001. The first one is on page 7.

Mr Moran—Senator, I think I might be able to shed some light on it. I think it relates to the Health Insurance Commission.

Senator WEST—One does and the other one would relate to Medibank Private but it has gone through OASITO. I would have presumed that the administrative area of the department would have been the one that would answer.

Senator CHRIS EVANS—I think the reason Senator West is asking the department is that these are answers to estimates questions taken on notice by the department asking where you got the answer from and who authorised it. I suppose she was doing the polite thing in the sense of saying, 'Well, this is an answer from you saying you cannot give us this information.' It may well be as a result of your relationships or what you think are your contractual relations with other parties, but from Senator West's point of view and the committee's point of view this is an answer from the department signed off by the minister saying, 'You are not going to get the information'. We are quite happy for you to decide amongst yourselves who is going to explain why that is, but Senator West is really trying to take up the issue of why you are refusing to release the information. It is probably a question for you to decide amongst yourselves, or for Mr Borthwick to provide direction on, as to who wears what hat and provides that information.

Senator WEST—Bearing in mind the ANAO report. I am quite happy for you to take it on notice. The committee want to know, if confidentiality is being claimed, why it is being claimed. I am sure it could not be being claimed for the whole document. Maybe it is appropriate for you to black out parts of the document—whatever.

Dr Harmer—At least part of your question related to a document that was the Health Insurance Commission's answer to questions on notice last time. The question as I understand it was in relation to the evaluation report for the IT outsourcing of the health cluster. Question 0 that you read from was 'Can we make the evaluation report available to the committee?'

Senator WEST—Yes.

Dr Harmer—The HIC's answer was that the evaluation report was jointly produced by OASITO, the department, Medibank Private and the HIC and contains information confidential to each of these organisations. The HIC is therefore unable to release the full report without the authority of these organisations because it contains in that report some information about each of the organisation's cost structures, et cetera.

Senator WEST—Is it possible to release the bits of the report that do not contain confidential information?

Dr Harmer—At the end of the day, Senator, I am assuming that OASITO who coordinated the production of the evaluation report would make a judgement whether some of that information was commercial-in-confidence or whatever. As far as the HIC is concerned, we would not have a problem with releasing the information there in relation to us, but we cannot give approval for the release of information in relation to other agencies.

Senator CHRIS EVANS—So on this occasion you are saying that the question really ought to be directed to OASITO?

Dr Harmer—Absolutely.

Mr Moran—The department would agree with that for exactly the same reasons that Dr Harmer has outlined.

Senator WEST—Maybe you would like to take on notice what you are going to do about the outages you suffered twice last week when Medicare's computer crashed. What are you going to do to IBM GSA?

Dr Harmer—Senator, are you referring to the two-hour outage last Tuesday?

Senator WEST—I am referring to an article that appears in today's *Australian* at page 27, 'Probe on Medicare Outage'.

Dr Harmer—Yes. It was a two-hour outage for the Medicare offices, I think from 12 noon until 2 o'clock last Monday. The issue was a failure of the power supply in our Tuggeranong office which runs the mainframe. It was not directly related to IT outsourcing but an issue for property management. We believe we have now rectified that. It was in a sense a shock to us. We went through our records; that has not happened for at least six years. It was a very unusual circumstance where the battery supply that backs up any short blip in our electricity supply failed. The batteries had been tested only a matter of a couple of weeks before and for some freak reason they failed. We have managed to install new batteries. We are very confident it will not happen again. It has not happened for six years. It is not an issue basically resulting from IT outsourcing. The article in the newspaper was not particularly well informed because the newspaper did not bother to check some of those issues.

Senator WEST—How much material did you lose?

Dr Harmer—We did not lose any material.

Senator WEST—You are very lucky, aren't you?

Dr Harmer—No, we have a very good system, Senator. We have very good backup.

Senator WEST—Thank you. That is all I have got.

[9.35 p.m.]

Senator HARRADINE—I refer to a grants publication which indicated grant No. 983210 to Professor G. Sutherland for understanding the human genome, molecular mechanisms of genetic disease:

> Arising from this basic genome technology, our project aims at identifying genes for specific diseases.

And the publication goes on:

> These include the genes involved in changes in sporadic non-familial breast cancer, genes for mental retardation; genes for a bone disease; genes for epilepsy.

Could the NHMRC inform the committee of the amount of allocation represented by this grant and whether any new allocations to Professor Sutherland have been made since that grant?

Prof. Pettigrew—I have some information that Professor Sutherland has a grant of the title and I think of the number that you read out, which was funded in the year 2000 for $1,020,685. The funding period ends in December 2002. I also understand that Professor Sutherland receives a small grant to fund access to the human genome project.

Senator HARRADINE—Is NHMRC aware of the report in the *Sun-Herald* of 25 February 2000—I think that may be 2001 but it is one or the other—which referred to a *7.30 Report* the week before then, in which Professor Sutherland said:

> If we can prevent the birth of handicapped individuals, then I think that society would be better off.

Has that sort of eugenic approach been drawn to the attention of the National Health and Medical Research Council? Has it come to your knowledge?

Prof. Pettigrew—Senator, that was not to my knowledge, no. As you know, I have only recently joined the organisation. I will ask Professor McLachlan if she is aware of it.

Prof. McLachlan—I am not aware of it either. This comment by Professor Sutherland is not related necessarily to his NRMRC funding but to his views of his own research work and what its implications are. I think he is referring to the possible introduction of gene therapy to prevent the birth of handicapped children.

Senator HARRADINE—Are you aware of the response by the advocates for the disabled. I quote what Ms Carolyn Frohmader, Executive Director, Women With Disabilities Australia, has said:

> It is alarming that Professor Sutherland can make such a discriminatory value laden statement that somehow he has the right to decide who can or who can't be born.

Now, that is how they saw it.

Prof. McLachlan—I am aware this is a contentious issue in the community and that views are divided on the issue. I do not think that Professor Sutherland is advocating anything other than the introduction of improved methods to prevent the birth of handicapped children.

Senator HARRADINE—This is quite a serious matter. Will you take that on notice and examine whether or not a grant has been made in respect of an activity to someone who has a eugenics approach. I asked the NHMRC to examine the *7.30 Report*. The article goes on to say:

Professor Sutherland further angered disability advocates when he said he believed a visiting UK academic with dwarfism would prefer not to be handicapped.

Prof. McLachlan—We will take the question on notice.

Senator HARRADINE—I want to refer to a matter that was raised previously and the answers that were given in respect of the information paper on the termination of pregnancy working party. I do not want to go over the answers that were given and the confusion that it caused, not least to me. I think Dr Morris took on notice a question that I asked about cross-referencing the membership of that working party to the membership of the original working party responsible for the since disgraced information paper on the services for termination of pregnancy. Has that cross-reference been done? If it has, could I have the result; if not, could you provide it?

Dr Morris—Senator, firstly I would like to apologise for you receiving inaccurate advice on a question on notice I understand that is now in the past.

Senator HARRADINE—Yes.

Dr Morris—I believe that we have supplied that information in the questions we took on notice at the Senate estimates in February. If I can just refer to it: 'Is Dr Edith Weisberg a member of the original committee and why is she on it?' I think that was the question. We answered it by saying:

Dr Weisberg was a corresponding member of the NHMRC working party who developed the information paper. As a corresponding member Dr Weisberg was asked to provide written comments on the draft report and did not attend meetings of the working party.

Senator HARRADINE—Yes, thank you. I have got that but I was wanting a cross-reference, if there are any others who were on the original one and are on this one.

Dr Morris—I believe that was the only person.

Senator HARRADINE—Finally, on a question that I asked about whether or not there was somebody on the working party who had a significant knowledge of a post-abortion trauma, could I ask that question again. I noted on the last occasion that somebody—somebody maybe dobbed you in—said on the last occasion, 'Well, Professor Pettigrew is here and no doubt he'll be listening to what is being said.' I took it from that that there would be an opportunity to ask this question again and see whether the NHMRC has considered this in the executive situation and ensured that there was somebody who had that expertise on the committee.

Prof. Pettigrew—Senator, what I can report to you is that, as a result of the council executive meeting on 27 April, the NHMRC is not undertaking any further work on this project.

Senator HARRADINE—I see. Could I go to the report on the work of the NHMRC and various state health officials. I want to ask a few questions on that. First of all, is it a fact that the National Health and Medical Research Council is required to observe the Australian Health Ethics Committee guidelines when these are issued?

Dr Morris—Yes, that is the case.

Senator HARRADINE—Were the National Health and Medical Research Council's guidelines on human cloning, which opposed the cloning of human embryos, upheld by the NHMRC representatives at the working party which prepared the report that I just referred to?

Dr Morris—At each meeting of the working party the NHMRC representatives made it clear what the NHMRC's position is on these issues.

Senator HARRADINE—But what role did the NHMRC play in the development of that report?

Dr Morris—The NHMRC was asked to facilitate meetings of state health representatives. This was a request of the Australian Health Ministers Council in July 2000.

Senator HARRADINE—The preferred position adopted in the report is that it is permissible to clone human embryos for research and experimentation purposes provided they are not transferred to the uterus of a woman. Surely that is not the view of the NH&MRC?

Dr Morris—The report has not yet been released by government so it would not be appropriate for me to talk about what is in the report. I can, if you like, talk about the process. If I can go back to the 1998 Australian Health Ethics Committee report to the minister. On consideration of this report the minister firstly wrote to all state and territory health ministers urging them to work towards nationally consistent legislation to regulate assisted reproductive technology and also to ban the cloning of human beings. The minister also referred the AHEC report to the Standing Committee on Legal and Constitutional Affairs, the Andrews committee. The recommendation of that report urged the minister to consult widely on the potential benefits and risks of human cloning technologies. The Commonwealth was taking the lead on the AHEC report and on the AHEC position that states and territories should legislate to regulate ART and, as a consequence of that, ban the cloning of human beings.

When this was considered in late 1999 through to July-August 2000 by health ministers through the AHMC process, it was decided that each jurisdiction would work independently on ART legislation rather than working towards nationally consistent legislation. However health ministers did decide that they would work towards consistent legislation to ban the cloning of human beings. It was this narrowly defined task which was assigned to the NH&MRC. That is a task which did not include ART legislation and did not look at the broader issues which had been assigned to the Andrews committee since the government has stated that it will be developing policy following tabling of this report.

Senator HARRADINE—Could I just sidetrack a little and go to the request that was made by the NH&MRC, or certainly by the minister, some three years ago to the states that the NH&MRC or some other organisation should facilitate the development of uniform legislation with regard to ART. Given the fact that anything goes in New South Wales and some other states as well, there are only three states, as I understand it, that have got legislation: South Australia, Victoria and Western Australia.

Dr Morris—Yes, that is correct.

Senator HARRADINE—Where is that up to now in that area?

Dr Morris—That was part of the process that I just described.

Senator HARRADINE—So it has been dropped. For example, aren't New South Wales being pressured on this in some way?

Dr Morris—The two large states that do not have ART legislation in place—New South Wales and Queensland—are currently working on the issue, but as I have stated—

Senator HARRADINE—With whom, do you know?

Dr Morris—I believe that both states have put out discussion papers and have working parties on the issue. It is a matter of state jurisdiction and states, through the health ministers, had decided to work independently on this issue.

Mr Borthwick—Maybe I can add a little bit of additional information. Apart from the health ministers progressing this work, last week the Prime Minister wrote to premiers and chief ministers suggesting that this item be put on the COAG agenda for the June meeting of COAG which is on 7 or 8 June. As I have said, he has written to premiers and chief ministers with a view to the Commonwealth pressing them to progress national regulatory framework covering assisted reproductive technology, including a ban on human cloning. So the Prime Minister is personally taking an interest in this and he is proposing to forward a paper to premiers, I think this week, to assist their discussions at the COAG meeting. In other words, he is not prepared to let it rest in terms of health ministers progressing it. He wants health ministers to progress it but he wants himself and the premiers and chief ministers to give the process a hurry along.

Senator HARRADINE—Dr Morris, the report to which we were referring before has been finalised and is with the minister?

Dr Morris—That is correct.

Senator HARRADINE—I am interested in what Mr Borthwick said.

Mr Borthwick—I have not got the Prime Minister's letter but it has gone to premiers and a paper will be following shortly. We will await the outcome of COAG's deliberations in early June.

Senator HARRADINE—Is it possible to have a copy of that letter?

Mr Borthwick—In terms of the letter, as I said it is the Prime Minister's letter to the premiers and chief ministers.

Senator HARRADINE—That finishes what I need to say.

Mr Borthwick—We will pursue it with the Prime Minister's department to see if a copy of that letter can be made available to you. My expectation would be that it could be since it has gone to all premiers.

Senator HARRADINE—I have just one more question for Professor Pettigrew. On stem cell research, that is to say research dealing with stem cells derived from the manipulation of an adult cell of a patient where there are no ethical landmines, is there anything in the current grants that covers that particular issue?

Prof. Pettigrew—I would have to take that question on notice but I would be very happy to look at our records to see if that is the case.

CHAIR—I thank the minister, all the officers from the Department of Health and Aged Care, Hansard and the secretariat. I declare the meeting closed.

Committee adjourned at 9.57 p.m.