COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Consideration of Budget Estimates

THURSDAY, 6 JUNE 2002

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SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Thursday, 6 June 2002

Members: Senator Knowles *(Chair)*, Senator Allison *(Deputy Chair)*, Senators Bishop, Denman, Herron and Tchen

Senators in attendance: Senators Allison, Buckland, Calvert, Crowley, Denman, Evans, Faulkner, Harradine, Herron, Knowles, McLucas, Tchen and West

Committee met at 9.04 a.m.

HEALTH AND AGEING PORTFOLIO

Consideration resumed from 5 June 2002.

In Attendance

Senator Patterson, Minister for Health and Ageing

Whole of Portfolio
Executive
Ms Jane Halton, Secretary
Dr Louise Morauta, Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Professor Richard Smallwood, Chief Medical Officer
Corporate Services Division
Mr Alan Law, Chief Operating Officer
Ms Wynne Hannon, Head, Legal Services
Ms Stephanie Gunn, Assistant Secretary, Corporate Activities Review
Ms Shirley Browne, Acting Assistant Secretary, Public Affairs and Parliamentary and Access Branch
Mr Peter Moran, Assistant Secretary ,Contestability
Ms Alison Larkins, Assistant Secretary, Staff Support and Development
Mr Tony Judge, Director, Corporate Development
Mr Chris Rosario, Director, Corporate Development
Portfolio Strategy Division
Dr Robert Wooding, Chief Information Officer
Ms Virginia Hart, Assistant Secretary, Budget Branch
Mr Paul Fitzgerald, Assistant Secretary, Health Information Policy and Projects Branch
Outcome 1: Population Health and Safety
Population Health Division
Ms Judy Blazow, Acting First Assistant Secretary, Population Health Division
Ms Marion Dunlop, Assistant Secretary, Strategic Planning
Ms Sue Gordon, Director Drug Strategy and Health Promotion Branch
Ms Sue Kerr, Assistant Secretary, Drug Strategy and Health Promotion
Professor John Mathews, Medical Director
Ms Sarah Major, Director, Preventive Health Services and Food Policy

Mr Greg Sam, Assistant Secretary Communicable Disease and Health Promotion
Ms Rae Scott, Director, Drug Strategy and Health Protection
Dr Judy Straton, Medical Advisor, Strategic Planning
Ms Carolyn M. Smith, Director, Preventive Health Services and Food Policy
Mr Steve Lowes, Financial Management Unit
Mr Rod Schreiber, Financial Management Unit
Ms Leanne Wells, Director, Drug Strategy and Health Promotion
Ms Jacqui Worsley, Research and Marketing Unit
Ms Laurie Van Veen, Director, Social Marketing Unit

Therapeutic Goods Administration

Mr Terry Slater, National Manager, Therapeutic Goods Administration
Dr Leonie Hunt, Assistant Secretary, Director Drug Safety Evaluation
Dr Brian Priestly, Director TGA Laboratories
Dr Fiona Cumming, Director, Office Complementary Medicines
Dr Sue Meek, Deputy Secretary, Gene Technology Regulator
Dr Margaret Hartley, Director, National Industrial Chemicals Notification and Assessment Scheme
Ms Elizabeth Flynn, Assistant Secretary, Office of Gene Technology Regulator
Dr John McEwen, Principal Medical Advisor
Ms Rita Maclachlan, Assistant Secretary, Conformity Assessment Branch

Health Insurance Commission

Dr Jeff Harmer, Managing Director, Health Insurance Commission
Mr John Lee, General Manager, Finance and Planning Division
Mr James Kelaher, Deputy Managing Director
Mr Lou Nulley, General Manager, Business Improvement
Mr Geoff Leeper, Executive General Manager, Business Improvement
Dr Janet Mould, General Manager, Professional Review
Mr David Num, Information Technology Services
Ms Ellen Dunne, Program Management Division
Ms Lyn O'Connell, Information Technology Services Division
Dr Brian Richards, Information Strategy and Business Development Division
Mr Lou Andreatta, Program Management Division
Mr Graham Mynott, Program Management Division
Mr Paul Fenton-Menzies, Legal Counsel
Ms Jeni Warbuton, Corporate Security
Mr Doug Marshall, Senior Pathology Officer

Australia New Zealand Food Authority

Dr Marion Healy, Office of the Chief Scientist
Ms Clare Pontin, Strategy and Operations
Mr Peter Liehne, Standards
Mr Greg Roche, Safety, Legal and Evaluation

Outcome 2: Access to Medicare
Health Access and Financing Division
Mr Charles Maskell-Knight, First Assistant Secretary, Health Access and Financing Division
Ms Jennifer Badham, Assistant Secretary, Better Medication Management System Implementation Taskforce
Dr John Primrose, Medical Officer, Pharmaceutical Access and Quality
Mr Terry Barnes, Assistant Secretary, Financing and Analysis Branch
Mr Allan Rennie, Assistant Secretary, Pharmaceutical Access and Quality
Mr Brett Lennon, Assistant Secretary, Pharmaceutical Benefits
Dr Jane Cook, Medical Advisor, Medicare Benefits Branch
Ms Jennifer Campain, Director, Diagnostics and Technology
Dr Bernie Towler, Diagnostics and Technology
Dr David Barton, Medical Officer, Diagnostics and Technology
Mr Ian McRae, Assistant Secretary, Medicare Benefits Branch
Mr David Reddy, Director, Medicare Benefits
Ms Sarah Byrne, Assistant Secretary, Medical Indemnity Tasforce
Health Insurance Commission
See Outcome 1
Outcome 3: Enhanced Quality of Life for Older Australians
Aged and Community Care Division
Dr David Graham, First Assistant Secretary, Aged and Community Care Division
Dr David Cullen, Assistant Secretary, Policy and Evaluation
Ms Jane Bailey, Director, Quality Outcomes
Mr Warwick Bruen, Assistant Secretary, Community Care Branch
Mr Marcus James, Assistant Secretary, Residential program management
Mr Mark Thomann, Assistant Secretary, Office for Older Australians
Mr Stephen Taylor, Assistant Secretary, Legal Section
Aged Care Standards and Accreditation Agency
Mr Gerald Overton, Acting General Manager
Ms Kristina Vesk, Communications Manager, Aged Care Standards and Accreditation Agency
Outcome 4: Quality Health Care
Health Services Division
Mr Andrew Stuart, First Assistant Secretary, Health Services Division
Mr Dermot Casey, Assistant Secretary, Mental Health and Special Programs Branch
Mr Peter Broadhead, Assistant Secretary, Acute and Coordinated Care Branch
Dr Rob Pegram, Senior Medical Officer, General Practices Strategic Development Unit
Mr Peter DeGraaff, Assistant Secretary, Blood and Organ Donation Taskforce
Ms Leonie Smith, Assistant Secretary, General Practice Branch
Mr Richard Eccles, Assistant Secretary , Office of Rural Health
Outcome 5: Rural Health Care
Health Services Division
See Outcome 4

Outcome 6: Hearing Services
Aged and Community Care (Office of Hearing Services)
Ms Jenny Hefford, National Manager, Office of Hearing Services
Outcome 7: Aboriginal and Torres Strait Islander Health
Aboriginal and Torres Strait Island Division
Ms Helen Evans, First Assistant Secretary, Aboriginal and Torres Strait Islander Health
Ms Yael Cass, Assistant Secretary, Workforce, Information and Policy
Ms Mary McDonald, Assistant Secretary, Program Planning and Development
Ms Margaret Norington, Assistant Secretary, Health and Community Strategies
Dr Trish Fagan, Medical Adviser, Aboriginal and 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, Assistant Secretary, Private Health Industry Branch
Dr Vin McLoughlin, Assistant Secretary, Priorities and Quality Branch
Ms Christianna Cobbold, Assistant Secretary, Health Capacity Development Branch
Medibank Private
Mr Steve Boomert, Corporate Development
Mr Peter Young, Manager, Corporate Affairs
Health Insurance Commission
See Outcome 1
Private Health Insurance Ombudsman
Mr Norman Branson, Private Health Insurance Ombudsman
Private Health Insurance Administration Council
Ms Gayle Ginnane, Commissioner
Outcome 9: Health Investment
Portfolio Strategies Division
See Whole of Portfolio
Health Industry and Investment Division
See Outcome 8
Office of the National Health and Medical Research Council
Professor Alan Pettigrew, Chief Executive Office, NHMRC
Ms Suzanne Northcott, Assistant Secretary, Centre for Research Management
Dr Clive Morris, Assistant Secretary, Centre for Health Advice Policy and Ethics
Mr Michel Lok, Assistant Secretary, Executive Support Branch
Ms Cathy Clutton, Assistant Secretary, Centre

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 Ageing portfolio. I welcome back the officers of the department. The committee has completed outcomes 1 and 5-9. We will now commence outcome 2, followed by outcomes 3 and 4, and then we will have questions on corporate matters, which are spread across all outcomes. I understand that there might be some answers to questions that Senator West raised yesterday. Ms Halton, would you like to go through those?

Ms Halton—With the senators' indulgence, I have with me, first thing this morning, the officers who can answer the questions in relation to practice nurses. If it is convenient, we can perhaps deal with those questions now, and then those officers can go away and come back later for one of the other programs.

CHAIR—That is fine. Thank you, Ms Halton.

Senator WEST—What is the state of play with the practice nurse issue?

Mr McRae—The practice nurse incentive program was put in place, I suppose, late last year, with the first payments being made in February this year. At this stage, there are 793 general practices participating, mostly in the rural areas because that is the way that the program was designed.

Senator WEST—So 793 practices have received the grants?

Mr McRae—That is correct, Senator.

Senator WEST—Is there a training component?

Mr McRae—I guess there are two answers to that. In order to be eligible for the grants, nurses have to be either enrolled nurses or registered nurses, and they have to be fulfilling particular functions within the practice. There is also some direct training being provided. Perhaps I could ask Ms Smith to discuss that.

Ms L. Smith—As Mr McRae has said, there are baseline qualifications for general practices when they—

Senator WEST—Yes, but those baseline qualifications are standard; there is nothing special about them.

Ms L. Smith—Yes, that is right. I was just using that as a bit of context.

Senator WEST—You are either an EN or an RN. I hope it is not going to AINs, because I think that would be an absolute—

Ms L. Smith—That is right. There is a scholarship program in place, which is directed at upskilling nurses who have not been registered for some time. That is the training component. We are working with a number of the peak—

Senator WEST—So the training component is only to upskill those who have been out of the game for a while; it is like a refresher course?

Ms L. Smith—There is that part of it, but there are also more training components being developed in consultation with the peak nursing bodies and general practice to ensure that the practices that are participating are providing relevant training for the nurses in that practice.

Senator WEST—Who will be providing that training?

Ms L. Smith—I think it is a combined initiative between the Royal College of Nursing and the Royal Australian College of General Practitioners. Joint working groups are coming up with the training to be provided.

Senator WEST—You said the nurses are fulfulling particular functions. What sort of functions?

Mr McRae—There is a list. Perhaps an easier way to do this, rather than reading out a page of things, would be to ask to pass it to you.

Senator WEST—That would be most helpful.

Mr McRae—Fundamentally, there is a page.

Senator WEST—Would you like to table it?

Mr McRae—Yes, I am happy to table it.

Senator WEST—That is probably the quickest and easiest way. I want an idea of the functions that they are fulfilling. I also want to know what standards are expected. Does this vary from practice to practice? Is it up to the individual practices as to what happens?

Ms L. Smith—No, there are some standards that apply across all practices. What will probably assist you a lot is a package of information here that has been developed by the Royal College of Nursing in conjunction with all of the other organisations that we have involved in this initiative. This really outlines in detail the information that you are after. It talks about qualifications, registration issues, codes of ethics for the practices and models of employment for nursing. So it has a whole lot of the detailed information about the kinds of things that practices are expected to adhere to when employing practice nurses. I have got lots of these here, if you would like them.

Senator WEST—That is wonderful. The thing I was chiefly checking on was whether the colleges are involved. Otherwise you would have seen me on the ceiling doing one of my fandangos. With all due respect to doctors, it is nurses colleges which can set nursing standards and nursing protocols, and they should be the ones that have the supervision and the ultimate control of training and what is taught to the nurses.

Ms L. Smith—Sure. If you like, I can go through the organisations that are involved on the steering committee which is driving the initiative.

Senator WEST—If it is all in here, that is fine.

Ms L. Smith—I am sure it is all in there.

Senator WEST—I also want to know who was providing the education, because I have a bit of a problem if doctors are going to train nurses. It has a certain feeling of the handmaiden role.

Ms L. Smith—It is all very collegiate.

Senator WEST—Good. It needs to be. Are these practice nurses going to be building up a particular set of skills that are beyond that of the ordinary RN, that they are actually a specialty area?

Ms L. Smith—Again, the kinds of skills that they develop will probably depend on the practice that they are in, so it is difficult to say.

Senator WEST—I could throw in the question of what is going to be the difference between a practice nurse and a nurse practitioner.

Ms L. Smith—I do not think I can answer that question.

Senator WEST—If within that general practice you have the doctors encouraging and seeking that their RNs, particularly RNs, are working to a higher level—are working in areas of specialty and developing specialties and expertise to maybe triage, to maybe undertake health education, to maybe run their antenatal screening clinics, that sort of thing—what is the difference between them and nurse practitioners who might be working to that higher level in, say, a diabetes clinic in a major teaching hospital?

Ms L. Smith—The fundamental difference is that practice nurses work within a practice. My understanding is practitioners are more solo.

Senator WEST—No.

Ms L. Smith—Or can be.

Senator WEST—Can be, but there are certainly specialty areas and there are intensive care areas and some of the other, say, renal areas where I know there are professors of a particular medical faculty looking to actually move their senior, most highly competent RNs up to nurse practitioners. I am wondering what the difference is going to be.

Dr Morauta—Perhaps I could come in here. I think that with this initiative we are setting the scene for the development of enhanced primary care roles for nurses in general practice. I think what we are doing at the moment is establishing that base out there with much increased roles for general practice. But with the bodies involved, as Leonie Smith has described, I think it would be absolutely appropriate that skills are gradually defined and areas of primary care specialisation developed. Some of the areas where these nurses will be working are in health assessments for older people, in immunisation and in a number of population health areas. I think that over time we will see emerging additional skills and training, but I think at the moment this initiative is establishing the base. As you know, that base was not particularly strong before, and by getting nurses out there in general practice I think we are setting the scene for the kind of future which you are perhaps hinting at in this area.

Senator WEST—I shall wait to see how it evolves. Thank you for the material. I will leave it at that.

Senator CROWLEY—I shall follow that with a couple of questions. It is interesting to hear you say that nurses in practice might do immunisations. Some of the practices that I have had an association with have been doing immunisations for the last 50 years. I appreciate your point that some nurses in general practice have had a fetch-and-carry role rather than use their brains and initiative. If that is what we are talking about, that is fine. I would be interested to know whether you have in mind an outreach role such as home visits of the nurse practitioner from the practice.

Senator WEST—Now you are getting into the role of the community nurse. I might want to put my DCHN cap on.

Senator CROWLEY—Notwithstanding the senator's contribution, do you envisage that practice nurses might indeed have a visiting role in the community?

Dr Morauta—I think they already have some role in that area, in health assessments. A number of the health assessments of older people are done in the home by practice nurses, and they bring back the findings for discussion with the doctor. They are already in that area in some respects.

Senator CROWLEY—Will the practice be assisted with any grants to pay for the increased costs of such a qualified person?

Mr McRae—In the first instance, in relation to a program which is run as part of the practice incentives program, we commenced making grants in February for practices that employ practice nurses. To date we have spent $9.8 million on those grants.

Senator CROWLEY—Presumably that money is largely to go to increase the nurses' salaries.

Mr McRae—The money is to be used by the practice as necessary to assist them to employ the nurses. In some cases they will have no nurse at all to begin with and it will assist them to employ a nurse at whatever salary is appropriate.

Senator CROWLEY—How many practices have no nurse at all?

Mr McRae—No, we cannot do that, I am sorry. We can tell you how many practices we support, but of the remaining 4,000-odd practices we do not know what they do. There is some evidence from a few years back but it is a bit dated now.

CHAIR—I thank the officers for coming in this morning.

[9.18 a.m.]

CHAIR—We will now consider outcome 2.

Senator McLUCAS—I want to ask some questions about the department's role in the development of the Intergenerational Report.

Ms Halton—Depending on what the nature of the questions is, this probably is not technically program 2. We may or may not be able to answer now. Are they related to program 2?

Senator McLUCAS—They are general questions that I imagine will fit here, but it is about—

Ms Halton—Why don't we sally forth and see how we go?

Senator McLUCAS—Yes. What involvement did the department have in the development of the Intergenerational Report?

Dr Morauta—We were consulted about it and we made comments on various drafts. I do not think that we were in any way accountable for the final product. I think that lay with the Treasury portfolio.

Senator McLUCAS—Yes, but were you consulted?

Dr Morauta—Yes, and we provided comments on drafts.

Senator McLUCAS—What is the assessment of the department in terms of the validity or the intent of the recommendations of the Intergenerational Report?

Ms Halton—I think the Intergenerational Report is a very significant contribution in relation to raising community awareness of issues around ageing. It has raised a number of issues in respect of, firstly, the future structure of the population challenges that we might face as a nation in terms of meeting, for example, the health care costs—which is an issue obviously of relevance to our portfolio—of an ageing population. There are clearly a range of issues that will face us as a nation in relation to the employment of older workers. We could go through a range of those issues.

Senator McLUCAS—That is not the question I asked, I am sorry. How does the department view the recommendations of the Intergenerational Report and their validity?

Ms Halton—In total or particular recommendations?

Senator McLUCAS—Particularly to do with health issues.

Ms Halton—I think our view in relation to the Intergenerational Report is that the challenges of ageing in relation to health are identified in that report. They are challenges that we have been aware of and are aware of and will continue to face on a day-to-day basis.

Senator McLUCAS—Does the department agree with the intent of the report in the issues that have been identified and with the recommendations that the report makes about those issues? Are there points of difference?

Ms Halton—There is no fundamental point of difference between ourselves and the Treasury in this respect. There are always issues at the margin in relation to, if I can describe it this way 'statisticians at dawn'. Every statistician perhaps has a different approach in terms of anticipated rates of growth and things of that ilk. In terms of the broad issues identified in that report, we have absolutely no difference.

Senator McLUCAS—But there are differences at the edges, you said?

Ms Halton—It has never been our role to debate or contest the precise statistical detail in that report. The point I am merely making to you is that we agree that the issues that are identified in the report are the issues that we confront as a nation. We agree that there are issues in respect of meeting the health care costs of older Australians. That is an issue we confront daily. We agree that we need to consciously examine and plan for those issues.

Senator McLUCAS—I think the report goes a little further in trying to identify how that might occur. It is that nexus that I am trying to get to. Does the department agree with the recommendations about how we deal with an ageing population?

Ms Halton—I suppose we have a certain policy construct that we are operating within at the moment, which is government policy. Beyond that, I suspect probably you are asking me to comment about policy. The government made a number of decisions in the recent budget, some of which were designed to address the kinds of pressures that you are talking about. As I have said, in broad the issues that are identified in the report we have no dispute with.

Senator McLUCAS—Did the minister sign off on the report? Was there a process for the minister to sign off on the report before it was published?

Ms Halton—I think you are probably asking us to comment about a cabinet process now.

Senator McLUCAS—I understand that the report essentially focuses on Commonwealth health expenditure rather than total health expenditure. In terms of a report that is meant to guide us for the next 40 years, is that a good methodology to use?

Ms Halton—I think that is probably a question you would sensibly ask the Treasury. In terms of, again, the issues that are identified that we as a nation need to focus on I think those issues are generic and the issues confront not only us but state governments. We know through the dialogue we have on a regular basis through ARMAC and in other forums that states are conscious of those issues as well. In terms of what is happening in health and health expenditure, those issues face not only us but our state colleagues. I do not know that it would necessarily have augmented the report particularly to have tried to broaden its scope. I think there is a question about the charter of the Commonwealth government in that respect as to whether that would have been appropriate.

Senator McLUCAS—But it is a document, I understand, that is meant to direct the nation. If we are focusing simply on expenditure from the Commonwealth it is very thinly focused in terms of total expenditure on health.

Ms Halton—My understanding of the document—and perhaps my understanding is flawed—is that it had several functions, one of which was to raise awareness of the issues of ageing. Having had over 20 years working on ageing as a personal interest and the major professional interest in my career, getting the issue of ageing on the broader public agenda is

something which some of us have tried to do for some years, perhaps not as successfully as we might have liked. If nothing else, you have to accept that the publication of that report has caused a much greater community debate and level of interest such that I do not think I have ever been asked these kinds of questions in Senate estimates before. To the extent that one of its objectives was to raise the profile of the issue, I think it might have succeeded.

Senator McLUCAS—I understand that in 1996 an audit of the health department was conducted by the government when they came into power.

Ms Halton—The Commission of Audit?

Senator McLUCAS—Yes.

Ms Halton—If my memory serves me correctly, the Commission of Audit document was produced by the Department of Finance, as it was then. The Commission of Audit covered a range of issues in relation to the operation of government; it was not just focused on the department of health.

Senator McLUCAS—Thank you. I understand that one of those recommendations was that the government should urgently implement measures to reduce the potential for longer term age related funding increases. It has taken a little while, if the recommendation in 1996 was to urgently implement measures to reduce the potential for longer term age related funding increases, wouldn't you think?

Ms Halton—I have to confess that the full detail of the 1996 report escapes me.

Senator McLUCAS—Sure; I understand it was some time ago.

Ms Halton—To the extent that there would have been recommendations about broader issues of expenditure control, that is certainly consistent with what I understand was the focus of the Commission of Audit. There is no doubt that in the health portfolio in the last six years there have been multiple measures, not to mention a broad approach, which looked at levels of expenditure across the portfolio. I can think of an initiative that was announced some years ago—forgive me if I cannot be precise about when, but it would be over four years ago—and the whole need for a national strategy on ageing has been a focus of part of the portfolio. To the extent that there was an acknowledgment in 1996 that these issues were confronting us, there has been active work inside the portfolio since that time.

Senator McLUCAS—With regard to the national strategy on ageing—

Ms Halton—The officers who are responsible for that initiative will be here for the next program.

Senator McLUCAS—Yes, I am aware of that. I think it was clear that the report identified a range of contributors to health costs in the future. Can you tell me what Treasury requested of the department in terms of reports that you have done over the last few years in order to inform the development of the Intergenerational Report?

Ms Halton—The officers who can answer that in detail are not here at present. I can tell you that the group in the Treasury who have responsibility for this report are officers who we have a very regular dialogue with, so there is quite close sharing of information on issues around, for example, growth and expenditure in particular areas and the statistical work around what contributes to that growth. You have already alluded to the fact that there are different drivers of growth in health, one of which is ageing but there are other things—for example, technology utilisation et cetera. Certainly, we would have been in regular dialogue

with the Treasury about any material in our portfolio that is germane to those issues. I can get the officers concerned, when they are here, to give you more detail if you wish.

Senator CHRIS EVANS—Which officers are those? What section are they from?

Ms Halton—That is the portfolio strategy division. It would be a whole of portfolio issue, which I think is scheduled for the end of today.

Senator CHRIS EVANS—Like Senator McLucas, I am interested in asking some questions on that issue as well. It might be better for us to do that while they are here; it might make for a more useful discussion than to do it now and then have them come in and do it again.

Ms Halton—Certainly.

Senator CHRIS EVANS—What program would we do that under?

Ms Halton—The whole of portfolio issues, which I think is scheduled as the last item for today.

Senator CHRIS EVANS—The bits and bobs at the end.

Senator McLUCAS—We might leave that whole discussion.

Senator CHRIS EVANS—Central to it is those assumptions about growth and costs.

Senator McLUCAS—Yes, that is fine.

CHAIR—Then we will move to the Pharmaceutical Benefits Scheme.

Senator McLUCAS—I understand that every federal electorate office received recently a copy of the brochure I have here outlining the proposed changes to the PBS and the copayment safety nets. How broadly was the brochure sent out?

Mr Lennon—That brochure was sent out quite widely. I believe it was sent out to all pharmacies, amongst other distribution channels. It was certainly put up on the PBS web site. The aim was to try to make sure that people received objective and accurate information about the extent of the changes which were proposed as a result of the budget measures.

Senator McLUCAS—Given that the changes that were proposed require legislative action, do you think it was a little premature to promote a change that had not yet been put into effect?

Senator Patterson—One of the problems was, and always will be, that the information that people were receiving in the press was not always correct and there was a lot of scaremongering going on. I think people need to be informed about what the government is proposing.

Senator McLUCAS—So it is actually promoting a policy, not promoting changes that may or may not occur?

Senator Patterson—It was informing people about what was in the budget—

Senator McLUCAS—Which may not occur?

Senator Patterson—But it was informing people about what was in the budget.

Senator McLUCAS—How much did the document cost to print and distribute?

Dr Morauta—We will take that one on notice, I am sorry. We will get the information during the day for you.

Senator McLUCAS—Can you give me an indication of what we are talking about—$100,000 or $1,000?

Dr Morauta—We do not have it in front of us, but we will get that almost immediately for you.

Senator McLUCAS—How many brochures were produced?

Dr Morauta—I am sorry, again we do not have the answer. We will get it for you straightaway.

Senator McLUCAS—Where did the funds come from?

Mr Rennie—The funds came out of the budget allocation from the previous budget measure about consumer education around the PBS—a budget measure for 2001-02—and there were funds put aside for informing consumers about their medicines' use and about the PBS.

Senator CROWLEY—Does that mean that money was not all spent in the past 12 months, or was it a forward estimate amount?

Mr Rennie—It was built into the funds that were going to come out of that allocation.

Senator CROWLEY—I am sure it was, Mr Rennie. Was it supposed to be spent in the 12 months after it was in the budget or was it a forward estimate of that budget line?

Mr Rennie—The funds were available in 2001-02.

Senator CROWLEY—Yes. What were they for? Had you already anticipated this need?

CHAIR—I think Mr Rennie has already answered that question. He said that the funds were there for any expenditure on advising people of the PBS, not specifically for any budget announcement. Am I correct, Mr Rennie?

Mr Rennie—That is true.

CHAIR—What you said was there is an allocation there for advising people about their medicines.

Mr Rennie—That is right.

Senator McLUCAS—About their medicine or about—

CHAIR—About the medicines and the PBS.

Senator McLUCAS—government policy?

CHAIR—No. Heavens above! If there is a policy change in the government then it is not the first time that any government has advised the people about a policy change. That is not unusual. It happened in child care, particularly when Senator Crowley was minister for child care. Huge amounts were spent.

Senator Patterson—I seem to remember a lot of ads with trees about superannuation. Senator McLucas, one of the reasons that it was to go to pharmacists was that it was a change that people were likely to ask pharmacists about. Pharmacists are very busy people, and it is important that they have accurate information about proposed changes in the budget.

Senator McLUCAS—When were they sent out? On what day?

Mr Lennon—They were sent out shortly after the budget.

Senator McLUCAS—How shortly after?

Senator Patterson—As soon as possible.

Mr Lennon—I do not have that precise information but we could get that for you.

Senator McLUCAS—Could we get that, please?

Senator CROWLEY—Does that mean, Minister, they were printed in anticipation of the budget?

Senator Patterson—They were sent out as soon as possible to ensure that people had accurate information and that pharmacists were not left without the information and having to rely on newspaper reports.

CHAIR—Just while we are talking about newspaper reports, let me raise with you something that I saw which I think is just scandalous. It was an article by Sue Dunlevy in the *Daily Telegraph* on Thursday 16 May. It was regarding the cost of the contraceptive pill. Is it true? Ms Dunlevy reported that on 1 August this year when the announced increases in PBS patient copayments are due to take effect that:

Almost one in three women aged 15-45 will have to pay the full cost of their contraceptive pills from August ...

Mr Lennon—In answer to that question, general patients already pay the full cost of their contraceptive pills because the cost of contraceptive pills falls below the level of the general patient copayment of $22.40.

CHAIR—That is right.

Mr Lennon—That means that, contrary to what was asserted in the article, there is no increase in charges at all as a result of the introduction of the revised copayments for all of those general patients who take contraceptive pills. For concessional patients, who are the only ones who receive a subsidy under the Pharmaceutical Benefits Scheme for contraceptive pills at the moment, their charge will increase from $3.60 under the budget proposals to $4.60. That is $1 per script up to 52 prescriptions. In regard to contraceptive pills, one prescription lasts four months, which means you get three prescriptions a year. That means that the most that concessional patients will need to pay additionally per year for their contraceptive pill prescriptions will be $3.

CHAIR—I should not be asking you why, but I find it incredible that Ms Dunlevy would report that the contraceptive pill will cease to attract a PBS subsidy for women paying the non-concessional PBS copayment. Minister, have you raised any of these issues with some of these journalists who quite deliberately want to put into the people out there the fear that they are not going to be able to afford their medicines?

Senator Patterson—I met with some of the journalists and talked to them. I think Mr Lennon has explained the example about the contraceptive pill. For people who are non-concessional there is absolutely no change. They pay for the generic medication at its full price now, and they pay for the non-generic at its full price now—nothing different.

CHAIR—How many other—

Senator Patterson—Let me finish. For concessional, if they want the non-generic they pay the full price, as they do now. If it increases to $4.50, as Mr Lennon said, the maximum they can pay is $3.00 additional a year. But they may have reached a safety net when they get their second or third script, so it may only be a dollar. The maximum is $3.00. I do find it

disappointing when people do not get the information clearly. That is why it is necessary to ensure that people are given information directly rather than via the press.

CHAIR—I raised this issue in conjunction with the pamphlet that Senator McLucas referred to because presumably there are many other drugs that are below the PBS already. Is that right?

Mr Lennon—Yes, that is right. Each year, a large number of prescriptions are written for Pharmaceutical Benefits Scheme drugs that are below the general patient copayment level. About 30 million prescriptions are currently written a year for PBS drugs that are below the general patient copayment level. They would include, for example, a range of antibiotics, such as Augmentin; a range of contraceptives that we have already talked about; a range of analgesics, such as Panadeine Forte and Panamax; a range of antihypertensives for the treatment of high blood pressure, such as Tenormin and Capoten; drugs for hormone replacement therapy such as Estraderm; and drugs for the treatment of sleep disorders, such as Normison. In relation to all of those drugs that are already below the general patient copayment—currently $22.40—there will be no increase in charges as a result of the increase in copayments levied by the government. There is nothing in the government increase in charge that will flow through to patients.

CHAIR—For 30 million drugs?

Mr Lennon—For 30 million prescriptions.

CHAIR—On Page 2 of the *Age*, on Saturday, 18 May this year, different families are represented and the headline is claiming to show how they fare in the budget. One example is that of a single income family. They are quoted as saying:

We were paying $17 to $18 a script before, now it's going to be in the $25 to $27 mark.

Mr Lennon—If they were paying $17 to $18 per script before, they are general patients below the threshold above which we subsidise for $22.40. That means they come under this group of 30 million prescriptions that will face no increase in charges from the government as a result of the increase in copayments. There is no reason why there should be any increase as a result of the government charge. So I do not agree with or understand that comment.

CHAIR—Minister, contrary to restricting the distribution of the pamphlet to which Senator McLucas refers, I would hope that we could have more people out in the community aware of the reality of this proposal instead of the complete and utter lies that have been told about the proposal by sections of the media. Is there any plan so that the community can be informed about the reality of this initiative?

Senator Patterson—One of the things of concern to me as health minister is that people are not really aware of the rate of subsidisation of medication. Before I came into the portfolio, I was not aware that the most commonly prescribed medication on the PBS costs on average $80 per script per month. Some people have a script for $54, some for $120, but on average it is $80. Some people are not aware that some of their medication costs over $1,000. Others have medication which costs over $2,000, and one has recently been put onto the PBS which costs approximately $50,000 per year per patient. There is another one knocking at the door which looks like costing $20,000 per patient. I have just had an audit done looking at what other medications are likely to come before the PBAC in the next 12 months to two years, and it is a fairly daunting list. The most important thing for me is to ensure that we can consider those medications.

I think the message that I have a responsibility to ensure all Australian's understand is the level to which their medications are subsidised. We as a community have a responsibility to use medicines wisely and not to demand medications from doctors when maybe they are not necessary and when doctors prescribe medicines we should talk to them to ensure that we actually take them correctly. So there is a need for the community to be aware that, when they get a script for some medications, they are receiving a benefit from the government of $70, $80 or even $1,000, and that it is important for us to use that resource very carefully and very wisely if we are going to maintain our ability to provide a new generation of medications.

CHAIR—Minister, would you consider putting the true value of a drug on a pack when it is dispensed? You have quoted some of the exceedingly high-cost drugs. I have a list here in front of me. For example, the true cost of Zyban—used for nicotine addiction—is $249.51. Am I correct in saying that someone will now be required to pay $28 for that prescription? Is it possible therefore to put the actual value of that product on the pack when they get it?

Senator Patterson—Some of them will pay $28.60. If the measure goes through, some of them will pay $4.60 for that.

CHAIR—That is right.

Senator Patterson—And I am sure people were not aware of that. Also, there are stipulations when the PBAC puts a medication onto the PBS that it has a guideline about how it should be prescribed. For example, with Zyban, the company presented evidence that said it was 30 per cent efficacious if it was prescribed in conjunction with a Quit-type program. In the first 10 days, I think it was, $10 million worth of Zyban was prescribed. I defy anyone to believe that every single one of those scripts had gone to a person who was actually in a Quit program in February. So we have to ensure not only that the guidelines are adhered to but also that people are aware of the cost. There is consideration being given to actually making sure people are aware of how much that subsidy is so that they can see the importance that needs to be placed on the fact that they use that medicine wisely.

CHAIR—How would you do that, though? Would you consider putting the price on the pack?

Senator Patterson—There are some difficulties in putting the price on the pack. One of the possibilities is to put the price on the script and then work towards if and how the price could go on the packet.

CHAIR—What else would you consider an appropriate measure to advise people of the true cost of these drugs for which they may be paying $4.60 or $28.60?

Senator Patterson—One of the ways is with our colleagues on both sides of the House. It should not be a cross-party issue; it should be a bipartisan issue. We need to educate people about the subsidy of the medication and the importance of using them wisely so that they have a sustainable PBS system into the future.

CHAIR—I have not seen any indication of that bipartisanship— maybe we will today—to go out there and say to people that, if they want new and expensive medicines put on the PBS, somehow or another they have to be paid for and the willy-nilly prescribing of a lot of these expensive drugs has to be curbed. Given that the likelihood of bipartisanship in the political arena is at best remote—because if there was going to be evidence of it I think we would have had it—

Senator CHRIS EVANS—If the Liberal Party wants to make an announcement about PBS policy, I am happy for them to make it, but this is estimates. I feel obliged to take up the challenge. I do not think anybody in Australian politics argues that a proper understanding of the cost of drugs and broadening that understanding is a bad thing. Successive governments have promoted that. We can have that debate if you like, but it seems to me that it is a bit of a misuse of estimates. I am pleased that the minister is trying to broaden understanding. If that is helpful to you, I support that effort. People ought to understand the costs involved, but I cannot let it go unchallenged if you keep on with this line of argument or whatever. I think we ought to get back to what we are here for.

CHAIR—I take exception—

Senator TCHEN—It is hardly a debate, Senator Evans. The chair is only putting her position and reinforcing the need for a bipartisan approach.

Senator CHRIS EVANS—The chair is very quick to point out that we should not make speeches and I have always supported her in those rulings.

CHAIR—I actually let people make very long comments. I think anyone in this room would bear testimony to the fact that I let people make very long comments, whereas I could do what the former chair of this committee did under the previous government and say, 'Do you have a question? Do you have a question?' I do not do that and I take very great exception to the suggestion that I am misusing my position as chair. I have a right to ask these questions—

Senator CHRIS EVANS—Sure—just ask a question then.

CHAIR—and I have a right to make sure that people out there understand what is happening here, particularly when it is being so severely misrepresented. So, Minister, I hope that there will be an initiative. I do not know whether any more funding is to be allocated in this budget for a campaign to ensure that people do understand it, in addition to what has been allocated for this particular pamphlet.

Senator McLUCAS—I think you were talking about a bipartisan approach. Certainly from this side, we would welcome adoption of the policy that we took to the last election, which was to put the cost of drugs on the medication. I do not know that we are having an argument about informing the public. That was Labor's policy at the last election. We would welcome greater understanding of the cost of medication.

CHAIR—I raised this in the context of criticism of a pamphlet being produced for information purposes. If there is no such criticism of such a pamphlet for information purposes, I am quite happy to proceed. But, if there is criticism, I will certainly ask the department and the minister to justify such criticism of such a measure, such an initiative.

Senator McLUCAS—Do we have the cost of the publication and distribution of the document yet?

Mr Maskell-Knight—We are getting that faxed to us now.

Senator McLUCAS—Thank you. If those measures do not get passed through the Senate, one would assume, given that we have sent this document out, we would have to do another mail-out.

Mr Maskell-Knight—I think that is a hypothetical question, Senator.

CHAIR—Or are you advising the committee that there will be no bipartisanship for the vote and the measure?

Senator McLUCAS—You could say that this is a hypothetical brochure.

Senator WEST—Let us see the colour of your legislation.

Senator McLUCAS—Will there be a recall of this brochure if the measure is not passed?

Mr Maskell-Knight—I do not think we are in a position to speculate.

CHAIR—The department cannot answer a hypothetical question. If you tell the committee that you will be opposing it in the Senate, then we might have a better indication.

Senator WEST—Madam Chair, we have not seen the colour of the legislation; we haven't even passed the appropriations. We are 28 votes out of 76. Don't blame us.

Senator TCHEN—Senator West, you are the alternative government. If you do not take the responsibility—

Senator WEST—I am talking about reality, Senator. I would much prefer to be talking about the National Prescribing Service and a few other things like that. Let us get back to it.

Senator TCHEN—I was only responding to your comment that you have no power.

Senator WEST—We do not have the numbers, even you got here by knowing how to do the numbers.

Senator TCHEN—And no responsibility either.

CHAIR—Order!

Senator WEST—Let us see the colour of your legislation first.

Senator HARRADINE—Just to follow up, the chair referred to a journalist's comment about the contraceptive pill. Mr Lennon, I do not know whether you were here or whether you heard the discussion with the TGA yesterday, but I am hoping to hear from someone in the Department of Health and Ageing who might have passed year 10 biology to agree or not agree with the proposition that conception commences with the fusion of an ovum and a sperm.

Senator Patterson—Senator, with all due respect—and I do respect you, Senator Harradine—I do not think this is an appropriate question for an officer about the PBS.

Senator HARRADINE—Why? We are talking about public moneys being spent on a contraceptive pill—

Senator Patterson—I know we are.

Senator HARRADINE—and what is coming down the track if Postinor-2 is approved by you—and you have the decision to make—for importation. So in my view it is perfectly relevant.

Senator Patterson—I am advised it is not listed on the PBS. I do not think an application has been made to the PBAC.

Mr Lennon—No, it is not listed on the PBS.

Senator HARRADINE—I am not sure it has even been approved for importation as yet. I am not asking about that; I am asking about the issue was raised by the chair about the contraceptive pill and the concern that has been expressed.

Ms Halton—This officer is in a position to advise you about the costs and subsidy of drugs that are listed on the Pharmaceutical Benefits Scheme and their utilisation and about the questions that senators were just asking in relation to publicity. This officer is not in a position to answer questions that are not relevant to this program.

Senator HARRADINE—Madam Chair, I am asking the officer—and I will again ask the officer since he has the responsible position in the PBS area. In that area, do you or do you not have specific regard as to the terms used for drugs on the PBS so that those terms are not misleading?

CHAIR—Senator Harradine, I understand where you are coming from. However, the TGA is the one who is responsible for the listing. The officers before us today are only the ones who are responsible for the implementation of the recommendation of the TGA. So the officers here do not have any responsibility for the listing of any particular drug.

Senator HARRADINE—Isn't it a fact that the officers will probably be the ones who will be involved in any court action? Surely their particular area ought to ensure that persons who are taking drugs are being properly informed. Who is responsible for that?

Mr Lennon—The terms of registration of drugs for their marketing approval in this country is undertaken by the Therapeutic Goods Administration. Before a drug can get onto the Pharmaceutical Benefits Scheme it has to be registered, and the sort of hurdle it has to go over is that the drug has to be determined to be safe and efficacious. That is the point at which those things are determined. What the Pharmaceutical Benefits Advisory Committee then does is to take the terms of registration that are given to it by the Therapeutic Goods Administration and determines whether the particular drug is eligible for subsidy under the Pharmaceutical Benefits Scheme. To be eligible for subsidy under the Pharmaceutical Benefits Scheme it needs to be safe and efficacious and cost-effective—that is, value for money as compared with other drugs that are on the scheme.

Senator HARRADINE—I understand that. Does your section have anything to do with ensuring that the name of the drug represents its operation?

Mr Lennon—No.

Senator HARRADINE—Do you take the overall responsibility, Ms Halton? We are talking about this possibility in the future. Apparently nobody in the health department has passed year 10 biology, because nobody yesterday would give me a response and nobody today will give me a response as to when conception takes place so that the people concerned—the clients of the department as it were, the people who are receiving the drugs—know what the operation is.

Ms Halton—The officers from the TGA answered your question on that at some length yesterday—

Senator HARRADINE—They did not answer that question.

Ms Halton—in relation to the particular line of questioning you had about the particular product, its uses and the advice on which they were relying and the basis on which that advice was given. That advice was copied and was tabled for all of the senators to review, and I do not have anything further to add to the evidence that they gave yesterday.

Senator HARRADINE—Madam Chair, I have read that document. It says nothing at all about when conception takes place. I am asking the department because we know what is coming down the track. There is a drug coming down the track which is going to be called an

emergency contraception. Presumably you, Ms Halton, are the responsible officer and presumably you, Senator Patterson, are the responsible minister. This is going to be labelled an emergency contraception, but that is a physical impossibility because its main design is to render the endometrium hostile to implantation of the embryo. This is important for women. Or are you not permitting them to make an informed choice?

Ms Halton—Senator, I have nothing further to add to the evidence given by the officers from the Therapeutic Goods Administration yesterday. This issue was canvassed at considerable length. Their position was quite clear on the basis on which they were operating and the advice that informed the basis on which they were operating. They were operating consistent with government policy and, more importantly, with legislation. The legal advice that they tabled yesterday is the basis on which they were operating.

Senator HARRADINE—Minister, is it the policy of this government to deny a basic fact of life as to when conception occurs so that the drug can be given a misleading title?

Senator Patterson—Senator Harradine, some people, and you are one of them, say it is misleading; others, including the legal advice we have been given, say it is not. I do not think we are going to resolve this here in this estimates hearing. It is a deep philosophical question. I know you are not going to be satisfied with the answer that was given yesterday, but that is all I can add.

Senator HARRADINE—Madam Chair, I am approaching this from a completely scientific basis to ensure that it is properly and truly labelled if it is given importation approval.

CHAIR—Senator Harradine, it is quite clear that there is not going to be any additional information given to you other than what was provided yesterday. What is it that you want now to resolve this so that we can move on? Clearly someone is not going to change a view or an opinion that was given yesterday. So what is it that you would like so that we can move on?

Senator HARRADINE—The response by the health minister was that this is a deeply philosophical point. I do not think when conception takes place is philosophical at all. I have been in other committees and scientists have been talking about the use of human embryos, the harvesting from human embryos of stem cells. They know when conception takes place and they would surely not describe something as a contraceptive when conception has actually already taken place.

CHAIR—Senator Harradine, what do you want so that we can resolve it? You have a view and the department has given you an opinion and a legal opinion.

Senator HARRADINE—I have read that.

CHAIR—I realise that, but what is going to change? Clearly no-one is going to say, 'Yes, Senator Harradine, we go along with all of that. Now we will move along.' So what do you want?

Senator HARRADINE—I am simply wanting them to acknowledge the fact of life—a simple fact of life. I cannot get out of the department an understanding that that is the situation, that that is when conception takes place and it is totally false and misleading to the potential users of the drug to call it an emergency contraception.

CHAIR—There is no further answer to be provided?

Ms Halton—I do not think we have anything further to add.

Senator HARRADINE—What is the government policy? Is it the government's policy to call this an 'emergency contraception' when the main purpose of it is to act after conception takes place?

Senator Patterson—I think we explored this in great detail yesterday. We do have a process through the Therapeutic Goods Administration to address some of these issues, and the legal advice we have been given based on that was that the information is appropriate. There are going to be people who disagree, but I am not going to add any more or less to that; it was canvassed quite broadly yesterday.

Senator HARRADINE—Who makes the final decision? If this is given importation approval, who makes the final decision as to what it is called? Is it government policy to go along with the drug company and its false labelling of this particular drug?

Ms Halton—This was explained to you by the TGA yesterday and I would refer you back to their evidence, which I think canvassed the indications for this product in some detail. I would also refer you back to the legal advice, and in particular the first page of that advice which explains that the operations in this area are governed by the Therapeutic Goods Act 1989; it talks about what in fact is a restricted good and the issues that are relevant to that decision. As the officers yesterday explained to you, they consider an application from a company in respect of the indications for a product and the circumstances under which it might be used. I think that was explained at some length by the medical officer from the Therapeutic Goods Administration yesterday.

Senator HERRON—Madam Chair, yesterday I entered the debate and I have had a chance to look at that legal opinion. As I said yesterday, and I have discovered subsequently, that legal opinion has never been tested in Australian courts; it was an opinion based on a decision made in the Privy Council of England. Legal opinions are legal opinions—there is a contrary legal opinion. So I want to make it clear that that is the position. You cannot hide behind a legal opinion that has not been tested in a court and base a decision on it.

Ms Halton—With respect—

Senator HERRON—You need not have respect, Ms Halton; I just want to get the semantics clear on this so that we know what we are talking about.

Ms Halton—I understand, and I think we should also be clear that in the implementation and the administration of government legislation—which is what we are discussing—officers in particular areas of the department, and indeed of the whole public sector, rely on the legislation which governs their operations. In this particular case we are talking about the Therapeutic Goods Act. In areas where there may be some difference of opinion, and sometimes for mere prudence, officers take legal advice to assist them in decision taking et cetera. You are entirely correct; this is a piece of advice. And you are entirely correct that it has not, in this particular instance, been tested in a court of law.

It is open to people to test decisions, and ultimately advice, in a court of law. But what the officers are doing in this particular case is operating in what I regard to be a completely prudent and proper manner in the administration and delivery of their responsibilities. In other words, they are administering their act and their responsibilities. In this particular case, advice has been taken to supplement their understanding, to give them a level of comfort in a particular area—which is, I think we would acknowledge, an area of some difference of opinion—and you are right that it may be tested at law in due course.

Senator HARRADINE—As to the difference of opinion—

Senator HERRON—Senator Harradine, we dealt with that legal aspect and we are agreed that it is an opinion. It has not been tested in the courts.

Ms Halton—Correct.

Senator HERRON—On the other hand, Senator Harradine's point is the scientific opinion, and then it is a matter of semantics and scientific debate. Now there is no question that when a human sperm meets a human egg and it is fertilised a human being comes out 40 weeks later. Nobody would disagree with that: it is not a monkey or a tadpole; it is a human being. A human sperm meets a human egg and, other things aside, it is a human being that is created. I do not know that anybody would disagree with that. If there is, I would like to know. Then we are discussing the scientific argument as to when fertilisation occurs. Does it occur instantaneously? There is argument that it is up to 72 hours, and then there is argument about implantation. I think it is reasonable to get a written response from the department, which may satisfy Senator Harradine's argument, as to what the department considers it to be in relation to conception. Is that difficult?

Ms Halton—This is a question that actually goes to the operation of the Therapeutic Goods Act and, at the end of the day, we are talking about activities of the Therapeutic Goods Administration which are governed by the Therapeutic Goods Act. What we are being asked for is an opinion which, under the terms of the act and this particular decision—and I will go back and review this and take some advice on it—I actually do not believe is germane to this particular decision. Now my understanding is that we are here discussing the estimates of this portfolio as the purpose of this committee as convened, and it is a fair observation that the examination of the department is relatively wide ranging and we did have a wide-ranging conversation yesterday about this particular product in relation to the decision-making process of the Therapeutic Goods Administration, which is governed by legislation. My point to you is that what you are now asking us, as I understand it, does not go to the operation of that particular piece of legislation. But I will go back and have a look at that and see whether it does.

Senator HERRON—Thank you.

CHAIR—Any further questions on outcome 2?

Senator WEST—Yes. I want to pick up the minister's comments on Zyban, because the way it took off was pretty spectacular. You did say that the prescription of Zyban was most efficacious in conjunction with counselling and other antismoking campaigns and that it should not be used on its own: it should be part of a regime. Do you know what percentage of patients for whom Zyban is prescribed undertake this counselling?

Mr Lennon—No, we do not have that information available.

Senator Patterson—The guidelines are there for the doctors and it is yet another burden to place on them to ask them to identify that, but it is an issue for a medication that costs over $200.

Senator CHRIS EVANS—What about the HIC? Do they follow up prescription patterns?

Senator Patterson—They know prescription patterns but they cannot know whether somebody is on a Quit program. The Quit program might be organised by—

Senator CHRIS EVANS—But I am just asking whether, as part of their auditing, that is what they do.

Senator Patterson—The thing is that you would then have to ask for the information from doctors.

Senator WEST—Has there been an increase in the amount of money spent on and given by the federal department to organisations that run Quit programs or those counselling sorts of programs?

Mr Lennon—In response to the earlier question, we have some officers from the Health Insurance Commission here to talk about monitoring activity on Zyban.

Dr Harmer—Senator, would you remind repeating the question please?

Senator CHRIS EVANS—Senator West rightly raised the same issue that the minister herself raised before about the link between Zyban being prescribed and a Quit program or counselling courses being part of the prescribed treatment. The minister responded that we did not know who was taking up the counselling et cetera. I just wondered whether, as part of your audit activities or involvement, you had information on that or whether that was something that you have picked up as part of your program.

Dr Harmer—Zyban is an authority drug, so a doctor does need to get approval through the authority process from the HIC to prescribe it. But the particular condition of the patient, in terms of what program they are on—which is part of the clinical record—we do not access. I do not believe, and Dr Mould may be able to clarify this, that we ask that particular question as part of the authority.

Dr Mould—It is an authority drug. That question is asked at the time that the authority approval is requested. There is no capacity for us to verify or audit the doctor's statement in that regard by access to, say, clinical records.

Senator CHRIS EVANS—Just so I am clear: the doctor has to put them onto a counselling course as part of his or her authority, but after that it is a question of honour or trust—not so much for the doctor, I suppose—as to whether or not there is any follow through. Is that how it works?

Dr Mould—That is correct.

Senator CHRIS EVANS—So despite putting that condition on as part of the authority, we have no way of knowing whether or not that is happening?

Dr Harmer—That is correct. The HIC operates on the basis that, if some information or advice came to us of an allegation about that not being the case, we would certainly investigate it. But we do not have it as part of our normal process to go and have a look at the clinical records of a doctor.

Senator WEST—Since the ready uptake of Zyban, what has been the decreasing state of smoking? Or has that not been happening?

Mr Lennon—It is probably a bit early to do that sort of analysis at this point in time. Zyban has only been on the list since February 2001. Also, smoking is a multifactorial thing. There are lots of programs that are aimed at trying to reduce the incidence of smoking, and trying to isolate one in particular—Zyban—is a bit of a challenge. There is no hard data that I am aware of specifically around the impact of Zyban. I can say though that the clinical trial evidence—which was about the impact of Zyban on reducing the incidence of smoking when it was taken in conjunction with an overall treatment program—that was given to the Pharmaceutical Benefits Advisory Committee at the time that it decided to list the drug on the Pharmaceutical Benefits Scheme was quite impressive.

Senator WEST—Yes, but you cannot tell us if it is being taken in conjunction with an overall treatment program, because you do not know. Is that correct?

Mr Lennon—We do know that this is an authority drug and that doctors are asked the question before the drug is prescribed.

Senator WEST—Yes, but I am asked how I feel every morning. When you meet people and ask, 'How are you?' and they all say, 'Very well, thanks,' and they could be dying from a whole variety of things.

Senator CHRIS EVANS—I do not say that after three days of estimates!

Senator WEST—Maybe not. But you cannot give us any indication as to what the uptake is of a total antismoking package—you can tell us what the uptake of Zyban is—and you cannot tell us what is happening to the rate of smokers.

Ms Halton—We had evidence yesterday that in fact the rate of smoking is decreasing. I think we now have one of the best successes in the Western world in terms of having people stop smoking. I think what Mr Lennon is trying to explain is that there a number of controls about the use of this particular product, and Dr Mould has explained that there is an explicit question asked when authority is sought for the drug. It is certainly the case—indeed, it is the case with a number of other products—that we do not go around and see whether what you have in your medicine cabinet you are actually taking consistent with the prescription. But I am sure that at the next estimates we will be in a position to make some more comment about this. This was only relatively recently listed, and I think to be able to make explicit claims at this point is perhaps a little premature.

Senator CHRIS EVANS—What do we know about the usage? I heard it had increased quite markedly. Is that still the case?

Senator Patterson—I anticipated a spike, because you can have only one treatment a year. I thought there might be another little spike in February, but I do not know if that has happened.

Mr Lennon—The evidence is that that spike has not occurred to this point in time. Zyban was listed in February 2001, and to the end of June—that is, for the first four or five months—it cost $66 million. For the first nine months of this financial year, it has only cost about $22 million.

Senator CHRIS EVANS—What did you budget for the first year—$10 million, wasn't it?

Mr Lennon—Something of that order, Senator.

Senator HERRON—I think it was about $10 million.

Senator CHRIS EVANS—And it cost $66 million in what was only—

Senator WEST—Six months.

Senator CHRIS EVANS—Less than six months—five months.

Mr Lennon—As you may recollect, there was a big bubble effect, a pent-up demand effect. As has been explained, the drug can be prescribed only once a year and there was obviously a big pent-up demand. A lot of people were prescribed the drug in the first couple of months, and it has tailed off ever since. We were wondering, in making an estimate, whether we would see another spike after the first 12 months—that is, around February-March of this year—but that spike has not occurred.

Senator CHRIS EVANS—What did you budget for this year?

Mr Lennon—I think we have this discussion around individual drugs before.

Senator CHRIS EVANS—I always weasel something out of you, though, if I keep at it. Just to get rid of me, you tell me something anyway.

Mr Lennon—I think we indicated that, after the first year, we do not make individual drug estimates. We base our estimates on broad therapeutic drug groups and then project forward, so there was no particular estimate made for Zyban. I think it is fair to say that we were estimating that the particular therapeutic group that includes Zyban would grow by more than has turned out to be the case this year.

Senator CHRIS EVANS—Is this the biggest selling product in that therapeutic group?

Mr Lennon—I could not answer that question, but it would certainly be one of the biggest.

Senator CHRIS EVANS—You expended $22 million in the first nine months and you are expecting it to cost only about $30 million or so for the year. Are you now saying that you think it will drop off in successive years as the fad passes?

Mr Lennon—If you are looking at the true demand for Zyban, it is of the order of $20 million to $30 million a year, not the $100 million-plus that was implied by the figures in the first five months.

Senator CHRIS EVANS—Has any of that drop off in the use of Zyban to do with HIC or other regulatory or education measures?

Dr Harmer—It would be very difficult to tell.

Senator CHRIS EVANS—Have there been any regulatory or education measures undertaken by the department or by HIC in relation to Zyban?

Dr Harmer—Not by the HIC. Our involvement in this is to receive and approve the authority requests by doctors to ensure that they provide the information necessary to allow us to give them authority approval.

Senator Patterson—From my discussions with doctors, I think the publicity surrounding it really shocked them. They are much more aware now of the guidelines and of what can happen if there is a pent-up demand. I think there is a much more sensible approach to it now.

Senator CHRIS EVANS—Often sensible approaches are assisted by measures that help provide education, and I was wondering if anything has been put in place in particular in relation to Zyban.

Senator Patterson—At every opportunity I have had, I have reminded doctors about the need to comply with guidelines.

Senator CHRIS EVANS—I am sure they found that very salutary too, Minister. I am sure you did; I do not doubt it for a minute. Dr Harmer, your procedures have not changed since it was introduced, have they?

Dr Harmer—No.

Senator CHRIS EVANS—That regime was in place from the start?

Dr Harmer—Yes, it was. In addition to the comments made by the minister, I think some adverse publicity around some dangers with the drug has probably also impacted on patient acceptance of it.

Senator WEST—What is the cost of Zyban per day? Is it 35c a day?

Mr Lennon—It is of the order of $240 per prescription.

Senator Patterson—For a course.

Mr Lennon—A course lasts for a period of a couple of months, but I would have to take some advice on that if you wanted a precise answer.

Senator WEST—I am interested in the use of nicotine replacement therapy—the patches and stuff like that—which you can buy over the counter. The cost of that a day can vary and is much higher than Zyban, and I am wondering which one is most efficacious.

Mr Lennon—Nicotine replacement therapy has been before the Pharmaceutical Benefits Scheme for listing in the past, and the judgment of the committee was that it was not as efficacious. It did not have the same clinical impact, in terms of the clinical trials, as Zyban did and therefore was not judged to be cost effective at the price that was being sought. Therefore, it was not recommended for listing.

Senator WEST—We are having some difficulty proving at this stage the cost efficacy of Zyban, aren't we?

Mr Lennon—No. We are saying that the drug has only been on the scheme for a little over a year and, to get good data, you would need ideally a longer period than that. Also, the government has a number of programs aimed at reducing smoking. To isolate the efficacy of any one drug is rather difficult.

Senator WEST—Aren't you glad I will not be here in 12 months time to ask you this question!

Senator HERRON—I might ask it for you, Senator West.

Senator WEST—Thank you Senator Herron. You and I have gone out on a limb on smoking.

Senator CHRIS EVANS—So rumours of your retirement are exaggerated!

Senator HERRON—The survey that was done by the Australian Institute of Health and Welfare, in relation to cigarette smoking incidents dropping below 20 per cent, covered that year period, did it not? Do you think it is too early to believe that there is any correlation between the availability of Zyban and cessation of smoking? Is it too early?

Ms Halton—I would want to take advice from my population health people on that. If you think about the range of measures we have had in respect of smoking—and there are many, and I think we gave some evidence about that yesterday—it would be too early to establish a causal relationship between that and statistically observable decreases in a population. The reason it was listed in the first place was that there was evidence that it does assist people in quitting smoking, but it would be a little early to say. That is not to say that, as I have said to senators, in 12 months time we would not be in a position to make a more definitive statement. I would anticipate we might.

Senator HERRON—Why I mention it is that I have been overseas recently looking at drug policy and speaking with drug authorities. They were talking about cigarette smoking and were very impressed with the fact that we have dropped the rate of cigarette smoking, as you mentioned, and they wanted some evidence as to what may have influenced that apart from education and those other things. It is quite fascinating that we have been successful in Australia in that regard—as you mentioned, Ms Halton. It is a huge problem on the continent

particularly, and they are starting to tackle it as well. It is at a pretty low level at the moment, and that was the reason behind the questioning. If you could get me a copy of the Australian Institute of Health and Welfare document you referred to, I would appreciate that.

Ms Halton—Yes, we can do that.

Senator CHRIS EVANS—I will ask about Celebrex while we have Mr Lennon here. How is that going?

Mr Lennon—It is not particularly useful to think about Celebrex in isolation now that there is another drug called Vioxx, which is another COX-II selective drug that has been on the scheme for quite a while now.

Senator CHRIS EVANS—They are competing for market share now, I gather.

Mr Lennon—Yes, they are. From June 2000 to June 2001, when one or both COX-II selective drugs were on the PBS for a period of 11 months, the total cost to government of those two drugs was $174 million.

Senator CHRIS EVANS—What did we budget for it?

Mr Lennon—In the first nine months of the financial year 2001-02 the cost is about $132 million, so there has not been any increased usage this year. In fact, use of the COX-II drugs has tailed off a bit.

Senator CHRIS EVANS—What have we budgeted for them in the first year? That was another huge payout, wasn't it?

Mr Lennon—For Celebrex in the first full year we were looking at something of the order of $50 million, off the top of my head.

Senator CHRIS EVANS—I know we have it in *Hansard* somewhere—and you will not tell me what we have budgeted for next year. What do you think is happening here? You say there are two products on the market competing for market share. I gather they both have a reasonable proportion of the market share, haven't they?

Mr Lennon—Yes, they do now. For the first nine months Celebrex costs were about $81 million and the cost for Vioxx was about $51 million. So they both have a reasonable market share; that is correct.

Senator CHRIS EVANS—What do you attribute that to? Is it anything medical or is it just that Vioxx is good for golf days or something?

Mr Lennon—One would have expected that the market share of Vioxx would have picked up over time. It was only on for a short time during the previous financial year. It is a good product and there would have been a preference amongst a number of doctors to use that product after it was tested and found to be effective in particular populations.

Senator CROWLEY—Would you describe one as being better than the other—fewer side effects, better for young people or anything?

Mr Lennon—Not really. In terms of the total clinical outcomes, they were judged to be equivalent by the Pharmaceutical Benefits Advisory Committee, and they were both judged to have equivalent safety advantages over the traditional non-steroidal anti-inflammatory drugs.

Senator CROWLEY—I understood that to be the case: there is not much to pick between them. I think Senator Evans's question is particularly important—to try to address what makes you go for one rather than the other if there is not much to pick between them.

Mr Lennon—We all know that pharmaceutical companies market their particular products. With only one drug out there and one particular company—Celebrex—one would have expected a different result from when there were two products and two companies.

Senator CHRIS EVANS—What about costs, Mr Lennon?

Mr Lennon—They are equivalent in terms of costs.

Senator CHRIS EVANS—They are marketed at the same price?

Mr Lennon—Yes. As to what we pay for them in terms of subsidy under the Pharmaceutical Benefits Scheme, they are equivalent. From the patient's perspective, they are also equivalent in the sense that they pay the same general and concessional patient contribution.

Senator CHRIS EVANS—Are there any price volume agreements in place now?

Mr Lennon—No, there are no price volume agreements in place for Celebrex or Vioxx at this point in time.

Senator CHRIS EVANS—You changed the price of Celebrex, didn't you?

Mr Lennon—Yes. There was a change in price over 12 months ago now, but it was not as part of a price volume agreement. That flowed through to the other product as well.

Senator CHRIS EVANS—Yes, because the price was renegotiated after the huge surge in the Celebrex take-up, was it not?

Mr Lennon—There was a price reduction, yes. It was renegotiated, Senator.

Senator CHRIS EVANS—Did that bring it into line with Vioxx?

Mr Lennon—Vioxx came on quite a bit later, and it was brought on at the same price at Celebrex in terms of the subsidy.

Senator CHRIS EVANS—It was brought on at the new Celebrex price?

Mr Lennon—At the Celebrex price existing at that point in time, but there was an adjustment—

Senator CHRIS EVANS—That is what I am trying to work out: did they both subsequently get reduced? That is probably not the right word. Did the price adjustment on Celebrex occur before Vioxx came on the market, or did they both get their price adjusted after they had both been on the market for a while?

Mr Lennon—I cannot recollect which of those two, but I am happy to take that on notice.

Senator CHRIS EVANS—Perhaps you could take that on notice. I just want to understand what happened there. Anyway, they are now marketed at the same price. I do not know whether this question is best directed to Dr Harmer or to someone from the department. It is the same question about education or regulatory activity but with regard to the COX-II inhibitors: What has been happening on that front?

Dr Mould—We have not undertaken any specific audit activities for those two drugs.

Senator CHRIS EVANS—No specific audit activities at all? Dr Harmer, you have not had any auditing activity with the COX-II inhibitors?

Dr Harmer—Not specifically. That would be part of our normal monitoring of prescribing patterns.

Senator CHRIS EVANS—So the suggestion put to me by some that you have been paying particular attention to doctors prescribing these drugs is not right?

Dr Harmer—Not that I am aware of, Senator. Dr Mould may have more information.

Senator CHRIS EVANS—A suggestion has been put to me that a bit of effort—and I am not being critical—has been put in to education and HIC activity in relation to COX-II inhibitors. I think we discussed last time the question of leakage and prescribing off-label. Is that what you call it?

Mr Lennon—Off indication.

Senator CHRIS EVANS—Off indication or whatever it is. I was just inquiring what was happening in relation to those issues and whether or not there had been an effort by the HIC to ensure that it was prescribed in terms of an appropriate decision.

Mr Rennie—I cannot comment on the HIC's activities on that, but the National Prescribing Service has been doing some work in educating prescribers about quality prescribing around the COX-IIs. Maybe that is where you are hearing about education.

Dr Harmer—Senator, I expect that is correct. We do provide the National Prescribing Service with some information, and I suspect what is happening is that they are using that and building it into their education.

Senator CHRIS EVANS—Is yours a more general education role? Are you saying that you have been contacting specific doctors or specific practices?

Mr Rennie—The National Prescribing Service is an independent company set up by the government to educate prescribers about quality prescribing. It will target specific drugs where it thinks it could perhaps influence a change in behaviour to make better health outcomes and, as a result of that, savings. I believe that COX-II is one of the drug groups that they actually have targeted in recent times.

Senator CHRIS EVANS—Who directs this private company as to what it should target?

Mr Rennie—It has a board of directors.

Senator CHRIS EVANS—So that is done quite separately from the department?

Mr Rennie—That is true.

Senator CHRIS EVANS—I take it, though, that the HIC would not be passing on the names of individual doctors to that organisation?

Dr Harmer—No, we would not be passing on names of individual doctors, but we would be passing on aggregated information on patterns of prescribing.

Senator CHRIS EVANS—That would be more general. It would not include locational patterns?

Dr Harmer—I do not believe so but I will check the precise definition of the information we give. I am pretty certain it is general information but it may be broken down, for example, by state. I am not sure whether it is regional; Dr Mould may know.

Senator CHRIS EVANS—In terms of your own role, do you have risk assessments and say; 'Dr A has prescribed Celebrex 100 times this month; the average is 50. We'll have a chat to him about it'? Is that how you operate?

Dr Harmer—As part of our standard monitoring of program integrity and compliance in the Medicare and PBS system, we are constantly looking at patterns of practice and prescribing and applying our pattern recognition technology to that. Where we identify something that looks a little strange or a bit out of the ordinary, we would perhaps send one of our counselling doctors out to have a chat and to ask for an explanation of why it is a little different.

Senator CHRIS EVANS—Would that include a pattern of what, on the face of it, might look like excessive use of a particular drug?

Dr Harmer—It could include that, yes.

Dr Mould—I will just clarify what Dr Harmer is saying. As part of the monitoring or prescribing of providers and ones who appear to be outside the norm, as you have referred to, we look specifically at the drugs that they are prescribing and the quantities. If they are concerned, it would lead to a visit by a medical adviser to follow that up with them.

Senator CHRIS EVANS—Who does that—the HIC?

Dr Mould—That is the role of HIC as part of its risk assessment and management of the program.

Dr Harmer—I should make it clear that we do not make the judgment whether it is clinically appropriate. Those decisions are made by the professional services review.

Senator CHRIS EVANS—I am sure a visit from you, Dr Harmer, is enough to focus the mind. I have a question on leakage—and I am not sure whether I have the term right—prescribing beyond the purpose for which the drug was approved under the PBS off-label indication. We had a bit of a debate last time about Celebrex. Could someone give me some idea of how we are going on that issue? I think you were concerned about Celebrex and the COX-IIs being prescribed more widely than the indications for which they were authorised. Is that the leakage term or do I have it wrong?

Mr Rennie—In the last budget, recently announced, there is a measure to put some effort towards clarifying the restrictions that apply to the COX-II drugs. It will follow the model set by the lipids measure last year whereby the Health Insurance Commission will be writing to prescribers, once those indications have been clarified, telling them what the restrictions are, following up the high prescribers with individual letters and following their normal compliance type activities. That measure is due to commence in 2002-03.

Senator CHRIS EVANS—Is that Sustaining the Pharmaceutical Benefits Scheme—increased information provision to doctors by industry?

Mr Rennie—No, it is not that one.

Senator CHRIS EVANS—Which one is it?

Mr Rennie—It is under evidence based medicine enhancement.

Mr Maskell-Knight—It is Sustaining the Pharmaceutical Benefits Scheme—reinforcing the commitment to evidence based medicine.

Mr Rennie—It is a component of that one.

Senator CHRIS EVANS—That is specifically directed at the COX-IIs, isn't it?

Mr Rennie—There are four drugs groups within one of the elements of that measure. Yes, the COX-IIs is one of those four drug groups.

Senator CHRIS EVANS—You estimate savings of $70 million not this coming financial year but in 2003-04. It is quite a large saving.

Mr Rennie—That is probably referring to the whole measure. I think there are five or six components to that measure, of which the restrictions element of it, if you like, is one component.

Senator CHRIS EVANS—Do you want to take me through that measure? I was going to come to it, anyway. I do want to cover off on the COX-IIs. I think—unless I am losing my marbles—we had a discussion in particular about the COX-IIs and prescribing outside the stated purposes. I thought we identified the COX-IIs as a particular problem. Is that right, Mr Lennon? Am I remembering that correctly?

Mr Lennon—Senator, I believe there was some discussion around the use of COX-IIs outside indication, and particularly for acute conditions rather than for chronic conditions like acute joint and muscle pain. I believe the discussion was around the fact that there is a good deal of anecdotal evidence that there may be significant prescribing outside indication of that kind. That is how I recollect the discussion.

Senator CHRIS EVANS—I guess that raises the question: do you agree with that; and, if so, what have you done about it? Am I to take this measure as, in part, a response to that?

Mr Rennie—No, I believe that is what this measure is primarily addressing.

Senator CHRIS EVANS—So we have had no specific HIC activity in response to that issue with the COX-II inhibitors other than your normal auditing?

Dr Harmer—Not as such. But, as Mr Rennie said, that program will commence—if it is passed through the Senate as part of the budget measure—from 2002.

Senator CHRIS EVANS—Perhaps the best way is for someone to explain that measure to us, and then we will see where that leads us.

Mr Rennie—Will I start from the top?

Senator CHRIS EVANS—Yes.

Mr Rennie—There are various elements to it, not all of which are my responsibility. Mr Lennon will have to help me with the first component, which is basically about changes to the PBS listing process to enhance the listing process.

Mr Lennon—Perhaps I will explain that one, Senator. What is involved there is the provision of additional resources to the department to focus on certain areas prior to listings being considered by the Pharmaceutical Benefits Advisory Committee. There are two areas there. The first one is to ensure that a more focused effort is put into discussions with the companies about proposed listing submissions to ensure that we get the financial implications and patient numbers as adequate and correct as we possibly can. So there is a more focused effort in that area.

Senator CHRIS EVANS—Better guesses!

Mr Lennon—They are always guesses, by their nature.

Senator CHRIS EVANS—I am not being critical, but they are. But, basically, you are trying to get better accuracy.

Mr Lennon—There is also a more focused effort at the point of looking at particular proposals for listing drugs and a more focused effort in trying to ensure that, when drugs are

listed with particular restrictions, we get the wording of the restrictions correct—correct from the point of view of ensuring that they are clear and that doctors understand what they mean and also from the point of view of ensuring that they are clear to the Health Insurance Commission so that they are capable of monitoring and auditing against those restrictions as necessary. They are the two initiatives happening prior to the point of listing. We are also putting more effort into resources for monitoring drugs on the Pharmaceutical Benefits Scheme, particularly new listings; tracking what is happening with actual as opposed to estimated costs in terms of dollars and prescription volumes; and, where they start to get out of line, putting resources into understanding exactly what is happening and what sort of remedial action might be appropriate.

Senator CHRIS EVANS—So would it be fair to say that that is a response to the Zyban and Celebrex type phenomena?

Mr Lennon—It is a response to the fact that the department and the government are very focused on trying to ensure that if drugs are put on the Pharmaceutical Benefits Scheme, firstly, we have a very clear picture of what their estimated usage and financial implications are; and, secondly, we have every possible remedial action in place so that, for example, we get the restrictions exactly right before they are put on the scheme. And, yes, that is against the background that some drugs listed have turned out to be significantly more expensive than was thought at the time of listing.

Senator CHRIS EVANS—I think I will interpret that as a yes for now.

Mr Rennie—Back to the second one on the list?

Senator CHRIS EVANS—Yes.

Mr Rennie—This probably relates back to what your original question was and, that is, to look at the four individual drug groups to see whether there needs to be any clarification of the restrictions the PBAC have placed on those particular drugs. What is complementary to it are the Health Insurance Commission's activities on compliance, the audit investigations of the Health Insurance Commission. Out of the four drugs that are being targeted for next year there are two groups: the proton pump inhibitors or PPIs.

Senator CHRIS EVANS—What are they to the layman?

Mr Rennie—They are for the treatment of ulcers and reflux, I believe.

Dr Harmer—Yes.

Mr Rennie—The second drug group for next year is the COX-IIs; the year after that is the SSRIs, the Selective Serotonin Reuptake Inhibitors; and the following year is the anti-asthmatic drugs.

Senator CHRIS EVANS—How have you selected those drugs? Are they the high risk ones?

Mr Rennie—We see them as being higher risk. We have had a look at the type of growth in those particular drug groups. For example, there has been a 500 per cent increase in the PPIs—the ones due to come in next year—in the last six years. In the last six years the SSRIs have had an increase of 180 per cent and the anti-asthmatic drugs an increase of 240 per cent. The COX-IIs, as you realise, have come on only recently, but there are some concerns about—

Senator CHRIS EVANS—What has driven the PPI increase? Is that because it is a new product?

Mr Rennie—I believe it is new technology initially. Mr Lennon may be able to help me out with the background to the PPIs. That was before my time.

Mr Lennon—They are a relatively new group of drugs for the treatment of peptic ulcers. They have been put on at higher prices than older drugs. Their usage has proven to be high. It was regarded as opportune that the restrictions around them be reviewed as part of this exercise.

Senator CHRIS EVANS—Is that because there is a suggestion that they might be one of those groups where there is off-indication prescription?

Mr Lennon—The concern would be to ensure that there is not significant use of those drugs outside restriction. In part, that might be helped by simply trying to make sure that the wording is absolutely clear-cut for doctors, but it may also be helped by other things.

Senator CHRIS EVANS—What are the brand leaders in that area?

Mr Lennon—I do not have that information before me; but I could easily get it, if you want it.

Senator CHRIS EVANS—I would not mind if you take it on notice. What are they more commonly known as; do you know?

Prof. Smallwood—One is called Losec. Omeprazole is its proper name and Losec is its trading name in Australia.

Mr Rennie—I have a list of all the drugs covered by each of the groups. I could table that if you like.

Senator CHRIS EVANS—That would be very helpful. You are targeting PPIs and COX-IIs next financial year; is that right?

Mr Rennie—Yes, that is right.

Senator CHRIS EVANS—And the other two in the following year?

Mr Rennie—No, the SSRIs in the following year and the year after that the anti-asthmatic drugs.

Senator CHRIS EVANS—How are you targeting them? I am sorry, I interrupted you midstream. What strategies are you using?

Mr Rennie—Basically, as Mr Lennon pointed out, we are reviewing the restriction wordings, not changing the meaning of the wordings, to clarify it for prescribers so that they are aware of what the intent of the instructions are and they know that they are prescribing in accordance with the legislation. For example, with the SSRIs the indication says something like 'for major depressive disorder'. My understanding is that that could be interpreted widely. It might need to be better defined.

Mr Lennon—As an example, I think Losec is a brand name and Omeprazole, which is the generic name, is the market leader in relation to this particular group of drugs.

Senator CHRIS EVANS—Do they have a nice big share of the market, Mr Lennon?

Mr Lennon—They certainly have had a big share of the market, yes. They were the first cab off the rank.

Senator CHRIS EVANS—What sort of share are we talking about?

Mr Lennon—I do not have a percentage in front of me but I will provide you with a detailed answer which will give you further information, including that information. Another example—and again this is the generic name—is Pantoprazole. I think the brand names are Somac, Rabeprazole and Lansoprazole.

Mr Rennie—Senator, in the right-hand column of that list I tabled is the PBS cost for each of the drug brands. If you run your eye down there you will see where the market share is.

Senator CHRIS EVANS—Thank you for that. I think you were on your second initiative, weren't you?

Mr Rennie—Yes, I was.

Senator CHRIS EVANS—Press on.

Mr Rennie—The third initiative relates to authority prescriptions whereby the Health Insurance Commission will be reviewing the requirements of doctors around the information. You mentioned earlier about Zyban. We are looking at getting additional information from doctors to help the audit and compliance process—

Senator CHRIS EVANS—This is different from that other budget measure about increased information and provision to doctors by industry.

Mr Rennie—Yes, different again. This one is basically whereby the Health Insurance Commission will be asking for additional information from prescribers when they seek the authority approval on the drugs that require authorities. Also, introduced in August 2003 will be the facility for doctors to obtain authorities by electronic means from the Health Insurance Commission, rather than using the telephone approval system currently in existence or sending the information in by mail.

Senator CHRIS EVANS—Can you give me an example of the sort of extra information you think you might require?

Mr Rennie—There might be such things as the date of a pathology test that might have been required to meet a condition, the date the treatment started in hospital, previous failed therapies, if those are built into the restrictions of the items—those types of things. It is not to make it onerous at all but, basically, where we can, to try to bring it down to small tick boxes or applying minimal information. Maybe the Health Insurance Commission could add some more details on that particular measure.

Dr Harmer—I think Mr Rennie has done a pretty good job in identifying the sorts of things. At the moment when a doctor calls up for an authority, we ask certain questions. With some of the drugs, this measure will add to the questions we ask. As he said, we will ask such things as the date of pathology tests, the date of hospitalisation, the name of the hospital—some of that additional information.

Senator CHRIS EVANS—Okay, thanks. If you want to join in, please do.

Ms Dunne—Would you like more information, Senator?

Senator CHRIS EVANS—No, I think that probably does it for my purposes. Press on.

Mr Rennie—Another component of this measure is GP electronic decision support. In fact, Mr McRae from the Medicare Benefits Branch has responsibility for that.

Senator CHRIS EVANS—That is not another five grand so they can buy another computer, I hope?

Mr McRae—The program looking at electronic decision support in fact has three components to be rolled out over a period of time. The first is to work with the software providers who provide the clinical software to general practitioners to include in their software the prices which apply to prescription drugs and to the pathology and diagnostic imaging that they order. International experience has shown that, when doctors are aware of the prices, it does influence the way in which they prescribe and order.

Senator CHRIS EVANS—So you want the doctors to understand what it is costing the taxpayer, or the system, before they order each of those tests?

Mr McRae—That is correct.

Senator CHRIS EVANS—And you say that international experience says that that has some impact on behaviour?

Mr McRae—Indeed, yes. That was the first part. The second part is around what one might think of as electronic decisions of support; of building into the software clinical guidelines and related matters so that, when a doctor has a patient in front of them and has their electronic record on the screen, they can more or less immediately call up the relevant clinical guidelines to assist them in their treatment processes.

Senator CHRIS EVANS—Don't some doctors have those sorts of systems already? My GP does that now.

Mr McRae—Yes, there are all sorts of things around, but probably by going out into a separate system rather than by calling it up automatically and probably with a relatively narrow range of things they can get to. There is a range of systems that individual GPs have. But, across the broad, there are certainly not easily accessible systems that work like that at this stage. The third component we are hoping to work on is to try to remove some of the advertising from the existing software that GPs use, which has quite a lot of pharmaceutical advertising at the moment.

Senator CHRIS EVANS—How do you do that?

Mr McRae—We have funds available. We will be working with the software providers. At this stage we still have a lot of work to do, but we will either do it by assisting with funds to the providers or by assisting with funds to general practitioners to help them purchase those packages that are more in line with good practice.

Senator CHRIS EVANS—And not replace them with health department ads—'Brought to you by the friendly Commonwealth health department!' What sort of funds are budgeted for that? I notice this is a savings measure.

Mr McRae—The numbers that we have are across the whole package. Clearly, the three things we are trying to do will each have different parts to them as we work our way through. The total amount of funding available to spend on this over four years is $52 million.

Senator CHRIS EVANS—What is it for the next financial year?

Mr McRae—For 2002-03, it is $5 million.

Senator CHRIS EVANS—Could you table for me or take on notice the full costings? Is that for your three measures that are the subset of the broader measure?

Mr McRae—That is correct.

Senator CHRIS EVANS—Could you take on notice the full costings of the breakdown of the measures? I see in the fourth year it is supposed to be saving $100 million a year, so it is obviously a fairly ambitious saving.

Mr McRae—I can really only talk about my component. Clearly, within my component, part of the international evidence is that, when doctors are aware of the costs of what they are prescribing, they will sometimes look for the cheaper alternative. Or, in looking at the costs of the pathology they are ordering, they may sometimes order two things when they could have otherwise ordered three. That does generate a degree of saving. Certainly, I would be hoping to get net savings out of this measure rather than net spend. The spend we are talking about is the gross spend to make the things happen.

Senator CHRIS EVANS—I am sure the Treasurer would too. He has budgeted to save $100 million in the fourth year. I think he will be having a chat to you if you are not. Is someone able to help me with where we think the savings will be in the broader measure? Is this in the PBS, basically?

Mr Rennie—Yes, the savings will come basically through the PBS. But we can take that on board and give you a table that breaks up the components.

Senator CHRIS EVANS—I appreciate that. Effectively, what you are saying is that you hope all those measures will see a reduction in expenditure on the PBS?

Mr Rennie—That is right.

Senator CHRIS EVANS—Before we move on could someone explain what looks like a related measure, the increased information provision to doctors by industry?

Mr Rennie—Yes, I can talk about that; it is a separate measure. Basically what has happened is that the pharmaceutical manufacturers have reached an agreement to work with the government to ensure that prescribers are aware of restrictions that are placed on PBS drugs at the time their medical reps go around talking to doctors and, at the same time, just making it clear in their advertising and promotional material, and that includes general advertising through print as well as through electronic means where it might be through software.

Senator CHRIS EVANS—So you are educating the pharmaceutical industry to provide better and more responsible information to doctors about the uses to which their drugs can be put?

Mr Rennie—Yes, the conditions that are placed on PBS medicines themselves. If there is a restriction around Zyban, for example, the medical reps will tell prescribers that these conditions do apply if you are going to prescribe under the PBS.

Senator CHRIS EVANS—Forgive me for sounding too cynical, but aren't you asking the bloke flogging the product to restrict the sale of this product by telling them that they are not allowed to use it or they should not use it?

Mr Rennie—The industry has said that they will instruct and ensure that their salesmen, if you like, do make this available as part of their commitment to the sustainability of the PBS.

Senator CHRIS EVANS—We are going to save almost $30 million next year from doing this, apparently. How are we going to test that?

Mr Rennie—Through evaluations and benchmarking evaluations. We will be doing that basically in cooperation with the industry but we will be making sure that it is independent.

Senator CHRIS EVANS—What does that mean? When we come back next year the PBS will have gone up another three or four per cent and all these beautiful figures that have all these savings will be lost in the wash; it will be a bit hard to work out just how all that happens. I am just keen to know how we know whether this sort of thing is effective.

Mr Rennie—We will be putting measures in place to ensure that we can measure it.

Mr Maskell-Knight—It might assist if we table the letter we have received from the Pharmaceutical Manufacturers Association. They set out how they see the measure working and the commitment they have made to having an independent evaluation carried out.

Senator CHRIS EVANS—That would be very helpful. Was this their initiative or was this a response to an approach the department made to them?

Mr Maskell-Knight—I think it is fair to say that in the lead up to the budget there were all sorts of ideas being floated around by various people with an interest in the Pharmaceutical Benefits Scheme as to how it should be changed. We engaged in discussions with some of those groups and they influenced the thinking that we had. I do not know that we are quite able to say, 'This was our bright idea' or 'This was their bright idea.' It was a jointly developed work.

Senator CHRIS EVANS—You had their undivided attention at the time, I gather?

Mr Maskell-Knight—Indeed, Senator.

Senator CROWLEY—My question is probably not directly relevant to that. I have been noticing the campaign of recent times to try and manage the use of antibiotics differently. Who is that addressed to?

Mr Maskell-Knight—That is an initiative of the National Prescribing Service, I understand. Mr Rennie may be able to help you with the detail.

Mr Rennie—It is an initiative from the National Prescribing Service. It is one of the targeted areas they looked at. As I mentioned before, they are an independent company that made this decision. It is an area where they believe that some benefit can be made by putting some resources towards it. That is where it has come from.

Senator CROWLEY—What sort of resources?

Mr Rennie—Some of their own resources. They operate under contract with the Commonwealth.

Senator CROWLEY—It seems to me as I have been watching—I do not where I have even seen it; I have a feeling that it was in advertisements—that people are very concerned about the closure of operating rooms, which I think was mentioned yesterday, because of infections, particularly bacterially resistant infections. What is the department's interest in this? Are you full partners? Have you got some way of measuring it because it would seem to me to be a matter of the greatest gravity?

Prof. Smallwood—As we alluded to yesterday, the whole issue of profligate use of antibiotics and the consequent resistance is a huge issue. It is not just an Australian issue; it is worldwide. The concern that we have all got is that, if we continue along the way we have done in the profligate use of antibiotics, we will be rapidly moving into the post-antibiotic era and we will start to see people dying from things that they died from 50 years ago.

A committee called the JETACAR produced a report. The government response to that was put together by both Agriculture and Health. An ongoing committee is looking at the

implementation of the government response which is, I think, a very important, ongoing piece of work. As I alluded to, the CMO report which I hope will be coming out later in the year has this as one of the major focuses, and then there is the expert antibiotic group under NH&MRC.

There is substantial momentum as far as the department and the government are concerned to try to move strongly on this. The health ministers advisory council also has a group that is looking at this, as I understand it. It is pivotally important, in my view. The general thrust—and there is good evidence to support this—is the more stringent use of antibiotics and you can actually reverse the situation with the prevalence of resistant organisms. There is something that can be done.

Senator CROWLEY—Thank you, Professor. I know this was referred to yesterday and I thought I should hold questions until we came to this part about prescribing. There has been a lot of discussion over the last while on prescribing practices and things that encourage doctors to do one thing or another. Even the budget paper provides better information, particularly to pharmacists and practitioners. Do you have a similar piece of paper designed for the doctors or the prescribers and/or the community? Some of the campaign I have seen is actually about suggesting to the community that they should not go asking for antibiotics—as though they all rush in and do. I think that is very valuable but I want to know if you have got a piece of paper already or in train on this extremely important and very expensive area?

Prof. Smallwood—I cannot say what is actually happening at the moment. Mr Rennie could do that. Again, a critically important arm of changing behaviour is changing consumer understanding and expectation.

Senator CROWLEY—Poor consumers, they always get hit on the head, don't they, Professor Smallwood?

Prof. Smallwood—It is not a question of hitting them on the head.

Senator CROWLEY—It think it is particularly important to say to the prescribers, particularly the medical profession. I am not sure that the consumers are going to be the best people to re-educate the doctors.

Prof. Smallwood—On the contrary, they are very effective.

Senator CROWLEY—They can be but I would expect that there was another dimension to this too: that is to say, we should also be directly addressing the prescribers themselves, as you have just been saying you are doing in a number of other medications that Senator Evans has been talking about. Do we have a piece of paper to the doctors yet about changing the practice for prescribing antibiotics?

Mr Rennie—Not here. I could obtain a copy of the material that the National Prescribing Service are using to educate. I could supply that to you.

Senator CROWLEY—I would very much appreciate that.

Mr Rennie—It cannot happen today. I would have to get that from NPS. I will get that to you.

Senator CROWLEY—Is it possible to provide for the committee the amount of money the government is actually spending in this particular project?

Mr Rennie—This particular project is basically funded within the National Prescribing Service's own budget. I could ask them whether they could give us an indication of the cost.

Senator CROWLEY—That would be useful. I think Professor Smallwood referred to a few other practices outside of them, as in research material. If you could provide for us a handle on the dollars being expended there that would be helpful too.

Prof. Smallwood—I will try and get you all the information of costs and what is going on at the moment.

Senator CROWLEY—Including any evidence of the cost when an operating theatre in a hospital has to be closed or when a hospital is discovered to have bug X that puts in jeopardy everybody who is admitted to that hospital. We have seen closures of wards as well as operating theatres. Do we have a handle on any of that kind of cost?

Senator McLUCAS—Just on that issue, it has been put to me that the whole question about medical indemnity insurance does play into this overprescribing of antibiotics. Is there an interrelationship, that doctors would be fearful of not prescribing an antibiotic, especially for a small child?

Prof. Smallwood—Intuitively, the answer would be yes, you could see how the two could relate. As to defensive medicine, I am not sure how you would gather data on that.

Senator McLUCAS—It is of concern though. Can I go back, Mr Rennie, to the issue of increasing information provision by doctors in industry. Thanks for your earlier comments. Have we looked at international experience in terms of this whole question of essentially asking the industry—and I got your letter on this—to tell doctors how to do it properly? Is there any international experience on that that you aware of?

Mr Rennie—Not that I am aware of right now. I would have to do some research on that. I cannot comment on that.

Senator McLUCAS—You are not aware of Eli Lilly and the US Food and Drug Administration event? Essentially, I think it is a very similar project. You might have a look at that and see if that is at all relevant.

Mr Rennie—Certainly in my brief it says that overseas literature experience shows that similar programs result in changes in behaviour of between two and 10 per cent. I do not actually have the literature references for you. I would have to get them.

Senator McLUCAS—Don't give me the literature. If you could give me the references on notice it would be good to have a look at that. They are saying between two and 10 per cent?

Mr Rennie—Yes, two and 10 per cent.

Senator McLUCAS—Of savings?

Mr Rennie—Yes, they are savings.

Dr Morauta—Two to 10 per cent of usage. Apparently the international evidence goes to better usage and that is the reduction in usage associated with more appropriate usage in this case.

Senator McLUCAS—That literature describes the model that we are about to adopt where we use industry to inform the doctors?

Mr Rennie—It is a similar scheme to what we are proposing happen in Australia, yes.

Senator McLUCAS—That then forms the $147 million savings?

Mr Rennie—That is right; it does.

Senator McLUCAS—That is the methodology we have used?

Mr Rennie—That is right.

Mr Maskell-Knight—If I could just go back to the cost of the brochure that Senator McLucas was asking about. I am advised we had 1.5 million copies printed at a cost of a little over $51,000. So far we have distributed approximately one million; 50,000 doctors received 10 copies each; 5,000 pharmacists received 100 copies each; MPs received six each; and the people on our general mailing list got one copy each and there were about 200 of them. That leaves us with about half a million left to distribute on request from pharmacists and doctors who seek additional copies. The cost of distribution is about $80,000. So in total we have spent about $130,000 so far.

Senator McLUCAS—The $130,000 is the cost of production plus the distribution?

Mr Maskell-Knight—Yes.

Senator McLUCAS—Thank you for that.

Senator BUCKLAND—Can I just ask about the Continence Aids Assistance Scheme. You might just able to help me with a couple of things on that. That scheme provides for the people—

Dr Morauta—Excuse me, Senator. We just have to work out whether we have the right people.

Senator McLUCAS—I just have a couple of questions on Celebrex.

Mr Maskell-Knight—I am sorry, Senator McLucas. We got distracted momentarily. Can you repeat your question?

Senator McLUCAS—I have been advised that there is a current review happening of all those COX-II inhibitors of those drugs and their effectiveness. Is the department aware of that?

Mr Lennon—Yes. One of the budget measures to review the evidence around all of the drugs recently listed on the Pharmaceutical Benefits Scheme drugs for the treatment of arthritis. And they are the COX-II selective drugs, which are Celebrex, Vioxx and a more recent drug that was listed which is also a COX-II selective called Meloxicam. Those drugs were listed on the Pharmaceutical Benefits Scheme on the basis of the evidence from clinical trials and elsewhere as it was then, which indicated that they had some safety advantages over traditional non-steroidal anti-inflammatory drugs, which were just as effective but in some instances not as safe. On the basis of that, Celebrex and the other COX-II selective drugs received a price premium over the traditional non-steriodal anti-inflammatory drugs. Since that time, more recent evidence has become available from a couple of large additional clinical trials, for example, the CLASS trial and the VIGOR trial.

They both raised some issues around the extent of the safety advantages which were thought to be there for the COX-II selective drugs. The government has asked the Pharmaceutical Benefits Advisory Committee to review the latest evidence in terms of those safety advantages for the three COX-II drugs and then to come back to it with a report by the end of this calendar year. And in reviewing that evidence the committee will start by asking for submissions from the three companies that are sponsoring each of those three COX-II selective drugs. Then it will evaluate the evidence, including those submissions, and will come up with some recommendations for government.

Senator McLUCAS—You did tell me the date and I did not write it down. When do you expect to be able to come back to us?

Mr Lennon—The Pharmaceutical Benefits Advisory Committee is expected to report by December of this year.

Senator McLUCAS—Have we been through this process before with any other drugs where we have had new evidence that would question evidence that has informed an earlier decision?

Mr Lennon—The Pharmaceutical Advisory Committee periodically reviews drugs that are listed on the scheme and it is not anything totally unusual or out of step with its procedures to review the latest evidence in relation to this particular class of drugs, no.

Senator McLUCAS—It is in the community eye, given the high knowledge of those drugs and their high usage of them, I think. There will be more interest from the community in the whole review process.

Mr Lennon—Are you asking me for comment on that?

Senator McLUCAS—No. By December we will have some advice from the PBAC. What happens then?

Mr Lennon—The government will have some advice and on the basis of the advice and recommendations it receives from the Pharmaceutical Benefits Advisory Committee—and I would expect it would need to go through the Pharmaceutical Benefits Pricing Authority as well to translate that advice into what it means in terms of pricing—the government will consider those recommendations and take decisions as appropriate.

Senator McLUCAS—Would that allow the government then to renegotiate with the companies about a price volume agreement? Will that trigger another round of negotiations?

Mr Lennon—That depends on the results of the review.

Senator McLUCAS—I understand that.

Mr Lennon—One result of the review might be to determine that the safety advantages which were originally thought to be there are confirmed as being there. Another result might be that, for example, those safety advantages are not as extensive or as significant as was first thought. In that latter case, the government may choose to undertake negotiations with the pharmaceutical manufacturers on the basis of that new evidence.

Senator McLUCAS—I realise that Celebrex and Vioxx were very much welcomed by those people with chronic arthritis. But have we gone too fast with the whole assessment of those earlier trials? I am aware that some state governments have not put those drugs in their hospitals.

Mr Lennon—First of all, the drugs have to be registered by the Therapeutic Goods Administration before they can be considered by the Pharmaceutical Benefits Advisory Committee, and they have been through that registration process and have been determined to be safe and efficacious and suitable for registration and marketing approval. Celebrex which is the first drug that went on was the subject of quite extensive consideration by the Pharmaceutical Benefits Advisory Committee. From memory, I think it was considered at least three times before it was eventually listed, so I do not think it would be fair to say it was rushed.

Prof. Smallwood—I think the process has been properly measured. The initial rationale was, of course, particularly for gastrointestinal safety and renal safety that both kidney problems and particularly bleeding from the gut were the issues. The selective COX-II inhibitors in the very early trials and then in the much larger ones looking for complications, not just the appearance of ulcers endoscopically, really did seem to show a very clear benefit, a very clear safety margin. One of the things that subsequently came forward was that a lot of the people who would be expected to benefit from that safety margin were older people who might also be on low-dose aspirin to try to forestall any cardiovascular event like heart attack or stroke. It turns out that those people get no benefit on the current trial evidence. The benefit of the combination of a COX-II inhibitor and some other non-steroidal drug such as aspirin and even low-dose aspirin is gone. With these later trials, there is some dispute about the interpretation of the benefit. I think the process has been properly measured.

Senator McLUCAS—Thank you, Professor Smallwood. I have a constituent inquiry. A constituent suffers from hyperpituitarism or Shehan's syndrome and, since her child was born, she has had to take a 100-milligram testosterone implant pellet. She advises me that she pays over $200 for this pellet but that men can get it for erectile dysfunction for $22.40. Can you give me some information about that?

Mr Lennon—I am not clear about the facts. She said that men can get it on the Pharmaceutical Benefits Scheme for erectile dysfunction?

Senator McLUCAS—Yes.

Mr Lennon—There is one drug listed on the Pharmaceutical Benefits Scheme for erectile dysfunction at the moment and that is Caverject. That is about to be de-listed. So that will not be the case from 1 August.

Senator CROWLEY—How come that will be de-listed?

Mr Lennon—The decision to de-list that was taken at the same time as the decision was taken not to list Viagra for the treatment of erectile dysfunction.

Senator McLUCAS—This is a testosterone implant pellet. I do not have the name of the product.

Mr Lennon—If you would like to provide me with some additional information, I will seek to answer your constituent's question in some more detail.

Senator McLUCAS—Thank you. I have some straightforward questions on the National Prescribing Service. Could you tell me the page number in the PBS where that item is? I have not got it written down here.

Mr Rennie—I believe that is last year's budget measure. I do not think there is anything in this year's budget measure.

Senator McLUCAS—Thank you. That is probably why there is no page number. What percentage of GPs participate in the National Prescribing Service activities?

Mr Rennie—The latest advice to me was about 75 per cent and I think that the National Prescribing Service has just moved into their 100th division—about 125—so it is getting very close to being the full coverage. Of the 25 that have not been covered, they are the more remote divisions around the country.

Senator McLUCAS—Isn't it all run by telephone?

Mr Rennie—I should clarify: through the National Prescribing Service, they have facilitators in divisions of general practice. That is what I am referring to.

Senator McLUCAS—There is a second part to the—

Mr Rennie—In 100 divisions, there are facilitators from the National Prescribing Service who are engaged in working those divisions. The first part of my answer was that in excess of 75 per cent of GPs are covered by the NPS through the divisions.

Senator McLUCAS—I understand there was an evaluation of the NPS which finished in December 2000.

Mr Rennie—That is right.

Senator McLUCAS—Is that evaluation in the public domain?

Dr Morauta—I think we can make it available. I will take that on notice for you. It occurred before the budget measure last time because the government's view was that it would not be renewing funding if the organisation had not delivered, and the evaluation showed that it had.

Senator McLUCAS—Going back to more general PBS questions, when that level of copayment changed, how did the government seek advice from the department in determining the changed level of copayment?

Mr Lennon—Are you referring to the current budget changes, Senator?

Senator McLUCAS—Yes.

Mr Lennon—The department was involved in providing advice about that copayment change which formed the basis of part of a cabinet submission which went to government for decision. The minister obviously interfaced with the department about the measure and then took the matter to cabinet.

Senator McLUCAS—I am just trying to get to how did we decide on those particular numbers? What informed that?

Ms Halton—I think you are now in the realms of asking us to talk about what actually happened in a cabinet process.

Senator McLUCAS—I am trying not to. What I am trying to find out is why we selected those exact numbers, like $1 for those on the pension and $6.20 for general consumers.

Ms Halton—What I can advise you is that there is a relationship between those two numbers which was a consistent increase for the two categories. In terms of how the numbers were precisely arrived at, you now are asking me to comment on something which was a source of cabinet discussion.

Senator CHRIS EVANS—When you say the relationship—

Ms Halton—There is symmetry between the two numbers in terms of the percentage increase.

Senator CHRIS EVANS—Symmetry as in a one and two zeros or was it simply as a percentage?

Ms Halton—No, I am actually talking mathematical symmetry, Senator.

Senator CHRIS EVANS—So you are saying that the same percentage increase applied?

Ms Halton—Yes.

Senator CHRIS EVANS—What was that percentage increase?

Mr Maskell-Knight—They were both 28 per cent.

Ms Halton—That is right.

Senator CHRIS EVANS—I guess what Senator McLucas is asking is what modelling underpinned the 28 per cent. I know at the end of the day it is a cabinet decision about the amount but you must have an understanding about the assumptions that underpin these things about consumer behaviour?

Ms Halton—Certainly. It is most certainly the case that in considering options the department, in conjunction with the Department of Finance and Administration, formed an agreed departmental view about the impact of savings, and I think you have already seen the published savings figures and some of the things that underpinned that. Those elements were agreed between departments and were consistent advice between departments to government about the impact of that particular package.

Senator CHRIS EVANS—For instance, one of the things that interests me is what do we know about the impact of price on behaviour? There is obviously a key assumption, key issue, at the core of this debate. I am not asking you to debate why the cabinet chose $1 or 97c but to understand what the department thinks a change in cost to consumer has on pharmaceutical consumption behaviour?

Mr Maskell-Knight—I think that in developing the estimates we had regard to what has happened on previous occasions when copayments have increased and what the demand responses at those times have worked out at.

Senator CHRIS EVANS—Can you take me through that historical knowledge in the broad sense, Mr Maskell-Knight?

Mr Maskell-Knight—I am not sure that I have the details with me, Senator.

Senator CHRIS EVANS—You have a long corporate memory, though. In broad terms what were the impacts?

Mr Maskell-Knight—I really cannot answer that without taking that on notice.

Senator CHRIS EVANS—I am sure you can tell me this: when the price goes up, does demand go down or does demand go up?

Mr Maskell-Knight—I think there is an interesting relationship, Senator. You are quite right in that demand goes down if the price goes up. For the Pharmaceutical Benefits Scheme estimates the process is complicated because when you increase the price for general patients from $22.40 to $28.60 you actually take a whole lot of drugs out of the coverage of the scheme for those patients. That means that it is very difficult to know what has happened. There are a whole range of drugs the price of which to the government falls between $22.40 and $28.60.

Once the general copayment is increased by that amount, the drugs that are priced in the middle are no longer covered by the Pharmaceutical Benefits Scheme. So it is quite unclear what demand effects may be in that range. And, similarly, when the copayment was last increased in 1996 and when it was increased quite substantially in 1990 or 1991 under the previous government there was the same issue. There was a whole group of drugs for which it is very difficult to measure what the demand response was.

Senator CHRIS EVANS—So you are saying to me that as a result of them falling into that group we actually do not know then what happened to the demand for them. I know that if you are not subsidising them on the PBS you do not have those figures generated—I can understand that. But you have these tremendous cooperative relationships with the industry that is going to save us millions next year, so surely we would have some idea of what we are still selling and what did not sell any more. Are you saying we do not know anything about what happened to those drugs?

Mr Maskell-Knight—I am not aware that we do. I understand that we get below copayment data from the Pharmacy Guild on various occasions, but I do not know that we have examined that in any detail about what happened in 1996. I think, indeed, I am not sure that we did have access to that information back then.

Senator CHRIS EVANS—What do we know about those that stay on the PBS, in terms of demand?

Mr Maskell-Knight—We would have to take that on notice and provide you with an answer as to what happened last time around.

Senator CHRIS EVANS—I would appreciate it if you could give me some detailed answers on what happened to behaviour as a result of those price increases. But is it fair to say that there was an impact in terms of reduced demand?

Mr Maskell-Knight—I think it is fair to say there has been an impact in terms of reduced demand. I think it is also fair to say that that impact does not last very long. It is very much a transitory thing. I am not an economist so I cannot talk about it in the technical terms, but I suspect it is something to do with sticky elasticities or something.

Senator CHRIS EVANS—I am very grateful you cannot, Mr Maskell-Knight.

Ms Halton—Do we mention accrual accounting at this particular point?

Senator CHRIS EVANS—You do well enough just with a couple of medical terms to throw me off the track. Are you saying that in the longer term that might not have such a huge impact on demand?

Mr Maskell-Knight—I think that is entirely right, yes.

Senator CHRIS EVANS—What about in terms of prescription patterns? Obviously there is a change in price if we double the price of Celebrex independently? What do we know about prescribing patterns and responses from doctors when there is a general increase in the cost?

Mr Maskell-Knight—I do not think we can disentangle how doctors respond as to how consumers respond. At the end of the day we know what the script volumes are but we cannot tell whether that was doctors not writing scripts or doctors writing scripts and patients not getting those scripts dispensed.

Senator CHRIS EVANS—I suppose it is fair to say that you would expect a drop in demand as a result of these measures but that that would sort of bounce back over time?

Mr Maskell-Knight—I think that is entirely right.

Ms Halton—I think if you look at the changes Mr Maskell-Knight has referred to, the 1991 changes, which introduced for the first time copayment for the connectional category, you can see that there is quite a nice diagram somewhere that shows the impact and then the growth but at a lower level.

Senator CHRIS EVANS—Although I presume that probably might have been greater in the sense that it was the first time there was a copayment. It might have had a much more dramatic effect—I do not know. Was there a change in the payment for concession cardholders in 1996 as well?

Mr Maskell-Knight—I believe there was.

Senator CHRIS EVANS—So that might be more informative in terms of impact.

Senator McLUCAS—I understand the department asked NATSEM to do some modelling in 1998 on increased PBS copayment charges. Is that the modelling that we used to inform this decision?

Mr Lennon—We would have used information from a variety of sources to inform the decision in relation to the copayment changes.

Senator McLUCAS—Are there other types of modelling? I understand NATSEM uses one particular style of modelling and I cannot remember the name of it.

Mr Lennon—Microsimulation modelling.

Senator McLUCAS—What other types of modelling would have been used?

Dr Morauta—I think basically it is the sort of thing to which Senator Evans was referring. We can look at historical data and try to tease out the trends in historical data from previous experiences of similar things.

Senator CHRIS EVANS—You do not say to me that you are going to save from this $300 million so next year; you tell me that you are going to save $298.6 million. I trust you, and your figures are always accurate, so we are going to save $298.6 million. What are the assumptions that underpin that? Is that based on demand remaining the same and that is just a straight multiplication of the reduction in subsidy? Is it $1 multiplied by 400 million prescriptions equals x or is it allowing for a two per cent drop in the number of scripts written? These are figures you have obviously had checked by Treasury and Finance rigorously no doubt. So what are the assumptions? What do I multiply by what to get to saving $298.6 million next year?

Mr Maskell-Knight—As I said before, it is a complicated interaction of a range of things. Part of it is demand. Part of it is the reduction in subsidy by $1 for all the concessional scripts. Part of it is the number of scripts that we no longer pay for the generals and part of it is the extra $6.20 for the general scripts that we still do cover. Now we are happy to provide you with something that indicates how all that works and how it interacts.

Senator CHRIS EVANS—I know that most things complicated generally throw me, Mr Maskell-Knight, but I would be interested in trying to understand that. So are you able to do that now?

Mr Maskell-Knight—That would be part of what I undertook to take on notice before.

Senator CHRIS EVANS—So you will be able to give me an explanation of the assumptions and where those savings then are generated?

Mr Maskell-Knight—Yes.

Senator CHRIS EVANS—Can you tell me in broad terms while the $1 reduction in subsidy effectively for concession cardholders, for instance, is a smaller dollar amount? My recollection is that the number of scripts written in that category is exceedingly high. Can you give me some rough idea of the proportion of where the savings are coming from?

Mr Maskell-Knight—I do not have that. I am not sure whether Mr Lennon does.

Mr Lennon—Overall savings over the four years are coming roughly 50 per cent from the generals and 50 per cent from the concessional group.

Senator Patterson—Senator Evans, when we use the word 'savings' we always need to remember—because there has been a bit of a furphy around—that we will spend the amount on the PBS this financial year as last and it will increase in the out years. What it is doing is curbing the growth.

Senator CHRIS EVANS—I am happy to concede that point. I was just trying to find ways of expressing the reduction in subsidy rather than increasing costs. I accept that the total PBS budget continues to rise.

Senator Patterson—The government will be spending the same of money on subsidy and more into the out years. We will have to spend more of our national budget on pharmaceuticals. To enable us to have access to the frontline medications, do we as citizens have to spend a slightly increased amount of our personal budgets? That is a decision Australian's have to come to. It will ever increase because we have got these very, very expensive medications knocking on the door.

Senator CHRIS EVANS—I understand that, Minister.

Senator Patterson—I believe that we supported you when there was an increase in 1991, I think it was, of $4 or so. I cannot remember the exact figure. You could buy a lot more for $4 than you can for $6.20 now. I suppose there was a responsible opposition in around that time.

Senator CHRIS EVANS—That may or may not be the case. But what I would rather do is understand where the $300 million savings are going to come from and test those. Mr Lennon, you say it is approximately 50 per cent from the concession cardholder changes and about 50 per cent from the other measure?

Mr Lennon—Over the four years, yes.

Senator CHRIS EVANS—You make that as a caveat, and that is different from other years?

Mr Lennon—I just make it as a general observation.

Senator CHRIS EVANS—Is it 50 per cent over the four years because it is 75-25 in the first year and the other way around in the second?

Mr Lennon—My recollection is that there are not large differentials year to year between the share. There are some, but they are not large. Roughly, it would be fifty-fifty each year and certainly, over the four years, it is close to fifty-fifty as between the concessional and general group in terms of the total dollar savings.

Senator CHRIS EVANS—I just wanted to understand whether the caveat you had added had any particular relevance. So thank you for that. Mr Maskell-Knight, that will include some estimation of the impact on behaviour then, will it?

Mr Maskell-Knight—Yes. It will explain what the assumptions are that underlie the numbers.

Senator CHRIS EVANS—Thank you for that.

Senator McLUCAS—Going back to modelling—I am not trying to be inflammatory here; I am just trying to have a discussion about the modelling used to inform the decisions to

increase the copayment. Did the department or the PBS look to modelling that talks about long-term public health issues that says, if you decrease your pharmaceutical investment at this point, there is potentially a greater cost in the long term? A body of people do argue that way.

Mr Maskell-Knight—No-one is talking about decreasing the pharmaceutical investment. As the minister said, we are actually going to be continuing to spend more and more under the PBS each year. We may be spending a little less than we otherwise might have had as a result of the demand effects. But, as I indicated before, those are fairly transitory and short-term in what we have assumed. I think it is a misrepresentation to say that we are going to be making any significant reduction in the level of pharmaceuticals.

Senator McLUCAS—I take your point. However, do you understand the point that people make? If you reduce investment in pharmaceuticals—which we are doing—'by a small amount', which is your comment, proportionally, that is correct. But there is a body of people who do argue that that is where we should be increasing investment rather than reducing it.

Dr Morauta—The PBAC, within its own assessments, goes to this very point. In assessing whether a medication is cost effective—when it provides that advice to government, it takes that point very much into account—built into our system are what we call 'economic offsets', for example in hospitals, which are taken into account in the work of the PBAC and in the advice to government. So I would say that the sort of principle you are talking about underpins the way we run the PBS and the way the government approaches the issues.

Senator McLUCAS—What literature informs that, through advice to the PBAC?

Ms Halton—There is a very detailed costing and modelling exercise that is done as part of advice to the PBAC. It would be excessive to describe it as an army of health economists, but there are a significant number of technically trained health economists who do this work. The work that is done is quite interesting. I found it very interesting having a detailed briefing on it recently. As Dr Morauta says, the basis on which we decide to list is much broader than is generally understood in the community. The kinds of issues that she has raised and those savings and the contribution that pharmaceuticals can play in moderating overall expenditure make up one of the significant factors. There is quite detailed and technical modelling done of that and given to the PBAC for its consideration, as part of any decision on an application that is received.

Senator McLUCAS—Do you essentially use that NATSEM model?

Ms Halton—No.

Mr Lennon—Models that go before the Pharmaceutical Benefits Scheme relate to requests for listings from individual companies. They need to put in a submission in a set format, and they have scope to argue for cost offsets in areas like hospital expenditure—not just hospital expenditure, but diagnostics and medical expenses. So the company, using its own resources, health economists and other expertise, puts in a detailed submission. That submission is then evaluated by an evaluation group. The department has contracted with three external evaluation groups in three universities: the Newcastle University, Monash University and University of Queensland. They are expert teams that evaluate those full submissions. They put in evaluations. The companies then have the opportunity to respond to those evaluations. All of that material then goes before the Pharmaceutical Benefits Advisory Committee for consideration.

Senator McLUCAS—Did the department look at the out-of-pocket expenses especially for those with chronic conditions—such as cardiac disease, diabetes or arthritis—in that whole melting pot of decision making about increased copayments?

Ms Halton—I suppose, inter alia, the answer to that is yes. As you would be aware, there are safety nets attached to the Pharmaceutical Benefits Scheme that are designed precisely to provide protection to individuals, or indeed families, both in the general and the concessional category, who have relatively high use of scripts. Continuing with the safety nets is in explicit recognition that, at a particular point where usage is fairly high, there should be an additional level of protection provided for people or families, as the case may be, with chronic disease who have high use.

Senator Patterson—Senator McLucas, quite a number of those people have already reached the safety net this year. The first person to reach the safety net will do so on 3 January in the calendar year—and I stand to be corrected on that.

Mr Lennon—Certainly the minister is correct in saying that, early in each calendar year, you do get some people reaching the safety net because they have a lot of prescriptions. The concessional patients, for example, only need to reach 52 prescriptions and then they hit the safety net. After that, their medications are free for the rest of the calendar year. That will continue to be the case under the budget changes.

Senator Patterson—Many people do take a large number of scripts—and I have been concerned about this. It is not an easy decision, but I want to preside over a system that is sustainable into the future, and I know the medications that are lining up. Many of those people who take a large number of scripts will have reached the safety net by now. That gives them, from when that brochure went out, about seven months notice from when the budget came down that their scripts will go up by $1, if they are concessional. Then they have 52 scripts and go back to their medication being free.

Senator McLUCAS—Do we have any estimates of existing out-of-pocket expenses for those groups with chronic illness? Have we done any work on that?

Mr Lennon—We do know that, for a concessional patient—and concessional patients are responsible for 80 per cent of the expenditure on the Pharmaceutical Benefits Scheme and write 85 per cent of the prescriptions—currently they have to spend a maximum of 52 prescriptions at $3.60 per script, that is $187. That is the most that they can pay out of pocket. After that, their further prescriptions will be free. That will rise a little as a result of the budget changes. For the concessional group, the most extra that they would pay as a result of the changes in copayments would be $1 per week—$3.60 to $4.60 for 52 prescriptions. So that is $52 a year. So we can be confident that there is substantial protection there in terms of out-of-pocket expenses for that group who constitute 85 per cent of the prescriptions and 80 per cent of the expenditure under the Pharmaceutical Benefits Scheme.

Senator McLUCAS—I am sorry; I am not talking about pharmaceuticals alone. It is the other costs that those people with chronic illness have. I am trying to ascertain what those costs are.

Mr Maskell-Knight—Are you thinking about medical expenses?

Senator McLUCAS—The total medical expenses of a person with chronic illness: have we done some assessment of those? There is a set pharmaceutical cost and if the person comes in under the safety net, yes, we can identify that cost very clearly. But there are a whole

range of other costs that you have if you have acute diabetes or acute rheumatoid arthritis. Have we done any analysis of those costs that a patient might have?

Mr Maskell-Knight—I am not aware that we have ever done any analysis of that sort. I think it is probably worthwhile drawing attention to the fact that there is also a Medicare benefit safety net as well. So at the moment we still have around three-quarters of consultations under Medicare direct billed at no cost to the patient. But there is also a safety net which says that if you are not bulk-billed then, once the total amount you spend between 85 per cent Medicare rebate and 100 per cent of the fee reaches a certain level, any further medical consultations are free of charge for the rest of the year. So there are protections there.

Senator McLUCAS—There is a whole range of costs though—medical, pharmaceutical and others.

Dr Morauta—I think they are in the study, I have just been advised, by the Australian Institute of Health and Welfare, which takes a series of diseases and looks at the cost of those. We might get you the reference during the course of today.

Senator McLUCAS—Just the reference, thank you.

Senator CHRIS EVANS—I have a couple of questions about some of the other savings measures. I will start with sustaining the PBS improved data analysis and compliance activity. I do not quite understand what it is saying about the savings because apparently this is a nil impact item because the savings have already been recorded. Is that because this is the old improved pharmaceutical benefits entitlement monitoring measure?

Mr Maskell-Knight—No, it is not. The reason there is no money there is that it is a sort of technical budget process. The original measure was only supposed to last for four years, but the government has decided to extend it. But the costs and savings from the measure were already reflected in the forward estimates. That is why there is no money shown there.

Senator CHRIS EVANS—Was it always called 'Improved data analysis and compliance activities'?

Mr Maskell-Knight—You take me back before my corporate memory. But what it is in the description is effectively what was called in the vernacular I think—the prescription drug smuggling initiative or rather the antiprescription drug smuggling initiative.

Senator CHRIS EVANS—I knew there was that element of this sending of PBS drugs overseas, but it just seems to have two elements. I just wonder whether the other part of the element relates to this use of Medicare numbers.

Mr Maskell-Knight—I do not believe that that is so. I might ask Dr Mould to help us out here.

Dr Mould—Would you mind repeating your question?

Senator CHRIS EVANS—I think it would be helpful if we could get a thumbnail explanation of the measure 'improved data analysis and compliance activities', why the savings are not recorded and what this measure used to be in the previous budgets? Could you put it in context for us, basically?

Dr Mould—I would defer to Charles on why it is not in the budget, but perhaps I can explain what we are doing in terms of enhancing the data analysis and the compliance activities. We have used a number of targeting tools in the past to analyse PBS activity and claiming. As a result of those, we have developed further tools, including features that could

indicate possible fraud and abuse to the programs. It is to expand and enhance what we have done in that pilot stage further to produce the benefits and to target our activities in the compliance area and the program integrity area in the future.

Senator CHRIS EVANS—But this is a local and an overseas component, is it?

Dr Mould—Part of the overseas component is the prescription drugs smuggling program, which we have devoted some significant resources to in the past. This involves either what we call prescription drug smuggling or overseas diversion whereby prescription drugs are illegally taken overseas for use either for sale or for use by other people who are not entitled to them.

Senator CHRIS EVANS—There is another measure which deals with pharmacy fraud in Australia. I am trying to understand how these all fit together. Again, there is an awful lot of savings anticipated in these budget measures from these things. I am trying to understand the overlap in relationships. How does the pharmacy fraud relate to this measure?

Dr Mould—It is true to say that there is some overlap between pharmacy fraud and prescription drug smuggling in that pharmacy fraud, or perhaps better described PBS fraud, can involve inappropriate claiming prescribing throughout the whole process, right from the time the prescription is written until the prescription is filled. Part of that might be that the drugs might be inappropriately taken overseas. Pharmacy fraud, however, is a much broader measure and, as I said, involves: was the prescription a valid prescription? Was it for the person it was intended—that is, the person who asked for it? Were they the person they said they were? Was it appropriately claimed? Was it delivered to the patient for whom it was intended? All those issues are covered in pharmacy fraud.

Senator CHRIS EVANS—But the pharmacy fraud measure in the 2003-04 was supposed to deliver $56 million worth of savings. That is an awful lot of fraud and an awful lot of fraud detection. I am trying to get an understanding of what you have identified as the targets and how we expect to recoup that sort of money.

Dr Harmer—The PBS is a $4 billion program now. We have had for many years a range of programs trying to protect the integrity of that important and rapidly growing program, including, as Dr Mould said, looking at overseas diversion of drugs, incidences of fraud in pharmacies, areas where doctors are inappropriately prescribing and a whole range of others. Over the last couple of years we have significantly enhanced our capacity in terms of technology—pattern recognition technology et cetera. We have also had some success recently using that technology and linking it with our investigation function with some fairly significant prosecutions in the pharmacy area. We are confident that if we have our resources increased that, combined with the use of technology, we will be able to identify some more. It is not a high number of pharmacies, but some of the pharmacies we have been able to identify were practising quite large frauds.

Senator CHRIS EVANS—So these were systemic frauds?

Dr Harmer—Yes, they were.

Senator CHRIS EVANS—Are you saying that they were actually deliberately providing the wrong drugs or recording the wrong drugs?

Senator Patterson—When somebody has a script in their hand, most of the Australian community do not realise that that has enormous value. We drive some of the lowest prices in

the world for medications on the Pharmaceutical Benefits Scheme. Some of those medications are much more expensive elsewhere. So a script has a value.

Senator CHRIS EVANS—Yes, I understand that. But this particular aspect of pharmacy fraud—I am trying to understand what it is that is happening. There are quite ambitious targets for savings, which implies there is massive fraud and massive fraud that will be addressed. I am just trying to get a feel for that.

Senator Patterson—Wouldn't it be better to give the committee a briefing? We do not particularly want to educate everyone as to how it is done.

Senator CHRIS EVANS—I am not particularly after that either. I appreciate the offer of the briefing and may take it up, but I also do not like getting told things I do not get to hear on the public record because they are not much use to you. So I just want to be clear what sort of activity we are targeting.

Dr Harmer—There is a range of activities across that range of overseas diversion. There are some activities in doctor shopping where patients go to a number of doctors and get scripts from a number of doctors.

Senator CHRIS EVANS—That is another measure under the budget as well, is it?

Dr Harmer—It is. There is, as Dr Mould said, fraud that occurs amongst a very small number but sometimes of significant amounts of fraud in the pharmacy. There is a range of measures. As I said before, over many years we have been quite successful but with some boosted resources we believe that we can be a lot more successful in this area.

Senator CHRIS EVANS—That leads me to the obvious question: what did you get as your boost for your HIC budget this year?

Dr Harmer—I do not have the figures with me, but there were significant resources to increase our capacity for monitoring and investigating some of these matters.

Senator CHRIS EVANS—Can you take that on notice for me?

Dr Harmer—Yes.

Senator CHRIS EVANS—Obviously we are relying a lot on you on.

Dr Harmer—I am advised that it is around $3 million I think.

Senator CHRIS EVANS—Additional for HIC?

Dr Harmer—Additional for 2002-03.

Senator CHRIS EVANS—That is for all your audit function?

Dr Harmer—Correct.

Senator CHRIS EVANS—So what happened to the provision of Medicare numbers on scripts and the savings from that? I do not see that flowing through in the budget papers. There is a range of new initiatives. I am trying to understand how all that links in together.

Ms Badham—The current status of that measure is that, from 1 May this year, the claims presented to the HIC without a Medicare number on them are not being paid. Because that was a measure from a couple of years ago, there is nothing in the current papers about that.

Senator CHRIS EVANS—But we did have savings identified for these years. I understand that it may not be under the new measures, but I am trying to track whether or not we are realising those savings.

Ms Badham—Certainly. That has now been built into the PBS projections. But there will be an evaluation later this year about the level of the savings. But the expected savings have been built in. We could not evaluate until after the transition period had been completed.

Senator CHRIS EVANS—Yes. But, as I recall, we were supposed to save $5.7 million this financial year and $18.4 million next financial year.

Ms Badham—The ongoing savings are about $20 million a year. It will increase to $22 million over a period of four years.

Senator CHRIS EVANS—How am I going to be able to check whether or not that is working? You have this evaluation.

Ms Badham—That is correct.

Senator CHRIS EVANS—Will that be publicly available?

Ms Badham—I expect the results of the evaluation will be available, yes.

Senator CHRIS EVANS—In broad terms, how are you testing that?

Ms Badham—We are intending to do a couple of different things. One is to look at the percentage of scripts that are private scripts as compared to PBS scripts. People who do not have a Medicare number who still purchase medications will have to pay full price. So if the people who are not eligible—for example, foreign visitors—wanted to purchase the medication, they would have to do that as a private patient. There is some information available about the numbers of private prescriptions. We are also expecting to do a survey of pharmacists and ask them about the level of, if you like, turning away scripts. We have a certain level of anecdotal evidence that pharmacists have been identifying that some of their customers, including long-term customers, are ineligible as a result of this, but there is no qualitative evaluation of that yet.

Senator CHRIS EVANS—But you are confident that you will get a better qualitative hold on that evaluation.

Ms Badham—We certainly expect to, yes.

Senator CHRIS EVANS—What do you know about whether those savings have been realised?

Ms Badham—As I said, at the moment we have only anecdotal evidence.

Senator CHRIS EVANS—So you cannot actually measure whether the savings have been achieved?

Ms Badham—Looking at the fact that the private scripts are a higher proportion, for example, will give us an indication of how many prescriptions have become private that were previously paid under PBS.

Senator CHRIS EVANS—I am not trying to be argumentative, but presumably that only gives you part of the picture because you think that some people would not get a script filled at all as a result of losing the subsidy and therefore you would have no information on that.

Ms Badham—That is correct. But we have some of the pieces of the puzzle.

Senator CHRIS EVANS—Yes. Coming back to the financial aspect of it, is there any real way of testing whether those actual cost savings are met or is it going to be more general?

Ms Badham—It is impossible to tell the results of the evaluation before it has occurred.

Senator CHRIS EVANS—I accept that. But are you going to be able to get to dollar amounts or is going to be a more broad-brush evaluation?

Ms Badham—We are hoping to get to dollar amounts for the bits of the puzzle that we can measure.

Senator CHRIS EVANS—What about the rest of the implementation scheme? Is the rest of it going ahead as planned? Have there been any major technical difficulties? What do we know about chemists presenting with scripts that do not include Medicare numbers?

Ms Badham—The figures I have are for PBS claims processed during the month of May. Some of those were for drugs dispensed before the 1 May cut-off. But within the month of May, 2½ per cent of prescriptions were presented without Medicare numbers. But, as I say, until the next round of processing, we will not be picking up scripts that are after 1 May.

Senator CHRIS EVANS—So are you saying that those would actually not be rejected because they were filled before 1 May?

Ms Badham—Some of them, yes, Senator. The measure is for PBS claims for drugs dispensed on or after 1 May.

Senator CHRIS EVANS—That was when they cut off, basically?

Ms Badham—That is correct. The May processing includes some drugs dispensed in April and some dispensed in May.

Senator CHRIS EVANS—Do you assume, therefore, that the 2½ per cent of people would be likely to be your highest figure?

Ms Badham—I would expect June to be lower than that. The number has been decreasing every month anyway.

Senator CHRIS EVANS—Do I take it, therefore, that as a result of that, for some subset of 2½ per cent, you have had to send them back to the chemist and say, 'Bad luck, mate, you're not getting paid'?

Ms Badham—That is correct.

Senator CHRIS EVANS—How many of those are there?

Ms Badham—I do not have those figures with me.

Dr Harmer—We do not have those figures but we can provide those for you.

Senator CHRIS EVANS—I would be interested if you could take that on notice. Does anyone have a ballpark figure? You say 2½ per cent, but I am trying to get an idea of what we are talking about.

Dr Harmer—It is a relatively small number. The Health Insurance Commission, in administering this, has set up a hotline for pharmacists to call and check eligibility for Medicare and Medicare numbers. We are trying to assist to make sure that, if possible, we do not go through that rejection. I think it is probably relatively small.

Senator CHRIS EVANS—But, at the end of the line, despite the hotline, if they do not have a Medicare number on it—

Dr Harmer—They are rejected, yes.

Senator CHRIS EVANS—So there is no—

Dr Harmer—It is a risk to the pharmacist in filling the script if they do not have a Medicare card or cannot identify from us that they have an eligible Medicare number.

Senator CHRIS EVANS—So, apart from someone physically giving them the Medicare card at the time, is there any other way that the chemist can meet your requirement?

Dr Harmer—If they do not have a card with them the chemist can call us, give some details of name et cetera, and check whether they are Medicare eligible. We have been doing that. Our calls have increased.

Senator CHRIS EVANS—Even if they do not have a card?

Dr Harmer—I would need to check.

Ms Badham—There are actually several things that can occur. It may be, for example, that a consumer uses the same pharmacy regularly and they may have had their Medicare details stored with that pharmacy and they will not need to re-present their card. There is the hotline, as Dr Harmer was talking about, where a pharmacy, with a consumer's consent, can ring to obtain the Medicare details of the consumer. Consumers can also ring another hotline. There are special—

Senator CHRIS EVANS—So the pharmacy can ring and ask for the Medicare details of the consumer?

Ms Badham—Yes, with the consumer's consent. The consumer would be providing certain information, like their name and address, sufficient for the HIC to be able to identify that that is the correct person.

Senator CHRIS EVANS—So the pharmacy rings up and says, 'Here's Mr Chris Evans and here's his address; can you give me his Medicare number?'

Ms Badham—The pharmacy also has to have gone through a consent process.

Senator CHRIS EVANS—Sorry?

Ms Badham—The HIC hotline operator will also need to be satisfied that the pharmacist has asked for the consumer's consent.

Senator WEST—Did any discussions on this before this was started?

Ms Badham—No, Senator, they did not.

Senator DENMAN—Does that leave it open to abuse in any way? Are you monitoring that?

Senator CHRIS EVANS—You might recall we raised these concerns when we discussed the implementation of the scheme. I know the department was very sensitive to those concerns about privacy. That is why I was a bit taken aback, to be frank, because I understood that you had to produce your card—

Senator WEST—Yes, every time.

Senator CHRIS EVANS—The suggestion that somehow someone else rings up and gets the number rings a few warning bells with the committee.

Dr Harmer—I will get you the details of exactly what happens. I do not have those details with me. But, thinking about how dangerous it is, remember that all we will be giving would be whether that person is eligible for a Medicare card. We do not give any other details about

their prescription medication record or anything else. We simply say whether they are eligible for a Medicare card or are enrolled with Medicare.

Senator CHRIS EVANS—You do not provide the number?

Dr Harmer—I am not sure about that, Senator. I will check.

Ms Dunne—We have in place an arrangement whereby up until probably October we provide a hotline service to pharmacies. Pharmacists can ring and, with the permission of their patient—the person for whom the script is to be provided—provide details that would accurately and uniquely identify that person. The Medicare card number will be provided based on consent and authority to the pharmacist so that it can be included in that claim and therefore be paid.

Senator CHRIS EVANS—That really begs the question: how do you determine consent of the customer?

Ms Dunne—I do not have the details of the questions that we ask, but I can get them for you very quickly. We would ask for certain details that we keep on record, such as date of birth et cetera, perhaps even an address, just to make sure that that is the person for whom the inquiry is being made.

Senator CHRIS EVANS—I would appreciate those details. But, effectively, the person ringing up tells you, 'I've got the consent,' and you proceed on that basis. Is that correct?

Ms Dunne—That is so. I can get the details for you. There would be a certain set of instructions provided to our operators that would determine which questions would be asked to actually validate that as a consent.

Senator CHRIS EVANS—I would very much like a look at those. I think I made it clear before that I am actually in favour of expansion of those identifiers in the health system, but only with very, very appropriate privacy protection. I think it has been a concern of this committee that this is one toe in the water of that development. Most people thought when they knocked off the Australia card they had won the battle.

Dr Harmer—Let me reassure you that all the training of the Health Insurance Commission staff, including those who answer calls on the hotline et cetera, is very much about protecting first and foremost the privacy of the information of the patient. That is ingrained in our training. We have a very good reputation and record in protecting that and we will not do any damage to that, I can assure you.

Senator CHRIS EVANS—While I appreciate the assurance, I would also like to have a look at the procedures.

Dr Harmer—Certainly.

Senator WEST—I am sure the minister from previous estimates, by my recollection, would share your concern.

Senator CHRIS EVANS—They change when they get into government.

Senator WEST—I did not realise that.

Senator Patterson—The HIC could tell you I have not changed. I reminded them of the many speeches I have given on privacy.

Senator WEST—Yes, my memory was ticking over on that too.

Senator CHRIS EVANS—Ms Badham, were you able to get the figures on the rejections of scripts?

Ms Badman—I have figures on rejections of scripts supplied after 1 May. There have been 16,435 scripts rejected as a result of there being no Medicare number. This is 0.1 per cent of scripts processed in May.

Senator CHRIS EVANS—0.1 per cent?

Ms Badman—Yes, 0.1 per cent.

Senator CHRIS EVANS—Just take me through what that means, in effect, for the pharmacist.

Ms Badman—Assuming that the pharmacist cannot actually resubmit the claim and have it honoured— and in many cases they can because they have the Medicare number and they just did not supply it—

Senator CHRIS EVANS—As in the case of a regular customer who they can get it off next time?

Ms Badman—That is correct. So, assuming that the claim is never honoured, the pharmacist will have paid for the drug at whatever price, will have supplied it at the $22.40 or $23.50 rate and will not be reimbursed for the difference between the price paid and the scheduled price.

Senator CHRIS EVANS—But there is an opportunity for them to resubmit those claims?

Ms Badman—That is correct.

Senator CHRIS EVANS—What can you tell me about the experience from the pharmacist's point of view about how the system is working and what analysis has been done on that?

Ms Badman—We have been working very closely with, particularly, the Pharmacy Guild and other representative bodies. There has been extensive communication.

Senator CHRIS EVANS—Didn't they have an evaluation or something? I am not sure whether you did it or they did it. I thought there was a bit of an evaluation going out among pharmacists about how it had gone. Is that not right? It may have been a Pharmacy Guild initiative.

Ms Badham—Are you referring to the government's investigation of the administrative costs—the health care management adviser's report?

Senator CHRIS EVANS—I do not think so. I thought it was an assessment on this. But the costing arguments were one aspect of it, were they not?

Ms Badham—Yes.

Senator CHRIS EVANS—Is there a report on the costing?

Ms Badham—There is a report on the cost to pharmacy of the IME initiative, which I think is the thing you are referring to.

Senator CHRIS EVANS—Yes. Where is that at?

Ms Badham—That report has been presented to government.

Senator CHRIS EVANS—Has that been made public?

Ms Badham—It has not been made public. The government has not responded to it at this stage.

Senator CHRIS EVANS—You say that the government has not responded to it. What was the charter of that report?

Ms Badham—To look at the cost to pharmacy of actually administering the Medicare numbers on prescriptions and also the savings from some other measures brought in at the same time.

Senator CHRIS EVANS—But there were a range of budget measures last year which went to help offset those costs, were there not?

Ms Badham—That is correct.

Senator CHRIS EVANS—Are they continuing or do they end in this financial year?

Ms Badham—The largest one was the 10c prescription. That ended on 31 January this year. There was some funding for swipe card readers, which was a once off, and there was also funding for communications.

Senator CHRIS EVANS—Is there currently any ongoing funding to pharmacies as compensation for the costs involved in this measure?

Ms Badham—No, there is not.

Senator CHRIS EVANS—So the January end of the 10c prescription subsidy was the last of it?

Ms Badham—There is still a bit of communications money going to the Pharmacy Guild.

Senator CHRIS EVANS—Forgive me, but weren't there two subsidies? I remember Minister Wooldridge made an announcement about the subsidy rate. Was that just a renewal or was it a question of two different levels of subsidy on this issue?

Ms Badham—I am not sure to what you are referring.

Senator CHRIS EVANS—I will go back and check. So you are saying that all the measures that provided compensation for pharmacists for costs associated with this measure have now expired?

Ms Badham—That is correct.

Senator CHRIS EVANS—So is the review to determine whether there is any ongoing cost and whether there ought to be compensation?

Ms Badham—It is to determine whether there is any ongoing cost. Whether there is any need for ongoing compensation is a separate question.

Senator CHRIS EVANS—Did the report canvass only the question of getting a handle on whether there were any ongoing costs and, if so, what they were?

Ms Badham—That is correct.

Mr Maskell-Knight—I think the review actually had problems, in that they were reviewing pharmacists' experience while the transition period was still going on. My understanding of the report is that it actually said it had difficulty figuring out what the ongoing costs would be. One of the issues they raised was that, in some cases, pharmacists were not using the swipe card readers to capture the Medicare number, and there were a whole range of issues around that. This suggested that were still improvements that could be

made to pharmacy practice which would clearly have an impact on what the ongoing costs were.

Senator Patterson—It was a very large initiative, and we have seen the result in terms of the number of people who actually provide their card. The pharmacists have been very cooperative in that exercise, getting people to present their card and explaining why. When you were asking about the savings, one of the difficulties of teasing that out is that there are other factors which will be interacting in terms of savings. So to tease out the effect of just one initiative is quite difficult.

Senator CHRIS EVANS—I accept that, Minister. But, as you know, year after year we get PBSs like this, with very impressive savings on the PBS and other measures, and in the next year we get another set—and the PBS has gone up all the time. I accept that is because of other factors as well, but one of the important things it seems to me about this whole process is being able to test whether or not government initiatives actually do deliver what they say they are going to deliver. We have a whole set of assumptions here—forward and others—which are significant contributors to the bottom line. I am trying to get a sense of whether they are realistic and achievable, and one of the ways to do that is to see whether the ones from previous years worked. Part of the problem is whether or not we get good information on whether these things work or whether they really only have to survive the budget estimates round, hold up that long, and then the caravan moves on and no-one worries about them too much—except when Finance come around to have a chat with Ms Halton about it.

Ms Halton—You took the words right out of my mouth—they do.

Senator CHRIS EVANS—Or the minister goes to the ERC and gets a bit of a pummelling. I am really looking after your interests here, Minister.

Senator Patterson—I appreciate that. I knew that was the only motive. You are totally motivated to look after me. I really appreciate that, Senator Evans. If only it were true.

Senator WEST—Minister, I am horrified that you could think that!

Senator CHRIS EVANS—Could somebody tell me how the doctor shopping initiative will work—just to finish off that package of measures?

Dr Mould—We started the doctor shopping initiative in HIC some years ago. We were looking then at specific drugs—codeine compounds, benzodiazepines, narcotic analgesics—and people who visit more than a certain number of doctors and obtain more than a certain number of prescriptions in one year. Owing to the success of that program—which has actually identified savings—we felt that, because there were elements of the program that we wanted to expand, we would expand the program to include more drugs which are also subject to prescription shopping and to look at the number of visits made by patients.

Senator CHRIS EVANS—So you actually do it by way of identified drugs rather than by total volume?

Dr Mould—Yes. The first phase of the doctor shopping program was aimed principally at drugs which are abused or sold. As I said, they are drugs which are open to abuse.

Senator CHRIS EVANS—Do you have a list of those?

Dr Mould—Yes. As I said, they are benzodiazepines, like Valium; codeine compounds, like Panadeine Forte or oxycodone; and the narcotic analgesics, like morphine, pethidine and MS Contin.

Senator CHRIS EVANS—And you are now going to add to that list?

Dr Mould—We are going to add to that list. We have a number of drugs in mind. We have not as yet firmed up on the particular drugs.

Senator CHRIS EVANS—What are the candidates? Can you give me some idea of the candidates?

Dr Mould—They are drugs that are again high use and high cost. Possibly we will expand the roll into some of the sedative range—not just the benzodiazepines—and perhaps some of the lipid lowering drugs. As I said, we have not firmed up on the list yet. We will do that over the coming months when this measure gets under way.

Senator WEST—Is this announcement or particular part of the package to crack down on overprescriptions or to monitor that?

Dr Mould—It is not specifically addressed at that. That is contained in other measures. This measure is designed specifically, as I said, for patients who deliberately visit a number of doctors to obtain excessive numbers of prescriptions for whatever reason.

Senator WEST—There was an article, I think in the *Herald Sun*, which mentioned doctor shopping and cracking down on overprescription. Have you seen that article in the *Herald Sun*, I think of 30 May? Mr Rennie gets quoted. It is said that there is going to be a crackdown on overprescription.

Senator Patterson—Who was the article by, Senator West?

Senator WEST—Andrew Probyn, I think.

Senator Patterson—I think he was just doing a summary—I cannot remember; he wrote a number of articles—of the whole package. That headline was probably slightly sensational—for example, the manufacturers putting on their advertising the guidelines for taking Zyban; that is, that it be taken in conjunction with an intensive comprehensive program. I cannot remember the exact words of the guidelines.

Senator WEST—No, I think we are on different—

Senator Patterson—No, I think what he was talking about the crackdown—he called it a crackdown—on increasing doctors' awareness of the guidelines. They were the sorts of things. I think he referred to them as crackdowns. But it may be another article.

Senator WEST—This is about tightening drug subsidies, a crackdown on overprescribing and the prescription guidelines for 20 specifically listed treatments. Mr Rennie, you presumably have some idea of what I am—

Mr Rennie—I was mentioned in there, yes.

Senator WEST—Yes, you get a mention in despatches.

Mr Rennie—Yes, that is right.

Senator Patterson—We have actually just been through all that with Senator Evans in terms of what we are doing in the next budget year and the budget year after with a particular group of medications.

Mr Rennie—Yes, that is what it is about.

Senator Patterson—We have just literally been through it.

Senator WEST—That is fine. I was out of the room for a bit, so I am sorry if we are actually revisiting something here. Mr Rennie might like to make some comment, as he gets a mention in despatches. The whole article is fairly negative. I would have thought, Minister, given your feelings about some of the articles that have appeared lately, you would have been well on top of this one. Mr Rennie, do you have any comments to make about the accuracy of the article?

Senator Patterson—I have read them all, Senator.

Mr Rennie—Essentially, the article was around the budget measure that I explained previously, around the four drug groups. I was quite happy with the way I was quoted in there—but not so much the start of the article.

Senator WEST—Okay, that is fine. If it has already been dealt with that is good.

Senator Patterson—The article says:

Mr Rennie said the clampdown would not stop doctors prescribing the drugs outside the guidelines but that in such circumstances the patient would not be able to claim the PBS subsidy.

Senator WEST—That was well down the article, Minister. You had to read half the article or more to actually get to the authoritative—

Senator Patterson—I am sure, Senator West, that if we were as inaccurate as some of the examples that have been shown today we would be called to task—on both sides I am talking about.

Senator CHRIS EVANS—What of the suggestion, though, that particular people would not be able to get the drug on the PBS?

Mr Rennie—That is the aim of the measure: if they do not meet the guidelines of the measure then it is not subsidised under the PBS. The drug would still be available through private prescription from a doctor outside the PBS.

Senator CHRIS EVANS—Yes, but the kernel of the argument, is it not, is that it is a question about whether they should be being prescribed that drug for that condition?

Mr Maskell-Knight—I think the kernel of the argument is that there are people who are being prescribed drugs which have been subsidised by the PBS, when the rules around the PBS say the government has taken a decision not to subsidise drugs outside particular circumstances. Take, for example, Celebrex. We suspect—anecdotally and all that—that there are many people receiving Celebrex for any old muscular ache and joint ache rather than for arthritis. The government has taken a decision that it does not want to subsidise Celebrex, but it is still open to a doctor to prescribe that outside the pharmaceutical benefits arrangements.

Senator CHRIS EVANS—But it might also be possible for them to prescribe a drug that is designed for any old ache or pain that is listed on the PBS for that condition?

Senator Patterson—Yes.

Senator CHRIS EVANS—That is what I wanted to establish. I do not think it had been clear before.

Senator Patterson—Senator Evans the thing is too that it is the PBAC that makes that recommendation and argues that, in terms of cost-effectiveness and efficacy, for some conditions there may be a medication which is equal and appropriate and cheaper. That is exactly that case: for a strained ankle, a cheaper anti-inflammatory may be just as effective because you are not taking it long-term. One of the effective things of the COX II medications

is its claim that it reduces gut problems and kidney problems. But if you are only taking an anti-inflammatory for a week because you have got a strained ankle it is less likely. That is why it is prescribed in that way.

Senator WEST—What about those who are having idiosyncratic reactions to particular drugs? Will there be a mechanism whereby that issue can be overcome?

Mr Maskell-Knight—I am not quite sure what you are getting at, Senator West. Can you elaborate?

Senator WEST—Various individuals react in various ways to various medications and have idiosyncratic reactions and disease paths. Come on, some of the doctors here, you are all quiet.

Mr Maskell-Knight—There is a range of drugs. For most conditions under the PBS, there is quite a range of drugs available. I would be amazed if, within the PBS remit, doctors could not find a drug that would avoid a patient's idiosyncratic reaction to one of the others. There are probably some conditions for which there is only one drug subsidised under the PBS, and in those circumstances there may be there is only drug full stop. I still cannot see quite what the concern is?

Senator WEST—I would have thought if you were having an idiosyncratic reaction to a particular drug that the medical profession might feel that it has a need to have just a little bit of flexibility to ensure that they are prescribing optimally for maybe one or two very unusual situations. What processes have you put in place? Is that going to be taken care of?

Mr Lennon—I think that situation is taken care of by reference to the considerations that Mr Maskell-Knight indicated—that is, that there is a range of drugs and often a range of different brands of drugs available on the PBS. So, if a patient has an idiosyncratic reason to a particular drug or a particular brand of a drug, in general there will be plenty of options available for the prescriber to prescribe another drug available on the PBS which is subsidised for that condition.

Senator WEST—Fine, that is the reassurance I am seeking, because if you have someone who has an idiosyncratic reaction you do need to be able to take care of their needs as well.

Proceedings suspended from 12.48 p.m. to 2.03 p.m.

CHAIR—I call the meeting to order. We will proceed with outcome 2.

Ms Halton—Before we start with questions, I wonder if I could table some material. We took some questions last night, and we said we would come back today. There is a letter from Professor Pettigrew to Dr George Stone of the NIH, there is some information regarding the NHMRC project grant relating to chronic fatigue syndrome and there is the NHMRC press release in relation to allegations of scientific fraud.

This morning we referred to the Australian Institute of Health and Welfare studies on disease specific costs. I can now tell you what they are; we did not have the precise detail this morning. Firstly, there is a publication entitled *The burden of disease and injury in Australia*, dated November 1999. Then there is *Health system costs of cancer*, which, similarly, is a 1999 publication and, finally, *Health system costs of injury*, which is also a 1999 publication. We also table some material in relation to antibiotics, which is available as well. There is also *Evaluation of the national prescribing service in achieving savings to the Pharmaceutical Benefits Scheme*, dated February 2001.

Senator McLUCAS—Ms Halton, did you list a set of publications in answer to questions I raised?

Dr Morauta—If I might remind you, Senator, it was about whether we had information on the full costs of disease. I think your question was around those suffering chronic disease.

Senator McLUCAS—Yes.

Dr Morauta—This was some information in that area that we knew of, so we just provided it for your information.

Senator McLUCAS—Thank you.

CHAIR—Are there any further questions on outcome 2?

Senator McLUCAS—I have a question about Zyban. I know we have traversed that earlier but we have come back. I am advised that the active ingredient in Zyban, bupropion hydrochloride, is an antidepressant. You give doctors information that you ask them to pass on to their patients, and we talked about the quit smoking programs and those sorts of things earlier. Do we also tell them that they are receiving an antidepressant?

Dr Primrose—I did not quite catch the second part of your question.

Senator McLUCAS—I understand that the active ingredient is a commonly used antidepressant. Is that correct?

Dr Primrose—Yes. Bupropion was developed as an antidepressant, that is true.

Senator McLUCAS—I am interested that so many people are taking Zyban. Do they all know that they are taking an antidepressant? When we did an analysis of Zyban and its usefulness, did we also factor in that side effect of giving a whole range of people who are not depressed, potentially, antidepressants?

Dr Primrose—The drug will not have any antidepressant effect unless the people are depressed coincidentally, which of course most of the people will not be—they have a tobacco dependence or addiction, but they are not depressed. In general, drugs have a multitude of effects beside their therapeutic one. Sometimes drugs can have more than one therapeutic effect, for example ACE inhibitors are used to treat high blood pressure and also heart failure. So obviously, if somebody has heart failure due to severe hypertension, it is a very good drug to use. Most of the time, though, the other pharmacological effects of a drug are side effects—they are adverse effects. I think that probably most prescribers are not aware of the use of bupropion as an antidepressant. That is not its use in Australia; it is for tobacco dependence. But I do not think that is an issue. The side effects of the drug are things that people would be made aware of either by the doctor or the pharmacist or by the consumer product information that comes with it.

Senator WEST—What are the interactions that Zyban has with other medications if it is an antidepressant? What about other antidepressants or other tricyclics?

Dr Primrose—I am not sure about that. I am not a pharmacist. I think we will have to take that on notice.

Senator WEST—That is okay. But multipharmacy and the issue of drug interactions and contraindications are not an insignificant problem.

Dr Primrose—The drug product information and the consumer medicines information would have complete advice about the range of adverse effects and drug interactions. The consumer product information would have the most common ones.

Senator McLUCAS—Thank you.

CHAIR—What happens if the person is on antidepressants already?

Senator WEST—That is what I was alluding to.

Dr Primrose—I think we would have to take that on notice, because there is the risk of adverse interaction. You are right: some classes of antidepressants are contraindicated in the presence of others.

Senator WEST—And other tricyclics.

Dr Primrose—SSRIs and tricyclics would be a classic example, so we would have to check that one.

Senator McLUCAS—But essentially you are telling me that if the person is not depressed and they take Zyban it will not affect their mental state?

Dr Primrose—It will not make them euphoric, if that is what you are asking.

Senator McLUCAS—Maybe they will be happy about not smoking.

Senator WEST—Maybe we should all be given a dose here.

Dr Primrose—Antidepressants are not mood elevators in that sense. They actually correct the biochemical imbalance that causes the depression. They are not like amphetamines, which actually do cause euphoria.

Senator McLUCAS—A review of the pharmaceutical wholesalers is occurring. Can you give me some background to where that is up to, please?

Mr Lennon—Yes, I can. In the budget before the most recent one, the government took a decision that it was going to lower the margin which wholesalers receive—which is a 10 per cent margin at the moment—under the PBS for distributing pharmaceutical products to community pharmacies. That was announced in the budget and, subsequent to the budget, negotiations were undertaken with wholesaling groups and also with the Pharmacy Guild of Australia, which represents community pharmacy. There were some concerns raised about the measure having an adverse impact on the ability of wholesalers to continue to provide the standard of service that they are currently providing to community pharmacies. As a result of that, the then health minister, Dr Wooldridge, agreed that there should be a review undertaken of the budget measure and of the effectiveness and efficiency more generally of the wholesaling function under the PBS.

That review was set up in late 2001 and contains representation from the National Pharmaceutical Services Association, which is the peak wholesaling group; the Pharmacy Guild of Australia; and Direct Generic Medicine Distributors, which is responsible for distributing certain medicines direct from the manufacturer to community pharmacies without the wholesale intermediary. The review is chaired by the Hon. John Mathews, a man of considerable expertise and experience in the wholesaling area. The Department of Health and Ageing is also represented on the review group.

The review group has called for public submissions and received one public submission. All of the main stakeholders who are on the review reference group also put submissions in, but in their capacity as review reference group members. So we have had submissions from all the main stakeholder groups. We are in the process of writing up a report, which is looking at analysing the current arrangements in terms of their efficiency and effectiveness and looking at options for improving those arrangements. We expect to be in a position to provide

a report to the minister within the next one to two months. It would then be a matter for the minister to determine where to take it from there.

Senator McLUCAS—What savings were expected through the renegotiation of those wholesaling arrangements?

Mr Lennon—The anticipated savings from reducing the wholesale margin were never made publicly available. They were included in the budget figuring and included in their contingent reserve item explicitly because it was felt that—given the fact that the department needed to negotiate these savings with the wholesalers—it was not particularly appropriate to indicate the sorts of savings at the end of the day that you thought were achievable in the budget figuring. We have not made those numbers publicly available or available to any member of the review reference group at this point in time, so I am not able to provide that figure to you.

Senator McLUCAS—But you can tell me that those savings were not achieved?

Mr Lennon—The savings have simply been moved out by a period of months in terms of their achievement. I think it was originally in May this year that the savings were due to kick in and they have been moved out by a period of six to eight months from memory. They have not been achieved to this point in time but the intention is that, as a result of this review of the efficiency and effectiveness of the current wholesaling arrangements, we will improve those arrangements and provide a mechanism for achieving savings, amongst other things.

Senator McLUCAS—When the report is made available to the minister and has gone through that process, is it the sort of report that would come to this committee or be made available to the committee?

Mr Lennon—The decision as to whether or not to make the report public would need to be taken at the time, in the light of what the stakeholders who were involved in the review reference group might want. They will probably have views about whether to make it public or not. The department will have views and, no doubt, the government will have views. So it is not really a question I can answer at this point in time.

Senator McLUCAS—Can you give me a quick explanation of the pharmaceutical health and rational use of medicines program?

Mr Rennie—There is an advisory body to the minister called that. As far as a program—

Senator McLUCAS—Sorry; it is not a program?

Mr Rennie—I am not aware of a program by that name, Senator.

Senator McLUCAS—I understand. Can you tell me who is currently on the board?

Senator Patterson—Of what?

Senator McLUCAS—Of the Pharmaceutical Benefits Advisory Committee.

Mr Rennie—It is a committee, not a board. It is an advisory committee to the minister. I do not have those details with me of the committee membership but I can certainly provide those this afternoon, Senator.

Senator McLUCAS—Thank you I think I will put these questions on notice.

CHAIR—Are there any other questions on outcome 3?

Senator McLUCAS—Yes. Minister, earlier today you were talking about drugs that you are expecting to come onto the list. Can you tell me how many drugs have been approved by the PBAC and the PBPA and are currently awaiting approval for PBS listing?

Senator Patterson—We would need to take that on notice because at any one time it is an interim phase, and I do not know exactly. The PBAC has just met or is just about to meet, and I would not want to lead you astray; so we will take it on notice.

Mr Lennon—The minister is quite right in saying that at any stage in a process there is normally particular drugs that are going through the approval process. The process takes seven or eight months in total. You start with the submissions before the committee. Once the committee recommends the drug, it then goes before the pricing authority. Once the pricing authority has taken decisions and the government is happy, we need to do the negotiations with the manufacturers, to make sure the price is acceptable to them. At this point in time—we have a Pharmaceutical Benefits Advisory Committee meeting today—we are at the end of one process. There are still some drugs for which the committee and the authority have made some recommendations. We are in the process of discussions and negotiations with pharmaceutical manufacturers about the pricing arrangements for those. There is not a large number. There would be less than half a dozen, I would have thought.

Senator McLUCAS—So it is basically the negotiations of price that delay what is usually a seven-month process?

Mr Lennon—Sometimes that is correct. It would typically be negotiations around pricing that would cause a delay, if there was a delay around the typical process, yes.

Senator McLUCAS—What other reasons delay listings?

Mr Lennon—Drugs have to go through a process called assay, where they must be determined to be of a certain quality etcetera. It is a process that happens after listing and pricing to determine that they are of suitable quality—that they are what they purport to be—for PBS subsidy. That sometimes takes a bit of time. Overwhelmingly, I would think that if there is a delay caused, it is around issues over the price of the drug and an inability to reach agreement on a price.

Senator McLUCAS—Once the PBAC recommends to the minister that a drug should be listed, how long does that process usually take?

Mr Lennon—The normal process is that the PBAC would recommend that a drug be listed, but then it has to go through the pricing authority to get an appropriate price. That would take another month or so, at least. Then there would normally be another cycle of up to three months before it went on for listing. It has to go through the government approval processes and get listed in the pharmaceutical benefits schedule. So, roughly, if you are talking about times, that would be it. Until it is listed in the pharmaceutical benefits schedule, it would probably be three to four months from the time of approval by the Pharmaceutical Benefits Advisory Committee, to going through the processes of the pricing authority giving approval, to getting the relevant government approvals, to getting it in the pharmaceutical benefits schedule, which is distributed regularly during the year.

Senator McLUCAS—When you give me the other list of drugs awaiting approval between the PBAC and the PBS , could you also tell me how many drugs are waiting in the system, between completed negotiations and ministerial approval?

Mr Lennon—Yes, I can.

Senator McLUCAS—I understand there are some asthma management drugs in that delayed situation. Is there anything untoward or unusual about the delay we are experiencing to do with those drugs?

Mr Lennon—There is a particular drug for the treatment of asthma that has received a recommendation from the Pharmaceutical Benefits Advisory Committee, subject to meeting certain conditions. It has been through the pricing authority, again with conditions attached to it. We are now at the stage of trying to finalise the arrangements for the drug, particularly around the pricing of it. Those arrangements have not been finalised at this time. As a result, the particular drug has not progressed to the point of being listed on the schedule. There is also a general requirement that, where drugs cost in excess of $10 million per year or are estimated to cost that, they need to go through a cabinet process. That also is part of the government decision making process.

Senator McLUCAS—Does that affect this particular asthma drug?

Mr Lennon—Yes, it does affect that particular asthma drug. But we are still at the point of discussions around pricing. If the pricing arrangements can be agreed, the cost of that particular asthma drug would be estimated to cost in excess of $10 million per annum to list and therefore would require the further stage of the process of cabinet consideration before it could be listed.

Senator McLUCAS—Could you give me the time line of how that particular asthma drug has gone through the process, on notice?

Mr Lennon—That particular asthma drug went up several times to the Pharmaceutical Benefits Advisory Committee and was rejected several times. It was eventually accepted, subject to certain conditions. From that point it has gone through the pricing authority and is now at the stage that I described to you.

Senator McLUCAS—Thank you.

Mr Maskell-Knight—We have got the list of the committee members now, if you would like us to give you that.

Senator McLUCAS—Could you please table that and I will pursue those other issues on notice? I would like to follow up the reference to the issue of the GST savings that were budgeted for and not subsequently achieved to the ACCC. Can you tell me where, from the department's point of view, that is up to?

Mr Lennon—Yes, I can. There have been discussions with the ACCC about that matter with the department. I understand there has also been discussions with the peak representative group for manufacturers, the Australian Pharmaceutical Manufacturers Association. I believe that the ACCC is still considering the matter.

Senator McLUCAS—Considering whether to conduct an inquiry?

Mr Lennon—It is conducting some process of discovery and going through an assessment process. That is where it is at. It has actually started its work and it has interviewed representatives of the Department of Health and Ageing as well as the Australian Pharmaceutical Manufacturers Association, as part of that assessment process.

Senator McLUCAS—Were the direct threats to withdraw pharmaceuticals that were made around the time that this issue bubbled up reported to the ACCC?

Mr Lennon—I cannot comment on the matter of what other stakeholders who may have talked to the ACCC may have said. From the department's point of view, we simply went through the facts of the situation. They were that a decision was taken to implement this particular budget measure and to achieve savings, which did require price reductions, and that the pharmaceutical manufacturers resisted those price reductions. We were able to achieve some, but not all, of them in the first year and have not been able to achieve any more subsequently. So we simply reported the facts from the department's point of view.

Senator CHRIS EVANS—You didn't initiate the reference to the ACCC, though, did you?

Mr Lennon—The department did not, no.

Senator CHRIS EVANS—Did they do that on their own initiative?

Mr Lennon—My understanding was that they may have been asked to look into the matter by another party. It certainly was not something that was initiated within the department anyway.

Senator CHRIS EVANS—So Health did not initiate the ACCC being called in?

Mr Lennon—It was not done by Department of Health and Ageing officials.

Senator CHRIS EVANS—So what have you done to pursue the savings?

Mr Lennon—The department has pursued the savings to the maximum extent it can. In the first instance, the department wrote out to the companies in the first year and informed them of the government decision and of the need to reduce their prices. We were able to get some companies to do that—mainly generic manufacturers. As a result of that, we were able to achieve some savings during the year, but the other manufacturers were not prepared to agree to a reduction in prices, at which point the only sanction that the department or the minister had was to take the particular drugs off the Pharmaceutical Benefits Scheme, which they were obviously not prepared to do.

There was an agreement that, for the second year, when there were somewhat higher savings required, a process would be auspiced by the Pharmaceutical Benefits Pricing Authority. This process was that we would have a look at a consultancy that was to be done by Econtech, which was the group that advised the Treasury originally around the GST savings and the embedded wholesale sales tax savings as part of those. The Econtech study was done and it indicated that certain savings were available. But it was the view of the manufacturers, again, that, on the basis of that study, they did not think they should be required to undertake further price reductions. Since that time, we have had the ACCC process, whereby the ACCC has got involved and has gone through a process of discovery and assessment of the facts. And I guess that it will be up to the ACCC in the first instance about where it takes the matter from here.

Senator CHRIS EVANS—Can I just take you back, so I understand it? When you say that you pursued them and wrote to them, does that mean you wrote to them and said, 'Dear AAA Drug Company, please reduce your price on Celebrex, Zyban et cetera by 30c'? Or was it, 'Would you please apply the projected GST savings'? What sort of level of detail was involved?

Mr Lennon—It was the former rather than the latter, Senator. We advised them about what the expected price reduction was in the first year, which was one per cent, and that they would need to take that price cut.

Senator CHRIS EVANS—So was it one per cent across the board, across all products?

Mr Lennon—Across all products for the first year.

Senator CHRIS EVANS—And what was it in the second year?

Mr Lennon—Three per cent.

Senator CHRIS EVANS—So it was expected that each and every one of their products that was PBS listed would be reduced by one per cent and then by a further three, or by a total of three?

Mr Lennon—A total of three.

Senator CHRIS EVANS—And you say that some, mainly the producers of generic brands, did that.

Mr Lennon—Yes, that is right.

Senator CHRIS EVANS—And did the others ignore you, or did they write back to you and tell you what you could do with your suggestion?

Mr Lennon—No. They wrote back and indicated that they did not think the savings that were indicated were of that magnitude and, therefore, did not feel that the price cut was justified.

Senator CHRIS EVANS—Was there a consistency of approach across the drug companies on that matter?

Mr Lennon—There was a general consistency, yes.

Senator CHRIS EVANS—Do you have an understanding of why the generic manufacturers applied and the others did not?

Mr Lennon—We were more successful in our negotiation process with the generic manufacturers.

Senator CHRIS EVANS—I see. What was the level of their understanding or appreciation of the need to reduce their prices prior to this? Was that negotiated with them?

Mr Lennon—There was no negotiation process prior to the budget; this was a budget measure.

Senator CHRIS EVANS—The GST?

Mr Lennon—Embedded wholesale sales tax savings arising as a result of the introduction of the GST, yes.

Senator CHRIS EVANS—I am trying to get to whether there had been a discussion with the pharmaceutical manufacturers as to your expectations. Was there any acceptance by them that, all things being equal, this saving would be passed on?

Mr Lennon—The intention was never that the saving would be passed on; it was always intended that they would take real price cuts because they got real savings. The savings were estimated on the basis of Treasury modelling not just across the PBS program or, indeed, the Health portfolio but across government generally. So it was part of a bigger savings exercise.

Senator CHRIS EVANS—I understand that; I think Senator Knowles and I debated it round and round the country, time and time again. I am going to tell her, 'I told you so,' at the end of this—we will have that argument privately no doubt. I am trying to understand what the pharmaceutical manufacturers' involvement was. Prior to them getting the letter from you which said, 'Please reduce your prices by one per cent, in accordance with the government's

plans,' had there been a consultation, negotiation, involvement, discussion or agreement process?

Mr Lennon—No, there had not been because this was a budget measure. As you will appreciate, there is usually no process of consultation and dialogue before the announcement of a budget measure.

Senator CHRIS EVANS—As you said that, MRI came to mind, didn't it? To be fair to them then, the first they heard about it was when you wrote to them saying, 'Cut the prices.' Is that fair?

Mr Lennon—We explained the basis of the decision and asked them to move forward and assist with the introduction of a budget measure; that is correct.

Senator CHRIS EVANS—But is it fair to say that they would not have had much warning prior to that, or any involvement? I want to be fair to them. I had assumed that there had been, so I am a bit surprised that there had not.

Mr Lennon—I think that that is a reasonable thing to say.

Senator CHRIS EVANS—You wrote them the first letter, and they did not comply. What happened after that?

Mr Lennon—Some of them did comply.

Senator CHRIS EVANS—What percentage of the market does that represent?

Mr Lennon—We achieved savings of $11 million, out of an expected $26.5 million, in the first year. As for the rest who did not comply, we pressed the matter with them unsuccessfully. The decision was then taken that we would move forward—through the Pharmaceutical Benefits Pricing Authority—to have a look at this consultancy through Ecantech, which was going to have a look at the savings that might be available.

Senator CHRIS EVANS—Was it agreed with the industry that that would be the way of progressing it?

Mr Lennon—Yes, that was agreed with the industry.

Senator CHRIS EVANS—Who paid for that?

Mr Lennon—That was paid for by the industry.

Senator CHRIS EVANS—You commissioned it jointly?

Mr Lennon—The authority debated various ways to try to get this information. Because the industry already had some of this work in motion and Ecantech was a very reputable organisation that had already done a lot of the initial modelling work for Treasury, we took the decision that we would allow that to proceed as a basis for having a look at what had happened in practice.

Senator CHRIS EVANS—But the industry picked up the bill. Did you jointly determine the terms of reference for the study?

Mr Lennon—There was an understanding between ourselves, industry and the other authority members in terms of the content.

Senator CHRIS EVANS—But, in the end, they formally commissioned the study?

Mr Lennon—They did, yes.

Senator CHRIS EVANS—When was the study completed?

Mr Lennon—The study was completed towards the end of last year.

Senator CHRIS EVANS—Can you be any more specific than that?

Mr Lennon—The results of the Ecantech study were provided to the PBPA in August 2001.

Senator CHRIS EVANS—What flowed from their consideration of that?

Mr Lennon—There was a view from the industry that there was not sufficient justification in the Ecantech study to proceed with offering further price reductions.

Senator CHRIS EVANS—That was the industry view. I guess you would say, 'They would say that, wouldn't they?' What was the department's view or the PBAC's view?

Mr Lennon—The Ecantech study did indicate that there were savings of around one per cent from the reduction in prices of non-capital items, following the introduction of the new tax system. But it also concluded that, over the period, there were other impacts which were acting to increase prices. Those included higher world oil prices and the depreciation of the Australian dollar. So there were issues around disentangling the effects of the savings from the abolition of an embedded wholesale sales tax vis-a-vis other cost factors.

Senator CHRIS EVANS—So, even before that complication, the study found that there was only one per cent rather than the three per cent—is that it?

Mr Lennon—No, the Ecantech study also noted that long-term savings of around three per cent would be achieved by the industry in input costs as a result of the reduction in prices of capital items flowing from the new tax system. But that would not be achieved immediately; it would be achieved over a period of years.

Senator CHRIS EVANS—Basically, though, their findings confirmed their original proposition that it would be a smaller increase in savings at the start of around one per cent, but that three per cent over the longer term was still a reasonable conclusion.

Mr Lennon—I think the issue was around how quickly the three per cent would show up, how quickly the capital replacement would happen.

Senator CHRIS EVANS—What was their judgment on that in this second report?

Mr Lennon—That it would take some time.

Senator CHRIS EVANS—Is that the conclusion: that, therefore, the three per cent saving in the second year was optimistic?

Mr Lennon—I do not think they went that far. They made some broad conclusions.

Senator CHRIS EVANS—Could you characterise it by saying that they thought it was probably more sustainable over a greater number of years to mount that argument about that saving?

Mr Lennon—They took the view that it would take longer than an additional 12 months to get the full three per cent.

Senator CHRIS EVANS—What happened then? You have the report. Industry say it proves their case. Clearly, from what you have told me, you and the government say it does not. What happened then?

Mr Lennon—The ACCC became involved in the matter.

Senator CHRIS EVANS—Have you decided, as a result of that, to leave the matter in the hands of the ACCC?

Mr Lennon—I think we want to hear the results of the ACCC's work before we take the matter any further.

Senator CHRIS EVANS—Is there anything else that you are currently doing to pursue those price reductions?

Mr Lennon—No. We are awaiting the results of the ACCC's work.

Senator CHRIS EVANS—So what is your estimation now of the savings? You told us last year, I think, that you saved $11 million rather than the budgeted $26.5 million. Was that for 2000-01?

Mr Lennon—Yes, that is correct.

Senator CHRIS EVANS—What are you budgeting for savings now, in 2001-02?

Mr Lennon—We have not included any higher savings than the original—just the straight $11 million, which is an ongoing saving. We have adopted a conservative attitude, pending the results of the ACCC report and what might flow from that.

Senator CHRIS EVANS—So you are working on the basis that what you have now is all you are going to get, subject to something else happening?

Mr Lennon—It is all that we could confidently predict for estimates purposes. We took that decision some six months or so ago.

Senator CHRIS EVANS—I think the original estimate was $288 million over four years, wasn't it?

Mr Lennon—I think the original estimate was $26 million in the first year and $60-odd million in year 2, so it was about at least $200 million—probably $250 million—over the four years. I am just pulling those numbers out of my head but I think they are basically accurate.

Senator CHRIS EVANS—Yes, I have $288 million written down here, but I would not argue with you about it. Do you have any idea of the time frame on the ACCC progression of matters?

Mr Lennon—They have not given us an indication of when they expect to report on the matter.

Senator CHRIS EVANS—Thank you, Mr Lennon.

Senator WEST—The next question I have is on the pathology lab accreditation for Pap smears. We asked some questions about this last time.

Dr Morauta—Have you finished dealing with the PBS now?

Senator WEST—I think so.

Dr Morauta—Can we let those people go?

Senator WEST—Yes.

Dr Morauta—Thank you.

Senator WEST—If we have missed any questions, they will have to go on notice. We dealt with pathology lab accreditation a bit at the last round. I want to know what the latest

situation is with the accreditation, because we have had some labs that have not done as well as they should have, haven't we?

Dr Harmer—The process with the accreditation of pathology labs is this: the Health Insurance Commission is the body that makes the decision, but we make the decision on the basis of a report from an independent group called NATA, the National Association of Testing Authorities. I am not sure how long they have been operating, but over a period there have been three laboratories which have received adverse reports from NATA. One of those laboratories has gone out of business and so there are two remaining that have received adverse reports. The Health Insurance Commission has acted in both cases to try to remove accreditation, particularly of GDL for Pap smears because the NATA evaluation indicated that there was some question mark about the way that lab performed its testing. That lab has not been performing Pap smears since March, I think.

Senator WEST—That is March 2002?

Dr Harmer—March 2002, yes. The other lab was a lab in Sydney called Medtest, whose accreditation we attempted to remove in March this year. They appealed to the AAT, which they are entitled to do, and received a stay, so that lab is still operating. There has been a subsequent NATA assessment of this lab, but we are not yet satisfied from that report that they should receive from us a new accreditation or authority to perform tests and receive Medicare payments.

Senator WEST—So GDL are not performing Pap smears?

Dr Harmer—They are not performing Pap smears that attract a Medicare rebate.

Senator WEST—And Medtest still are?

Dr Harmer—Medtest still are.

Senator WEST—Even though you are not satisfied with their standards? You are not happy with the results you are getting from the national testing mob, even to date?

Dr Harmer—There was a slight difference in the results of the NATA investigation. With GDL, there was quite specifically a dissatisfaction with the quality of their Pap smear testing. That was one of the key planks of NATA's concern about that lab. With Medtest, the NATA review revealed a range of concerns around staffing, quality of labelling and a range of other measures in their battery of assessment tools. There was nothing in particular about their Pap smear testing that concerned NATA, other than the way they operated with supervision and staffing. So we certainly were not happy with them continuing to operate, but we were not as concerned about their Pap smear testing as we were about GDL's.

Senator WEST—Are you aware of whether GDL is still undertaking Pap smears—still receiving samples for testing?

Dr Harmer—No, I do not know. They are certainly not claiming from Medicare for Pap smears and have not been since 31 March.

Senator WEST—When a woman has a Pap smear, which nobody enjoys, and her doctor sends it off to a laboratory, the woman has no say as to which laboratory it goes to. Nor would she have any knowledge unless she were in the industry, and there are not too many who are in the industry. What are we doing to make sure that women who were tested by GDL and, to some extent, Medtest are getting a repeat screen somewhere to make sure that they are not given dodgy results—presumably a false negative rather than a false positive—but are given accurate results they can have confidence in? What are we going to do to ensure that this

happens and that there are not still women out there today having Pap smears with their GPs that are being sent off to GDL? Getting a bill might make her a bit annoyed, but the issue of greater concern to me is the standard and accuracy of the test.

Dr Harmer—Indeed. A GP would not be sending it off to GDL at the moment, given the publicity and the fact that their accreditation has been removed and they have stopped receiving Medicare rebates for Pap smears. That would be fairly well known. GDL operates in Melbourne, and its reputation would be fairly well known amongst doctors in Melbourne. There was quite a lot of publicity about it at the time. We had a hotline for women to check with their doctor. I expect doctors would have been behaving in a way such that they would tell the patient whether they had sent their test to GDL, in which case they would probably have recommended a new screening test. Mr Maskell-Knight may have more information.

Mr Maskell-Knight—I could elaborate somewhat on other activities that have been going on. In relation to GDL, the Pathology Services Accreditation Board of Victoria, which is a state instrumentality, sent letters to about 15,000 women who had a Pap test reported by GDL during 1998 and 1999 and have not had a later Pap test done by someone else. Those letters were sent on 18 March. There was then, as I understand it, a further NATA performance report dated 4 April. As a result of that report, the Victorian minister Mr Thwaites announced that the Victorian department would be writing to women who had had smears from 2000 through to March 2002. I am advised that about 26,000 women were expected to be covered by that. In addition, the Victorian department also wrote to the general practitioners who had referred those tests. So we believe that both the doctors and as many women as were registered with the Pap smear register in Victoria would have received personal advice about the circumstances.

Senator WEST—What about Medtest, though? They are taking it through the AAT, and NATA has general concerns about their standards. I understand that they did not quite fail the NATA inspections but that concerns were raised about them in 1998, 2000 and then again in April of last year. What has happened with Medtest?

Mr Maskell-Knight—In relation to Medtest, in terms of communication, the Commonwealth Chief Medical Officer wrote to doctors in New South Wales over the weekend of 16 and 17 March informing those doctors of the concerns about the overall quality of Medtest. The New South Wales cervical screening register then wrote to the women registered with them who had had their most recent Pap test reported by Medtest. There is something of an issue which we are still considering in that for some reason the proportion of women who had their smears carried out by Medtest and are on the New South Wales register is actually significantly lower than the general norm for pathology labs, and we are contemplating writing directly to the women concerned, as well as to a number of women the New South Wales letter would not have reached because those women were not on the register.

Senator WEST—Is that an indication that Medtest were not reporting or participating adequately in the cervical screening reporting data collection?

Mr Maskell-Knight—I think it is unusual and disconcerting, but we can only speculate about why the rate of registration was significantly lower. There may be some stochastic abnormality that we do not understand; it may be some peculiarity about the sociodemographic profile—we do not know. But it is a concern and we are contemplating writing directly to the women as well as to the general practitioners.

Senator WEST—Or incompetence and lack of high standards, which would tend to go back to some of the other concerns that Dr Harmer raised. What are the requirements for these laboratories to get back up to standard?

Dr Harmer—The laboratories are given a copy of the NATA report. These reports are quite detailed about what aspects of the accreditation and assessment process they have failed, so it is quite clear from the NATA report what the lab needs to do to gain accreditation. Medtest has had a number of these reports. A recent review by NATA of Medtest about which we have some information indicates that they have made substantial improvements and reforms to their procedures. They are probably close to getting NATA approval but they have not yet got there.

Senator WEST—Is the laboratory given a time frame in which to improve its standards?

Dr Harmer—New labs are given a chance to start operating and developing their systems, and they do it in full knowledge of what the NATA accreditation process and conditions are. That takes six to 12 months. For a lab that is operating, when NATA undertake a review they provide the report. Remember, there have only been three pathology labs that have attracted an adverse NATA review, only two of which are still operating. Labs are given some time. If NATA remove accreditation, as in the case with Medtest, we would take a decision to withdraw their Medicare eligibility unless, of course, the lab invokes the appeal procedures which are available to them in the process. That is exactly what has happened. There is no specific time frame on the appeal, although the delegate in the HIC, with a concern to public health issues, continues to press both the lab and NATA to ensure that this occurs as quickly as possible.

Senator WEST—How often does NATA check these labs?

Dr Harmer—I am advised that, for a well-performing lab, it is once every three years. But, if there are concerns raised in the NATA evaluation, then they perform investigations yearly.

Senator WEST—When does HIC get informed?

Dr Harmer—We are involved on a yearly basis because we approve on a yearly basis. Of course, if there are appeal proceedings that stem from, as in the case of Medtest again, an adverse finding, we are regularly in contact with both NATA and the lab.

Senator WEST—Was it true that Medtest had a problem in 1998, 2000 and 2001?

Dr Harmer—My notes indicate that NATA first issued an adverse assessment report on Medtest Laboratory in Fairfield Heights, New South Wales, on 9 October 2000.

Senator WEST—You are not aware of anything in 1998?

Dr Harmer—Not that I am aware of here. I could check that for you.

Senator WEST—What I want to know is how long NATA sit on these results before they tell you.

Dr Harmer—NATA are usually very good at providing the reports to us. In this case, the NATA report did not suggest any particular public health risk in relation to Medtest. It was a report of concern on some elements of their operation but it was not a heightened concern about the validity of their testing, as it was in the case of GDL, for example.

Senator WEST—After 2000, when were you notified?

Dr Harmer—It was on 20 August 2001, when the board of NATA resolved to cancel Medtest's NATA accreditation.

Senator WEST—As a result of checks. When were you advised about that?

Dr Harmer—We would have been advised shortly after that.

Senator WEST—Do you want to take that on notice?

Dr Harmer—Yes. This is an important detail, which I will take on notice and for which I will provide the answer.

Senator WEST—I want to know when the HIC was informed and when the women were informed as well; whether there were any delays and, if there were delays, why were there? Since these three episodes, have any changes been made to the way you address these issues?

Dr Harmer—I will let Mr Maskell-Knight deal with that. There is a process under way at the moment to have a look at the whole process of the interaction between NATA and the labs and at the process of accreditation.

Senator WEST—Thank you.

Mr Maskell-Knight—We have put in place essentially a working party that includes us, the Health Insurance Commission, NATA, the Royal College of Pathologists and the Australian Association of Pathology Providers. The group have met twice, firstly on 18 March and then again on 29 April, and they have identified a range of changes to the way the processes work. Part of those changes will involve amendments to the principles determined by the minister which govern how the accreditation arrangements work. We are in the process of preparing a revised draft of those principles to send back to the interested parties for comment. Clearly we would like to get the changes in place as soon as we can; but it is important that NATA, in particular, and the Association of Pathology Providers feel able to support them, because at the end of the day it is NATA that will be largely responsible for implementing them.

CHAIR—Senator West, do you have much more? Senator Harradine wants to ask questions on access to Medicare as well.

Senator WEST—No, I am nearly wound up on this one. Are there any reports out on this working party yet, or not?

Mr Maskell-Knight—No, there are not. I suppose there is a parallel process in that we had already commissioned a review of the accreditation process more widely. It is due to report at the end of this month sometime, and at that stage we will give consideration to whether that will be made publicly available.

Senator WEST—Are the terms of reference publicly available for both of those inquiries?

Mr Maskell-Knight—There are no formal terms of reference for the working party; it is more 'how can we fix up what is not working?' The terms of reference for the review, which is being carried out by Corrs Chambers Westgarth, require the consultant to conduct a review of, and submit a report that evaluates, the current Australian pathology laboratory accreditation arrangements, in particular the effectiveness of the laboratory accreditation arrangements with respect to administrative and legislative requirements under Medicare.

Senator WEST—Were these reviews all brought about by these three pathology labs fouling up on Pap smears?

Mr Maskell-Knight—No, the working party was. The other accreditation arrangements review actually started in December last year; it was not initiated by these concerns.

Senator WEST—I will leave it there, thank you.

Senator HARRADINE—What is the status of the Medical Services Advisory Committee's consideration of adding the nuchal translucency test for Down's syndrome to the Medicare benefits schedule?

Mr Maskell-Knight—I am advised that the committee expects to finalise advice to the minister sometime in the next couple of months.

Senator HARRADINE—Are members of the public invited to make contributions to the process of having certain services considered or not considered by the committee?

Mr Maskell-Knight—Public submissions are not part of the MSAC process.

Senator HARRADINE—Why not?

Mr Maskell-Knight—I think you are going to an issue of policy. The committee has been established to provide expert advice to the minister on the basis of proposals put before it by sponsors of particular procedures.

Senator HARRADINE—I may take that up with the minister at some stage if you consider that that is a policy matter.

Mr Maskell-Knight—I think that it goes to what the committee is for: it is intended to conduct scientific evaluation. It can inform itself by engaging consultants to supplement the scientific expertise that is available to it. It is not clear to me that public submissions would assist a process of scientific review.

Senator HARRADINE—However, are you aware of the concern in the community that certain conditions are regarded as a handicap? Are you suggesting that Down syndrome is a gross foetal abnormality?

Mr Maskell-Knight—I am aware that some people consider that to be so, yes.

Senator HARRADINE—But you are not prepared to take into account the views of people who do not believe that that is so? What about dwarfism?

Mr Maskell-Knight—I am not sure how this is relevant to whether public submissions can be made to MSAC.

Senator HARRADINE—Who is on the supporting committee of the Medical Services Advisory Committee? Is Dr de Crespigny, for example, on that committee?

Mr Maskell-Knight—I do not know, Senator; I would have to find out.

Senator HARRADINE—I can tell you that Dr de Crespigny is a member. He is involved in foetal screening procedures at the Royal Women's Hospital and has been lobbying for the test to be included in the Medicare benefits schedule.

Mr Maskell-Knight—I have no knowledge of that; you have the advantage of me there.

Senator HARRADINE—Is there anybody here who does have that knowledge?

Mr Maskell-Knight—I imagine that members of the MSAC secretariat would be aware of the interests that particular members of the committee have. I think it would be difficult to get an expert supporting committee which did not have members who might ultimately have some sort of interest in the outcome. That is why the supporting committee essentially

provides support to MSAC, whose membership is less interested, in the potentially partial sense of the word.

Senator HARRADINE—However, does the committee consider that there is a conflict of interest on this matter?

Mr Maskell-Knight—I am not a member of the committee, so I am unable to answer that.

Senator HARRADINE—Is the chair of the committee here?

Mr Maskell-Knight—The chair of the committee is not a departmental officer; it is an independent committee.

Senator HARRADINE—Comprised of persons with a vested interest?

Mr Maskell-Knight—MSAC is comprised of clinicians and scientific experts; I believe that there is health and economics expertise as well, and a consumer representative.

Senator HARRADINE—What about the public? I again raise the question. Are you or are you not saying that that is a policy decision? If it is, I will not ask you questions on that particular aspect of it; I will direct my questions to the minister.

Mr Maskell-Knight—I think it is at the boundary line, Senator. There is a consumer representative on the committee who it is intended should reflect the views of health consumers.

Senator HARRADINE—Minister, would you kindly consider this question as to whether or not it would be appropriate to seek submissions from the public so that the committee can take into account public submissions?

Senator Patterson—Senator, I hope you were not casting aspersions on members of MSAC by saying that they had vested interests. That is of concern to me. I do not know whether you know the names of the members of MSAC.

Senator HARRADINE—I am sorry; I was talking about 'interests' in the disinterested sense—

Senator Patterson—'Vested', I thought you said.

Senator HARRADINE—I used the word 'interests' in the same way as Mr Maskell-Knight did.

Mr Maskell-Knight—Senator, I think we might be getting a little confused. I think what I said was that the membership of the supporting committee changes with the particular technology which is being considered. Almost by necessity, it will have to have on it people who are experts in the particular field of applying that particular test or technology. What I am saying, I suppose, is that it will be very hard to construct a disinterested committee which had the level of expertise that MSAC needs to have available. MSAC itself, however, is supposed to be—and I think is—comprised as a disinterested committee.

Senator Patterson—There is always a difficulty, Senator Harradine. It would happen even in America, having regard to the size of their population. In Australia, with NHMRC, despite the fact that you try to have an independent committee that is not involved in assessing somebody else, people who have the level of expertise needed are often involved in a particular project. I hope you were not meaning that they had a vested interest in influencing in that way. We have professional people who we expect to perform in a professional way. I would not imagine you were casting aspersions on their ability to be independent in the assessment.

Senator HARRADINE—I was referring to the MSAC supporting committee, or supporting group. I can quote from various sources, including an ABC program, which show clearly that Dr de Crespigny has been vigorously promoting the screening to be placed on the schedule.

Mr Maskell-Knight—It is standard practice by MSAC and its supporting committees for members to disclose conflicts of interest to the other members. So the members of the supporting committee would be very well aware of Dr de Crespigny's interest.

Senator HARRADINE—I request the minister to respond now, or to consider the matter at a later time. These decisions are taken by the committees; obviously the decisions mean that taxpayers' moneys are involved in one way or another. I would have thought that public submissions were desirable, particularly in these sensitive areas, if you are trying to get a procedure on the schedule paid for by the taxpayer. A lot of taxpayers would not want to see their money being used to pay for scans and screening of persons with Down syndrome, suspected dwarfism and so on.

Mr Maskell-Knight—Senator, by way of clarification, MSAC does not actually make decisions about what goes onto the schedule; it makes recommendations.

Senator HARRADINE—To whom?

Mr Maskell-Knight—To the minister and the government.

Senator HERRON—I declare a vested interest: I had a Down syndrome child who died at the age of 37. I should declare at the beginning that I have an interest in this field. Could you find out how many ultrasonographers are accredited for the evaluation of nuchal translucency? Nuchal translucency is a measurement of the thickness of the skin at the back of the neck. There is tremendous variation. It is a matter of millimetres: it can vary between one millimetre and 3.2 millimetres. The definitive measurement is 1.6 millimetres, so we are talking about minutiae. I suspect that what Senator Harradine was skirting around, in a sense—and I am much more blunt than Senator Harradine; he is more circuitous—was the fact that a child who had dwarfism and was suspected of having Down syndrome was aborted.

I do not agree with abortion just because a child has Down syndrome. I spoke of this in the Senate five years ago. But we are getting into the field of millimetres of measurement in determining whether a test is going to mean that a child is aborted—a child who may not have the condition. There are many other conditions that produce irregularities of measurement with nuchal translucency—for example, cardiac abnormalities and so on.

I put on notice that this is something that needs very careful consideration, apart from by the experts, and not counting my personal view on aborting Down syndrome children. Leaving that aside, it is a test that requires quite considerable accreditation. I have mentioned the difficulty of determination of that measurement. If we are getting into this field, I think it is important that the department knows how many people in Australia are accredited for the measurement of nuchal translucency. Could you find that out for me, please?

Mr Maskell-Knight—I will be happy to take that on notice.

Senator HARRADINE—Why would Dr de Crespigny be on the supporting committee?

Mr Maskell-Knight—I believe it is a matter for MSAC as to who they place on supporting committees. I would imagine—and I am speculating—they felt that he, as a practitioner in the area, had some value to add. Again, it is a matter for MSAC, which is an independent committee charged with informing itself on matters of scientific and technical evidence.

Senator HARRADINE—The Medicare benefits schedule provides for benefits to be paid for the 'management of second trimester labour, with or without induction, intra-utero and foetal death, gross foetal abnormality or life-threatening terminal disease'. You are aware of the outcry by disability groups and others following the abortion of an unborn 32-week-old baby at the Royal Women's Hospital because of suspected dwarfism—to use the technical term, skeletal dysphasia? Is the department aware of that?

Mr Maskell-Knight—I am aware of the case, as reported in the newspapers. I should point out that 32 weeks means that it was not covered by the Medicare item you quoted.

Senator HARRADINE—Are we are talking about the third trimester?

Mr Maskell-Knight—Yes.

Senator HARRADINE—I am talking about the second trimester; I read about the second trimester.

Mr Maskell-Knight—Yes; but I understand 32 weeks to be well into the third trimester.

Senator HARRADINE—Yes. It was performed in a public hospital?

Mr Maskell-Knight—So I understand.

Senator HARRADINE—Do you understand that Dr de Crespigny was associated with the ultrasound which was taken to ascertain whether or not the 32-week old foetus had suspected dwarfism?

Mr Maskell-Knight—I was not aware of that.

Senator HARRADINE—Were you aware that Dr de Crespigny commenced the abortion procedure in his own surgery, that the woman was then transferred to the public hospital to be induced and that the baby, Jessica, was delivered dead four hours and 40 minutes later?

Mr Maskell-Knight—No.

Senator HARRADINE—An article in the Sunday *Herald-Sun* on 7 April 2002 headed 'Aborted baby "not a dwarf"' reported that a doctor had said, presumably later:

> "It is unlikely, but possible, that the baby is a normal small baby."

Are you aware of that? It also reported that staff notes which were written immediately after the baby was delivered dead state:

> "The baby doesn't look small."

Are you aware of that?

Mr Maskell-Knight—No; and no.

Senator HARRADINE—We are dealing with the doctor from whom you are receiving advice, obviously.

Mr Maskell-Knight—I beg your pardon?

Senator HARRADINE—You have appointed this doctor to advise the—

Mr Maskell-Knight—I have not appointed him anywhere.

Senator HARRADINE—When I say 'you', it is a generic 'you'.

Mr Maskell-Knight—An independent committee has appointed him to assist them.

Senator HARRADINE—In cases where second trimester abortions have been carried out on the basis of false diagnosis, is there any requirement for moneys paid to the doctor through the Medicare benefits schedule to be reimbursed, as the benefits paid did not meet the categories?

Mr Maskell-Knight—That is an interesting question. I am not sure that it is down to me to answer that. I imagine it would be very difficult for the Health Insurance Commission, which would be responsible for reclaiming money, to get any evidence around the falseness or otherwise of the diagnosis.

Senator HARRADINE—Does the department consider that the abortion of a person with dwarfism or with suspected dwarfism is a clinically relevant service?

Mr Maskell-Knight—The decision to carry out a second trimester termination is one for the doctor and his or her patient to make. Whether Medicare benefits are then claimed is a decision again for the doctor to make, as to whether the procedure falls within the terms of the Medicare benefits schedule definition. In other words, I do not think that it is up to bureaucrats to make clinical decisions of that nature. We have put in place a regime which allows patients to recover a contribution towards the cost of their procedure under Medicare on the basis that the procedure fits within the definition. It is difficult for the department or the Health Insurance Commission to make judgments that are essentially second-guessing the clinical judgment that a doctor may have made. As the Secretary has just reminded me, medical boards in the states, which register doctors and supervise medical practice, are probably better placed to make those sorts of judgments.

Senator HARRADINE—I do not believe I am hearing this. We are talking about procedures that are taking place not only in respect of Dr de Crespigny. What about Dr Sutherland in South Australia?

Mr Maskell-Knight—I do not know the names of any of these doctors. It is not my role to.

Senator HARRADINE—Professor Sutherland? Did you not notice the outcry by disability groups when the same Professor Sutherland appeared on ABC television? An doctor advocate for the disabled was there, and Professor Sutherland said it would be better for society if persons with disabilities or handicaps—I think he used that word—were prevented from being born. Immediately after he said that, Dr Thomas Shakespeare, who was the advocate for the persons with disabilities, said that he would rather not have the disability. I am not saying that it is a disability. Would you say that dwarfism is a disability?

Mr Maskell-Knight—I think you are asking me for a personal opinion.

Senator HARRADINE—I will ask the department or even the minister. Do you think that dwarfism should be regarded as a disability?

Ms Halton—Perhaps I can reinforce what Mr Maskell-Knight has just said. Our responsibilities are in respect of the construction of the Medicare benefits schedule and, through the Health Insurance Commission, to ensure that benefits are paid for services that are legitimately delivered. We do not have an opinion on the issue you just raised; it is not relevant to our work. Can I also say that the issues you raise about particular instances of medical practice and whether those instances are consistent, effectively, with a doctor's registration are not a matter for the Commonwealth or the Commonwealth department. Medical registration is not something we control. We are concerned about whether a doctor is

medically registered, because that is of course a precursor to their being eligible for access to benefits under the schedule; but, beyond that, it is not an issue that we control.

Senator HARRADINE—So the department—you are responsible for our money—accepts and pays for abortions because of suspected dwarfism?

Ms Halton—As Mr Maskell-Knight has pointed out—and I do not think there is anything we can add to that answer—essentially, particular services are provided consistent with the terms of the Medicare schedule and are a matter between a patient and that patient's doctor. If there is an issue in respect of the doctor's practice, that practice issue would be an issue for the medical registration board and not for us. If there is an issue in respect of the payment of a benefit, the doctor needs to be registered and the doctor can be held accountable to the Health Insurance Commission in respect of the payment of a benefit.

Senator HARRADINE—Isn't it available to anyone to ask, on the basis of accountability, whether the words 'gross foetal abnormality' cover dwarfism? Who does one ask about that very important and vital matter?

Mr Maskell-Knight—That is a matter for the clinical judgment of the doctor.

Senator HARRADINE—What do you mean by 'clinical judgment'?

Mr Maskell-Knight—The considered view of the doctor, taking into account his clinical training and experience.

Senator HARRADINE—Dwarfism is dwarfism. You either pay for the abortion of a person with suspected dwarfism or you do not. The clinical and professional view of the medico surely does not come into it, when deciding whether to abort a baby because of suspected dwarfism.

CHAIR—Senator Harradine, I do not think you will get a different answer.

Senator HARRADINE—I know. This disturbs me. If they are unaccountable, they just pay out taxpayers' money for the abortion of persons with dwarfism.

CHAIR—But there is nothing further that anyone is going to add. So do you wish to move on?

Senator HARRADINE—I ask the minister: where does one get an answer—which certainly a number of disability people want to know—as to whether or not dwarfism is going to be regarded as a gross foetal abnormality? Where does one go to get an answer? We are the members of parliament, representing the people who are paying the piper. Where is the accountability?

Senator Patterson—The accountability lies with the doctor's clinical judgment.

Senator HARRADINE—So if the doctor's clinical decision was that there was suspected dwarfism—

Senator Patterson—I do not know all the details of the case. I believe Mr Maskell-Knight indicated that, given the stage of the pregnancy, that procedure would not have attracted a Medicare benefit.

Senator HARRADINE—I am talking about those that do.

Senator Patterson—You were talking about that particular case, and I am answering you on that particular case.

Senator HARRADINE—Mr Maskell-Knight, are any payments from the Commonwealth involved in that particular case?

Mr Maskell-Knight—Only to the extent that we are joint funders with the states of the public hospital system. But we are not responsible for the administration of the hospitals. Under the health care agreements, it expressly says that the administration of the hospitals is a matter for state and territory governments.

Senator HARRADINE—Minister, is it the policy of the government to support an arrangement whereby the unborn can be aborted on the grounds that they have dwarfism?

Ms Halton—As Mr Maskell-Knight has already said, the item on the schedule is written in a particular way. It is then invoked, if that is the procedure. It is a matter for the doctor's clinical judgment. As Mr Maskell-Knight has said, bureaucrats do not insert themselves between a doctor and a patient when a doctor is exercising that judgment.

Senator HARRADINE—So you would be quite relaxed about having the department pay out money for the abortion of persons with dwarfism? Are you saying that dwarfism is a gross foetal abnormality?

CHAIR—Senator Harradine, there is no different answer that the department can possibly give you.

Senator HARRADINE—I want some accountability. There are a lot of people around this country who want a bit of accountability about this. Are we going to have a situation whereby persons with dwarfism are going to be regarded as having a gross foetal abnormality, so that they can be aborted using these particular instruments—the ultrasound and the action thereby—and also a situation where you are using the person who performed that gross procedure on that baby with suspected dwarfism as your chief adviser in this area of ultrasound?

Senator Patterson—Senator Harradine, I know that you feel passionately about this, but there are other situations in which a medical practitioner has to make a decision about a termination—in most jurisdictions, to preserve the woman's physical or mental health or to save her life. As has been said, there must be a point where it is very difficult for a government, bureaucrats or anybody to interpose themselves between the patient and the clinical decision. There has to be a decision. Was it to preserve a woman's life? Was she so mentally unstable that she would not be able to care for this child or deal with a child? They are clinical judgments. We train doctors to make clinical judgments. There are many other areas where they have to make these clinical judgments. They may make a judgment that you do not like; they may make a judgment that I do not like; but, short of supervising every procedure that is undertaken, I think that you are asking for something that is almost impossible.

Senator HARRADINE—Minister, I am talking about the Medicare benefits schedule. Leaving aside the particular case of the 32-week-old person with dwarfism, the schedule provides that 'management of second trimester labour, with or without induction,' attracts a medical benefits payment 'for intrauterine foetal death, gross foetal abnormality or life threatening maternal disease'. Your response to me went to that third point. It did not go to the question that I asked, which was about the second reason for abortions in the second trimester, 'gross foetal abnormality.'

CHAIR—Senator Harradine, the point that we are trying to get at is: what are you suggesting should be done when a doctor and a patient make a decision and neither the depart-

ment, nor the minister, nor you or I even know that this is happening? Are you suggesting that somehow the minister or the departmental officers should intervene in something that is going on in a clinical setting and not known? It is not my judgment and it is not anyone else's judgment.

Senator HARRADINE—I am not asking them to intervene. I am asking: why don't they refuse to pay out for abortions which are undertaken on the basis of gross foetal abnormality, on persons who have dwarfism? This is an either/or situation: it has got a comma and then it has got a final 'or'. A response really went to the third reason that the medical benefits schedule says, not to the second. I was asking the question as to whether gross foetal abnormality includes dwarfism. If the government considers that it should not include dwarfism, that persons with dwarfism should not be aborted for that very fact that they have dwarfism, then obviously the persons in charge of paying out should not do so if it relates to a person with dwarfism.

CHAIR—There is nothing further to be added, Senator, to the answers that were given previously.

Senator HARRADINE—So, Minister, you are now prepared to allow a situation to continue where the unborn with dwarfism are aborted for that very reason only? That is the question I am asking. I understand the point that you make on the other one, but that is the question that I am asking.

Senator Patterson—Senator, there is a patient-doctor relationship. Doctors have criticised me already, in the six months that I have been health minister, for interfering in their relationship with patients in clinical situations, about whether they prescribe too many antibiotics or whatever. This is a difficult issue and I understand your concern, but I also have a concern about interfering between the patient and the doctor in a clinical decision. It is a dilemma. At the moment we have a situation where the doctor makes a clinical decision on a range of issues, and doctors can be held accountable to their medical board.

Senator HARRADINE—Thank you, Minister. I just indicate to you that I will follow the matter up in another area, if you do not mind.

CHAIR—Are there any further questions on outcome 2, Access to Medicare?

Senator CROWLEY—Minister or Ms Halton, could you bring us up to date with the situation that now prevails with medical indemnity?

Senator Patterson—Senator, if you look on the web site, through www.health.gov.au—I am sure you can access it through that link—the Prime Minister's statement of Friday is there, and it clearly sets out the situation at the moment. The medial indemnity issue is not of the government's making and is an issue that has been developing over a period of time. UMP/AMIL has particularly affected doctors in New South Wales and Queensland.

Senator Coonan has worked around the clock through very difficult circumstances to deal with this issue on a day-by-day basis as it emerged. We were in unchartered waters. Nothing like this has ever happened before. We gave the doctors a guarantee for a period of time between 29 April and 30 June, to give us some breathing space while discussions took place with the provisional liquidator to assess the assets and liabilities of UMP/AMIL, which we were not privy to.

As you know, doctors have preferred to indemnify themselves and were reluctant to come under the prudential general insurance regime. But, when things went wrong, as always peo-

ple looked to the government to solve the problems. Senator Coonan—particularly because she had carriage of the prudential area—and I have worked together. There has been a senior interdepartmental committee working on the issue to try and address the problem. We had a forum on 23 April with all the health ministers. We had all the medical defence organisations, the presidents of all the colleges and the chairman of the committee of presidents of colleges. We had representatives from the law. I cannot remember whom else. We had 80 people in a room.

Senator CROWLEY—Minister, would you be able to provide us with the list of attendance at that conference on notice?

Senator Patterson—Yes, I am sure it is available. There were presentations at that forum of the broader issue. There were a number of basic issues about medical indemnity. One was about the immediate issue of UMP/AMIL—the fact that it was in difficulties. And there was the question of what would happen to doctors undertaking procedures during the period of time when they were under the provisional liquidator.

There was the problem of the tail, which is the unreported but yet to be claimed IBNRs that were an issue as well. There were figures flying around from $300 million to $1 billion; there were all sorts of figures being passed around about that. There was the long-term issue of medical indemnity generally, which also takes in the issues of public indemnity. Some of the issues about public indemnity also impinged on medical indemnity. There was also the fact that one of the major companies in medical indemnity withdrew its reinsurance, and there was the effect of September 11. So a whole of lot of things came together in a way that put enormous pressure, in particular, on UMP/AMIL, and other factors.

So we worked to have a short-term solution. The Prime Minister, in his release on Friday, has outlined a period until 31 December while we consider again: working out the assets and liabilities with the provisional liquidator of UMP/AMIL, working out a way forward from then on and also working with the states.

This forum was about actually looking at the long-term issues in medical indemnity; things like claims—the fact that people can claim against their GP proceduralist obstetrician for 21 years, and there is a period of grace after that. I think it works out sometimes up to 25 years. That makes it very difficult to estimate and do actuarial assessment. Some jurisdictions have indicated that they will reduce it to seven years. Others are still looking at that. We have been working out ways in which we can deal with structured settlements at the Commonwealth level. That has also come through as a result of the public indemnity.

Within that forum, there was also a suggestion that we should look to some structured form to assist people who have long-term rehabilitation or care needs. That is being looked at at the moment. There are a number of issues that need to be addressed to ensure the long-term viability, not only of UMP/AMIL but of all medical indemnity, because there is increasing litigation and there are increasingly more difficult procedures—as you know only too well, Senator Crowley, as a doctor—where people are doing on-the-edge spinal surgery, neurosurgery and all sorts of surgery. That means that a person may be more likely to live a full life but may also be more likely to have serious disability, whereas, 20 or 30 years ago, they might have died. We are on the edge of medicine and I guess the community has to accept that there are risks in having those sorts of procedures done. It has been a difficult time and I understand that doctors have felt quite concerned about it. As health minister, I believed that my responsibility was to assure them that their procedures would be indemnified, that they should not stop undertaking procedures and that they needed to understand that we were

working with them to achieve a long-term outcome but that it was not going to be solved overnight.

Senator CROWLEY—That is helpful; thank you, Minister. I would like to find out about the payment the Prime Minister has authorised? Where is that money coming from?

Senator Patterson—I think it might be best if you read what the Prime Minister said, because it is not necessarily a payment. It is to ensure the viability, to guarantee—

Senator CROWLEY—Is it under the health department or is it under Finance?

Senator Patterson—We had a situation where the provisional liquidator may not have been able to take renewal of insurance from people. But if you look there carefully, you will understand the monetary procedures. Charles Maskell-Knight, who is here at the table, has been incredibly involved, and I want to put on record my appreciation to that section of the department. They were in the middle of the budget process and dealing with this. They were working not just round the clock but round the clock all weekend. It is appropriate for me to thank them. As I said, it was not an issue of the government's making, but Charles Maskell-Knight and his team worked their insides out to work with Treasury to come up with options that would be acceptable and would mean that we could have long-term viability. I ask you to read the Prime Minister's statement. The answer to your question is in that statement.

Mr Maskell-Knight—It might help if we table the statement that Minister Patterson has mentioned.

Ms Halton—We will table the statements.

Senator CROWLEY—That will be a help; thank you very much. I could flick over them but I will read them later. I appreciate the point you are making. What I would really like you to tell me about is the health department's responsibility. In particular, is there some person in the department to whom complaints, concerns or questions can be brought? For example, we have had questions already—I think from Senator Allison last night. What happens if, as she has been advised, nursing students are now not able to continue their studies because they have been told that the medical indemnity to cover them is not there. I do not know whether that is true or not. My suspicion is that it is, but I want to know: what is the procedure for people who are now raising questions like that with me or anybody else? Is there one person in the department they can speak to?

Senator Patterson—Senator Crowley, I am sure Senator Allison is going to ask more questions, but we have never insured allied health professionals or medical students. The medical indemnity issue is a separate issue. The other issue is an issue of professional indemnity. Those two issues are getting mixed up. A lot of companies have withdrawn their reinsurance. You know that, from pony clubs down, there are issues of insurance. We do have a hotline for doctors to call. Is that hotline still working, Charles?

Mr Maskell-Knight—Yes, there is a hotline that we have established in the department for doctors to call. The number is 1800 007 757; it is engraved on my heart by now. When the staff at the call centre cannot answer more difficult questions, the callers are referred to the department for an answer. In relation to the point that the minister was making about other health related groups: as the minister said, that is a matter more for professional indemnity insurance generally. It is appropriate that inquiries around that should be directed to the Treasury, because Senator Coonan has got responsibility for the wider issue of professional indemnity. Sorry, Senator, did you miss that?

Senator CROWLEY—I missed a bit. I suddenly found myself in Treasury, which was a bit exciting.

Senator Patterson—By saying that, it does not mean that it is necessarily the Commonwealth's responsibility.

Senator CROWLEY—I appreciate that.

Senator CHRIS EVANS—We have got all the caveats on the record. The committee is actually just interested in knowing what this means in terms of the health department's responsibilities and what is going on, what is churning beneath in Mr Maskell-Knight's section. We understand the broad stuff, Senator Patterson. As you say, it has been put on the public record, and I appreciate that we now have a copy of your letter to the medical practitioners.

Senator Patterson—That has been on the website since I sent it, Senator.

Senator CHRIS EVANS—That's good. I must say, I do not visit your website as often as I probably should, Senator Patterson.

Senator Patterson—I thought you visited it daily, since you were looking after me so carefully.

Senator CHRIS EVANS—No, I would prefer to see you in person. I think it is reasonable for us to ask: what liabilities fall on the department? Are there any costs involved? What other work is being done to address these various issues?

Ms Halton—I will answer that. Firstly, I could not let a description of the department 'churning' go uncommented on. I am sure we do not churn; I am sure we manage in a very orderly fashion.

Senator CHRIS EVANS—Well, that description of Mr Maskell-Knight's insides got me a bit worried.

Ms Halton—I am sure the department is not responsible for his insides, Senator. In terms of the responsibility of the department, firstly, in relation to any funds that may or may not be paid out in due course to the provisional liquidator or elsewhere: that is a Treasury responsibility. As the minister has indicated, there has been a high level taskforce, chaired by Mr Max Moore-Wilton, with relevant departmental heads assisted by other officers, which has been looking at this issue.

In response to the concerns about this issue, we have formed a taskforce inside the department. This is not a huge taskforce, but it is a taskforce to enable us to dedicate particular resources to the issue. We have, in fact, been working—as it probably will not surprise you—on the broader question of medical indemnity for a period with our state colleagues. So we have had ongoing work through the ARMAC working group—chaired by Dr Penny Gregory, who is the head of the ACT Health Department—looking at issues. The minister has referred to some of them, for example, the question of long-term care.

To summarise our role, it is to ensure that information is available to people—Mr Maskell-Knight has given you the freecall information line number—and to work with our state colleagues on the matters which are peculiarly health issues. The minister has talked about some of the other issues that are germane here, for example, a reform, et cetera. Our role is also to continue to feed the health perspective into what is a broader and more complex issue. But, clearly, there are some issues which are peculiar to us and we would continue to have responsibility for those.

Senator CHRIS EVANS—In terms of the medical indemnity for doctors issue, you say Treasury is picking up the can for that guarantee, which I am sure is a great relief to the health department. Were you able to do any work on it? I know that it is a potential liability only, but was there an assessment made about what the potential liability was to the Commonwealth from that guarantee? Those would have been quite frightening figures, I would suspect.

Mr Maskell-Knight—I do not think that is right. Notionally, if you look at their last set of accounts you will see that UMP/AMIL's assets were somewhat in excess of their liabilities. That says, at the end of the day, when everything is wound up and put to bed and so on, that I do not think we have exposed very much there. The issue the company faced was the incurred but not reported liabilities, which are not actually on their books at the moment because the accounting standards do not require them to be there. Those standards are in the process of being changed. The Prime Minister announced last week that the government will give a guarantee to meet those liabilities, to be funded from doctors over time. I guess that is a long way of saying that I do not think our exposure is as great as it might strike people who are coming to it new.

Senator CROWLEY—'To be funded by doctors over time'—I understand that to mean a levy.

Mr Maskell-Knight—Yes.

Senator CHRIS EVANS—Is that a levy on those doctors whose insurance no longer exists, or on all doctors?

Mr Maskell-Knight—The government's thinking on that is still working out. The Prime Minister has said that, essentially, the doctors who have got the liability are the doctors who we will be looking to to help fund it. The Prime Minister's statement says 'over at least five years' to ensure that it is an affordable impost.

Senator CROWLEY—I appreciate that there are lots of complications here and I do not know to what detail you can help us answer them but, following that question from Senator Evans, I could understand you to be saying that the Prime Minister suggests that the doctors who enjoy the liability will pay, which could mean that neurosurgeons and obstetricians will pay a lot and skin specialists will pay a little. Were those sorts of questions addressed?

Mr Maskell-Knight—Those are the questions which are being considered at the moment by the task force which the secretary referred to.

Senator Patterson—When you read the Prime Minister's statement, some of that will be clearer.

Senator ALLISON—Minister, just to pick up on my questions yesterday, we said we would get back with some information about where the issues were, and I am advised that Queensland, South Australia and Western Australia are those where the problem is most acute. This is for a number of reasons: partly the pressure on the private system to provide placements because of insurance problems. I am also advised that the department was advised of this some time ago. I think it was said yesterday that there was no knowledge of it, and I ask on notice if you could have a look at where that advice went to if it did not reach the appropriate people. The other matter which was raised yesterday, and again I will put that on notice—

Senator Patterson—I saw some letters from the vice-chancellors either yesterday or the day before, and I replied to them indicating—I cannot remember the exact words—that it was

the state's responsibility. They are university students. You get to the point where—this is not in the health portfolio—you get somebody out doing an engineering placement. There are all sorts of students doing placements in all sorts of things out of universities, not just in health.

Senator ALLISON—I am sure that this issue is a difficult one with regard to jurisdiction, and I know that you are going through all those machinations right now. Yesterday, it was said that students are there as observers in their clinical practice. I have had advice since then that this is not the case; that there is a very lengthy list of practical skills required by graduation. They include activities such as suturing wounds, nasogastric tube insertion, catheter insertion, rectal examination, lumber puncture, chest aspiration, pap smear, speculum examination and so forth. So it is not a question of these students being simple observers; they are having to develop those skills. It should be of concern if the department does not know that that is the sort of practical work which is going on; it ought to know.

Senator Patterson—I remember that comment. I do not remember who said it, but I did add to that that there were not just medical students, but allied health professionals. I think I used the example of an OT who could put a splint on and cause an occlusion, and the person could suffer serious damage, or a physiotherapist doing something that was inappropriate; I think we mentioned physiotherapists yesterday. The department is aware—and I am certainly aware—that, in clinical placements, students undertake procedures.

Senator CROWLEY—I understand that sometimes looking for clinical experience—particularly for nursing students, but in some cases also for medical students—has meant that there have been in some cases agreeable and in other cases less agreeable arrangements where the students have their practice in private hospital situations in particular, as apart from just the public hospital situation. In some cases, that is particularly what people are concerned about. I do not know absolutely, but my understanding is that the public hospitals are probably covered by the state insurance overreaching indemnity. When students then proceed in an arrangement to do their clinical experience in private hospitals, there is a concern about the insurance protection there. It is a terribly important question that has been raised and will certainly continue to be raised. Mr Maskell-Knight, when we looked at this question a couple of years ago for the childbirth inquiry, one of the things that was extremely interesting was the difference between insurance premiums from one state to another. Is this something that the committee will also look at?

Mr Maskell-Knight—I do not believe so. I think that those differences result from the different risks in different places. I suspect that, if you look at the incomes of the people carrying those risks in different places, they probably differ in a broadly similar way, just as the house prices do. New South Wales has the highest premiums; it is the most litigious state, I understand, and it has the highest settlements. I suspect that the people who work in New South Wales charge higher fees and are therefore able to meet those higher costs. I do not think that we are in the process of equalising risk across the country. Were we to do so, doctors would like their incomes equalised in a similar way.

Senator CROWLEY—They have tried some of that in the past, Mr Maskell-Knight. I think your corporate memory goes back as far as that, but we will not tease that one out now. However, the difference between $40,000 to insure you as an obstetrician versus $96,000 to do the same sorts of deliveries does seem curious, whatever the value of the house you live in in New South Wales or the income that you may be earning. I am not sure that the babies being born in New South Wales are being born of mothers that put them at higher risk. I suppose it depends how you define the risk, but it seems to me very curious that, when we did

the inquiry, the insurance premium for an obstetrician was $11,000 in Tasmania, $27,000 in South Australia and Victoria and about $45,000 in New South Wales, which I believe has now gone to $96,000. I would have thought that those figures would be worth your committee's consideration.

Mr Maskell-Knight—An element that contributes to those differentials is the extent to which the organisations charging those premiums have provisioned properly for their risk in the past. In other words, if people have been charging appropriate premiums over time, they do not need to charge such large premiums now. I suspect that one of the reasons that also contributes to the large premiums that UMP is charging in New South Wales is an attempt to catch up on the provisioning they should have made over a longer period of time.

Senator CROWLEY—That touches a terribly important point, certainly for me and a lot of other people who are concerned about who sets the insurance premium amount. I know that courts deciding that baby X deserves a payment of $1 million is very hard to anticipate. But if we leave the singularly huge payments off to one side, I do not think most of us have a sense of how insurance premiums are set. I wondered if your committee was addressing that. What sorts of factors do you put in? What is the right amount? I presume that has to do with the way you build up reserves and so on, but is that something the committee will address and is it something that would be made available to the senators?

Mr Maskell-Knight—I do not believe it is appropriate for the committee to look at that. MDOs are organisations of doctors, with boards elected by doctors, and management appointed by those boards. It is the management that sets the premiums according to what they see as the risk of particular groups and the overall financial situation of the fund. I do not see that it is down to the Commonwealth government to delve very deeply into how they do that.

The Prime Minister essentially said that we would be looking at whether the incurred but not reported liabilities have been appropriately provisioned for and the extent to which they have not. We will be offering a guarantee to those funds and seeking to recover the cost of that guarantee from doctors, over time. I do not see it as the government's role to delve beyond that. I do not see it as our role to delve into the premium-setting process that individual funds go down.

Ms Halton—The reality is that there are a number of provisions, which are properly the responsibility of Senator Coonan, to do with ensuring that insurers adequately provision for liabilities. You are aware of a number of those, I am sure. As Mr Maskell-Knight has said, these organisations are subject to operating consistently with those regulatory requirements. Those regulatory requirements, as we have already heard here today, have, firstly, changed and, secondly, been toughened up in the last little while—appropriately so. Subject to their meeting those regulatory requirements, the simple answer is that they will set their fees based on their experience and based on their need to meet certain prudential requirements.

We have experience in looking at this issue. I think it is fair to say that, in the last few weeks or so, we have crawled up every highway and byway that is probably known on medical indemnity. There are, without doubt, differences across the states in terms of litigation and things like long-term care costs. The relativities that you talked about—in fact, I recall that inquiry into birthing—in essence, have been maintained but at a higher level, and I think that is in part to do with that different experience across the states. One could have a view about sharing that burden and, as Mr Maskell-Knight has said, that might result in some strength of views amongst doctors, for example, who live in Tasmania.

In giving advice in this area, our ambition has been to ensure that we end up with something that is sustainable so that doctors can know that they are covered when they practise and so that patients can know that the doctors who provide them with treatment have appropriate cover in the event of any misadventure. In terms of the extent to which we inquire about the setting of premiums and things of that ilk, it is within that broader context.

Senator CROWLEY—I am interested to know what your continuing role is. Is it as a watchdog? Is it a committee role only? It is quite clear that if there is no insurance, doctors and nurses are not going to go and do their work, and this is something, of course, that the department would have a lively interest in. Just to be clear, are you telling us that there is now a formal committee group set up within the health department?

Mr Maskell-Knight—There is a small group. I think they have five or six staff.

Senator CROWLEY—And it is going to have the ongoing watchdog role in what is happening here?

Ms Halton—To the extent that the task force, the senior level exercise chaired by Mr Moore-Wilton, continues. In any event, so that we can advise our minister in any broader discussions, that group has a job to do in contributing not only to the cross-departmental work but also to the cross-government work. I think I indicated that there is an ARMAC working group. We have discussed this subject now on several occasions in ARMAC meetings, as recently as about a week ago. As to the group inside the department, I think the minister's colourful description of the state of some of my officers at the end of this process was very close to truth. The reality is that people had been trying to do this work as well as their day jobs, so, because it is so important to us, we have decided that it is more appropriate to resource the function with a separate and dedicated group of officers. I think it is fair to say that Health has been a vigorous participant in trying to get this issue addressed and resolved.

Senator CROWLEY—Who are the people who will be on that working group?

Ms Byrne—I have a team of five people. We have just been set up in the last few weeks.

Senator CROWLEY—If there is something you can provide to the committee, that would be appreciated. We have the number to ring. Will we be talking to you, if we dial that number?

Ms Byrne—That will take you through to the call centre. I am pleased to say I do not have the function of answering all those calls myself.

Senator CROWLEY—Will the call centre filter the calls or just take notes and pass that information on for you to deliberate about?

Ms Byrne—The call centre has been provided with a fair quantity of information and a list of frequently asked questions, so most of the questions that are being asked can be answered by the staff of the call centre. Where the issue is a bit more complicated or requires a bit more detail, the call centre will refer it through to somebody in the departmental task force and we will call those people back and go through the issues with them.

Senator CROWLEY—I understand it is pretty early days, but can you give us any figures on how many calls you have had to the call centre and who is calling?

Ms Byrne—As of Tuesday, we have had 1,128 calls to the call centre.

Senator CROWLEY—Over what time?

Mr Maskell-Knight—Since 2 May.

Senator CROWLEY—Since 2 May this year there have been 1,100 calls?

Mr Maskell-Knight—Yes.

Senator CHRIS EVANS—Are they mainly from medical practitioners affected?

Ms Byrne—They are. There have been a few calls from members of the public, but most of them are from UMP members.

Senator Patterson—The problem was that they were trying to get on to the provisional liquidator. They wanted access to the information, and I think this has been a very good service.

Senator CROWLEY—It is a fair tick: there is a real concern and a focus has been provided to address it. I am just whistling in awe because it is clearly a pretty big need you are meeting, and I think that is important. Have any of those people been other than doctors—nurses, for example?

Ms Byrne—I do not have any information about that. Some other health professionals and a few patients have called on the line. The line is available on the Health web site, so people have had access to that and have called, and we have endeavoured to help those people as well.

Senator CHRIS EVANS—I take it from what you said that as the medical indemnity working group your charter is limited to that issue, rather than the broader professional indemnity insurance issues. Is that correct?

Ms Byrne—That is correct.

Senator Patterson—Even the medical indemnity issue goes across a number of portfolios; that is why we have this high-level committee, as Ms Halton said. The prudential issues are within Treasury and are Senator Coonan's responsibility; my responsibility as health minister is to the concerns that doctors have about whether or not they are insured and ensuring that they are informed and that their procedures are covered.

Senator CHRIS EVANS—Because of your warning earlier about not confusing the issues, I was dealing with them separately, Minister.

Senator Patterson—Thank you. You are looking after me again, Senator Evans!

Senator CHRIS EVANS—Then I was going to ask what you are doing about the broader prudential issues inside the health industry, as they affect the health industry. Obviously you are one of the first ports of call for people who might have problems about insurance with nurses or other health professionals. I am interested in what information was coming into the department about that and what was being done to coordinate responses to that from a health perspective.

Ms Halton—The occasions on which issues around professional indemnity have been raised with us have been fairly limited. Yesterday, when we discussed Aboriginal and Torres Strait Islander health, there was an example of a particular service which had raised that and then managed to resolve it.

Senator CHRIS EVANS—It was a family planning association that closed its doors, wasn't it?

Ms Halton—Precisely. But they are fairly limited, in our experience so far. It goes without saying that, if there are broader issues of insurance, I should probably tell Sarah here and now that she will end up having to deal with them; but to date there has not been anywhere near

the volume of issues and concerns in respect of this matter. This issue, as you know, is something which has been addressed by Senator Coonan more broadly. She had that wider forum on questions of wider access to insurance and also reinsurance. We will keep a watching brief on what is going on there. There is clearly a relationship and, in some ways, an overlap between the work on medical indemnity and the broader issue, because things like reinsurance clearly impact on what is happening with medical indemnity.

Senator CHRIS EVANS—I would have thought it would have impacted on you more, because of the fact that you fund a range of organisations in community health, Aboriginal health and so on, organisations which, not to put too fine a point on it, run on a bit of a shoestring providing community health and related services in a way other departments do not.

Ms Halton—That is a very fair question. As you would know, our grants tend to run in cycles; they do not all expire at the same time. The example we had yesterday in relation to Aboriginal health is one particular example, and I think Ms Evans said to you that it would be an issue that would have to be addressed as the effects become clear. As another example, there are other industries where the indemnity issues are not as severe but where there are other sorts of insurance issues. Clearly, this is an issue which would affect all of the Commonwealth. As those effects become clear, we will have to consider them, but we have not had a deluge of people ringing us about this particular problem at the moment. The real focus has been medical indemnity.

Senator CHRIS EVANS—I know of situations where school pools have been closed as a result—those sorts of things are happening. It struck me that one of the things that might be impacting on you was that a range of the community organisations you fund may well be getting renewals for insurance which they are unable to meet or would have a struggle meeting, and that the funding levels you have applied for them might well not be sufficient if they are in high risk areas. I was wondering whether you had any feedback on that sort of thing.

Ms Halton—To date, no. It is an issue we are conscious of and will be paying attention to.

Senator CROWLEY—I do not want to anticipate what the answers will be, let alone the questions, at the next round of estimates, but, further to Senator Evans's questions or comments, I was wondering whether it is possible for you to assess what proportion of grants go to insurers through your community health programs.

Ms Halton—I think that would be extraordinarily difficult to do. As you would know, in some cases we make a contribution towards services—I am thinking of the Home and Community Care program—and in other areas we are the direct funder. I am not aware that we have a separately identified source of budget information about each of our services which would break out insurance separately. The point I was making to Senator Evans is that we are conscious that there is an issue here. It is something which each of the program areas will be keeping a watch on. If there are particular problems, we will have to deal with them. I am pleased you have not asked me to speculate about what the answer might be, because until we see, firstly, what the issues are and, secondly, what their magnitude is it is a little hard to anticipate how we might deal with that.

Senator CROWLEY—Having served on the boards of those sorts of organisations a number of times in my past life, I can certainly tell you that there is a separate item for the premiums for liability. Therefore, it might be an interesting exercise at some stage to follow

that up. If nobody rings you, then maybe we do not need to follow it up, but I think it will be a major concern to see how many organisations have to find the money.

Ms Halton—I take the point you make absolutely. My point is that the figures are probably on a series of paper files right across the department on those kinds of budgets. The physical exercise of finding and collating them would be enormous. We are alert to the issue and, from our discussions with organisations, I have absolutely no doubt that organisations that are experiencing that kind of difficulty will be very fast to raise it with us. We will have to gauge that over a period and decide on a case by case basis how we respond to each of those issues.

Senator CROWLEY—I do not think we need to go back to program 1 and I am certainly not suggesting we do that. But a number of organisations funded under program 1—for example, Family Planning—might indeed, in anticipation of the next lot of estimates, be able to provide that information for you, disaggregated or aggregated. They have already raised it as a real issue. I will be interested to hear what happens.

Senator WEST—The additional levy that the doctors are going to pay is really just another way of saying 'fee increase', isn't it?

Mr Maskell-Knight—I think it is very premature to speculate on what doctors might do. It depends on how big the levy is and on the competitive environment in which they are working.

Senator WEST—Given that the doctors in New South Wales have already been slugged with an additional year of their indemnity payments—three years in two—I would think that their capacity to absorb too much more is pretty negligible. Have we any idea? Has anyone looked at what the expected increase in doctors' fees is going to be and whether Medicare payments to doctors are going to increase to offset some of this increase?

Mr Maskell-Knight—I think they are all matters to be worked out over the next few months. The call on members is payable over five years, so it is not three years in two; it is six years in five, which makes it not quite such an onerous load.

Senator CROWLEY—It is hardly a sweetener, though.

Senator Patterson—We met with the President of the AMA at a very high level, and what the doctors were saying was that they needed time to deal with the tail.

Senator WEST—It is a complicated issue.

Senator Patterson—You do not have to tell me that, Senator West. I have lost many hours of sleep over it.

Senator CROWLEY—The other concern, following Senator West's questions, is that it depends on how big the fee gets and the pressure that that might be on Medicare payments. This is no more than you anticipated, but I think that questions will be asked about bulk-billing. One of the reasons why doctors are moving away from bulk-billing is that they can charge a larger fee to deal with the costs they have to pay. That pressure is already there and if six years in five adds to that, as clearly it will, I think that is a matter of serious concern for this committee.

Ms Halton—It goes without saying that there is a deal of work yet to be done in this area, and we in the department are going to be doing that in conjunction with our colleagues.

Senator McLUCAS—Still on medical indemnity, do we know how many doctors have stopped practising?

Mr Maskell-Knight—We do not know. We read various media reports about doctors not practising anymore. Doctors ring up the hotline and say that they are not going to practise anymore unless they understand what is going on. I suspect we will never be in a position to know the answer to that. Our sense is that doctors, by and large, are still practising. Following UMP/AMIL going into liquidation, we are aware that a number of surgical sessions in various places were cancelled. Once it became clear what the government's response was, we understand that surgeons started working again.

Senator McLUCAS—There have been some media reports suggesting that people have actually stopped practising.

Ms Halton—We have seen those as well.

Senator McLUCAS—Do you intend to try to track that? I do not know how you would do that—with their Medicare provider numbers?

Senator Patterson—All I would try to do as health minister is encourage them to understand that they have a government guarantee. I do not know if there is any other professional group that has that. As I have said and will say again, and as the Prime Minister has said, it has not been a problem of our making. The government has worked assiduously, and Senator Coonan has worked day in and day out, with the provisional liquidator and with the medicos to try to find a solution to an evolving issue which puts us in uncharted waters, and I have asked continually for doctors' confidence and trust that we are not going to leave them unindemnified or leave patients without services.

CHAIR—You have fixed a situation that was not of the government's making. We have gone around in circles on this; can we move on?

Senator CROWLEY—I have one last comment to make in case anybody should say, at some stage, that I was not completely open or in case there was any suggestion of a conflict of interest: UMP indemnifies me.

Senator HERRON—I should declare an interest, too. It is a long tale.

Senator CHRIS EVANS—No wonder they've gone broke!

Senator HERRON—I have never had a claim.

Senator Patterson—Are you leaving us, Senator Crowley?

Ms Halton—Senator Crowley, with the chair's indulgence, it had occurred to us that, as both you and Senator West are leaving our estimates committee, it would be appropriate that I wish you well on behalf of the officers of the department, some of whom have worked quite closely with you in the past and all of whom have had the pleasure of dealing with you in estimates committees. So, on our behalf, good wishes.

Senator CROWLEY—That is much appreciated. It allows me to say thanks to the department, in its many forms and guises—if not people—over many years. Thank you very much. I shall probably not turn on the television to watch you all at work in September, but you never know.

Senator Patterson—If you can get on the Internet, you can sit there watching it.

Senator WEST—I know.

Senator Patterson—I would like to say thank you to Senator West and Senator Crowley on behalf of the government. I think Senator Knowles has worked with you for 15 years. I

have worked with you for 15 years, except for a slight period off working on the Environment, Recreation, Communication and the Arts Committee and a few other things.

Senator WEST—The four of us have been a little team, haven't we?

Senator Patterson—As we all know, it is a tedious process—and we wish that both sides of the House of Representatives understood it better—but it is important for accountability. I know that the public servants find getting ready for estimates tedious, but it does make us think, 'How would we answer this in estimates?' It is part of the way our democracy works, but it is time consuming, I have to say. When you have to sit here and you cannot walk around, it is even worse. Anyway, thank you very much.

Senator CROWLEY—Minister, I am reminded that in opposition you once asked the department, to their shock and horror, how many Medicare reports or files they had destroyed. They said, 'None.' You said, 'But the legislation says after seven years you destroy them; it's 10 years now.' I would like to know whether you, as minister, are dealing with this same matter?

CHAIR—That question can be left unanswered.

Senator WEST—Someone might want to pursue it at the next round!

Senator Patterson—Do you recall the funniest question about sea sponge tampons in one estimates?

Senator CROWLEY—I certainly do.

CHAIR—Are there any further questions on outcome 2, before we go into too much reminiscing? We could be here all night just reminiscing.

Senator Patterson—And telling funny estimates stories.

Senator HERRON—Before you move on to that, I have attended a number of meetings and, while we were joking about Senator Crowley and me—

CHAIR—No, they were not joking.

Senator HERRON—this long tale of insurance is of major concern. For example, a radiologist friend of mine, because of the rush of people into claims, has just been sued for a myelogram X-ray of the spinal chord that he did in 1975.

Senator Patterson—It is your insurance company, Senator.

Senator HERRON—UMP was taken over by the Medical Defence Society of Queensland.

Senator Patterson—You are a member, Senator.

Senator HERRON—Even Senator Crowley and I can be sued for events that occurred 30 or 40 years ago.

Senator WEST—That is right; the statute of limitations does not apply.

Senator HERRON—That is the major concern of the older group, which you are aware of.

Senator Patterson—I know. It was your Medical Defence Union.

Senator HERRON—I am not disagreeing with you, but I am telling you that that is their concern.

Senator Patterson—We know what their concerns are.

Ms Halton—As there is a tiny pause, I table something we promised yesterday, which is the *Aboriginal and Torres Strait Islander health workforce national strategic framework*.

CHAIR—Thank you.

Senator McLUCAS—I am going to put this question on notice because it is statistical and it is a question that we are going to ask in each round. Essentially, it concerns rates of bulk-billing for the last four quarters disaggregated to GPs; bulk-billing for the last four quarters by federal electorate divisions; and bulk-billing rates by GPs for the last four quarters or 12 months—I will have to check that—by federal electorate divisions. They are the statistics that we will need, so I will put that on notice.

Ms Halton—Okay.

Senator WEST—My question concerns chronic fatigue and the funding that was given to the Royal Australasian College of Physicians. I understand that in 1996 they were provided with $130,000 to appoint a working group, to produce a set of guidelines for general practitioners and to prepare clinical guidelines on the disease of chronic fatigue syndrome. I also understand that those guidelines have only been released in May of this year. Why has it taken so long, and was additional funding given?

Mr McRae—The contract with the college was in fact for $200,000 to produce a set of guidelines. They produced the first draft of those guidelines in the first year or two—I will find that date for you.

Senator WEST—Was it 1998?

Mr McRae—You may well be right, Senator. The draft guidelines were put into the public domain for response from the community. There were large numbers of responses and the college of physicians then worked on bringing those responses together, along with the further evidence that was becoming available over a period of time, in order to turn the draft guidelines into final guidelines. They took, however, many years—I have to find that date.

Senator WEST—Six.

Mr McRae—They took a number of years to work their way through that process. It involved continual and ongoing interaction with the consumer groups and ongoing work by the college until the second draft of guidelines was brought out some months ago. That second draft went through another round of consultation until the finals came out in May.

Senator WEST—Was this initial $200,000 given for a particular period of time? Was the working group to have the guidelines out within a particular period of time? Did extensions have to be sought?

Mr McRae—There was a deadline in the contract which was obviously well before today and was well before these guidelines came out. I do not think any formal extensions were ever given but there was clearly a need to turn the draft guidelines into final guidelines. The draft guidelines were ones which generated considerable discomfort and a lot of work was done to turn them from the drafts into the finals. The process continued to move through until the finals were completed.

Senator WEST—Could you take on notice to provide details of who was on the working group?

Mr McRae—Yes. Do you want the organisations or the personnel?

Senator WEST—The personnel.

Mr McRae—Okay.

Senator WEST—I am happy for that to go on notice. So there were no applications for extension of time for this and, therefore, no reasons to give. Do we know what methodology was used? Was the methodology that was going to be used outlined in the guidelines?

Mr McRae—I think you will find the guidelines that are produced are the outcomes. Within the guidelines there is a section on guideline development.

Senator WEST—Is the methodology clear?

Mr McRae—Mr Maskell-Knight is pointing out that the members of the working group are also in the guidelines, a document which is on the *Medical Journal of Australia* web site.

Senator WEST—How long have they been there? Are they the draft guidelines that appeared on the *MJA* web site a while ago? A lot of people were upset that they were left there not noted as being a draft.

Mr McRae—No, these are the finals that were put up on 6 May this year. They are indeed the final guidelines from that process.

Senator WEST—Is there a clear distinction between the diagnosis of chronic fatigue and chronic fatigue syndrome?

Mr McRae—Can I ask a clinical adviser to address this question, please?

Dr Cook—In the document, they clearly distinguish between chronic fatigue and chronic fatigue syndrome. I can refer you to page S23 of the document; I can read it out if you want me to.

Senator WEST—No, that is fine. So do you think it is clear that they are different?

Dr Cook—It is certainly clear to me. They have tables and diagrams that talk about chronic fatigue as a prolonged and disabling fatigue lasting at least six months, whereas chronic fatigue syndrome is a prolonged and disabling fatigue lasting at least six months which is unexplained by other medical or psychological conditions and which meets a set of syndrome criteria, which are clearly outlined in the document.

Senator WEST—What is the way forward to address the urgent health care needs of those who are severely affected by this syndrome?

Mr McRae—I am sorry, Senator; I do not understand the question.

Senator WEST—You know what the guidelines for the doctors are. What is the way forward? I have not read the guidelines, but I understand that they talk about cognitive behaviour therapy, exercise and things like that. Do they do what the British survey that was released earlier this year does? That survey is very vague about what in fact might be the best method of treatment, but it gives three treatment options. Do the guidelines give those differing options and advise that there is still debate as to whether there are any workable treatments?

Dr Cook—The guidelines go into a process about the diagnosis and the evidence for the different potential causes of chronic fatigue syndrome. They give levels of evidence for each of those different proposed causes. They then go through quite an extensive item about evaluating people with fatigue and coming to the diagnosis of chronic fatigue syndrome, which is a

diagnosis based on exclusion and clinical history. There is no test that says that you have chronic fatigue syndrome.

The document goes on to 'Managing patients with CFS', 'Principles of management' and specific managements that seem to work—for example, exercise. It goes through a regime of how you might want to do this, whether you might want a second opinion and what other professionals you may want to use. It is quite comprehensive in terms of not only drug therapy but also other forms of therapy that you may want to use with a patient. That very much needs to be individualised for the person's particular needs and the need to identify any co-morbities that should be treated rather than just being put down to chronic fatigue.

Senator WEST—Does it adequately identify the differences of opinion that exist, particularly in some of the research happening overseas?

Dr Cook—It certainly mentions that the full answer is not known and that there is some divergence of opinion, but I would be unable to comment about whether or not that is a reasonable level. I think that would be an individual decision and one that I am not able to comment on.

Mr McRae—This document has been put together by a group led by the Royal Australasian College of Physicians, which is the pre-eminent group in the country to do that work. While we can help to describe to you what is in the document, since you have not had the opportunity to read it, we are not really in a position to be making value judgments on the quality of that work. Could I give you the dates that I could not find a minute ago? The contract was signed on 11 June 1996. The draft guidelines went out in December 1997. The redrafted draft went out on 28 June 2001. The final version came out on 6 May 2002.

Senator WEST—Was it clearly indicated that the initial draft that went onto the MJA web site was a draft? Why did it sit on the web site for four years?

Mr McRae—I believe it was indicated that it was a draft and it sat there for that period while work was progressing to take on board the commentary which was being brought to it.

Senator WEST—I understand that when this was initially being undertaken, the NHMRC guidelines were going to be followed.

Mr McRae—I will have to be careful with my words. When it was first commenced, the NHMRC guidelines were only available in draft. The NHMRC guidelines on how to develop a guideline were released in draft in 1994 and published in 1995 as a statement of suggested processes, but were not required to be used more formally until the 1997-99 triennium, with a second edition coming out in November 1998. Those guidelines were coming through more or less as this process was beginning.

Senator WEST—So there was no commitment to follow even the NHMRC draft guidelines?

Mr McRae—I do not believe so.

Dr Cook—It states in the literature review on evidence ratings:

The evidence contained within published studies was evaluated according to the process outlined in the NHMRC *Guidelines for the development and implementation of clinical practice guidelines*. The quality-of-evidence ratings were modified to provide an integrated system for evaluating diagnostic, epidemiological and pathophysiological studies, as well as treatment trials.

Senator WEST—So if somebody comes to me tomorrow and says, 'It did not follow the NHMRC guidelines,' I can tell them that it did?

Dr Cook—I suppose you can quote from the bit that says:

The evidence contained within published studies was evaluated according to the process outlined in the NHMRC *Guidelines for the development and implementation of clinical practice guidelines*.

Senator WEST—It was evaluated that way, but was the whole process undertaken that way? That is probably a different matter. There has been quite a bit of media concern about this particular set of guidelines, particularly in light of the reaction and response of the Chief Medical Officer in Great Britain to the British review that was undertaken. There seems to be some difference of approach here; is there?

Mr McRae—I am sorry, I do not know what the British Chief Medical Officer said.

Senator WEST—Maybe you would like to look at that and make some comment back to me. I will leave it at that. Thank you very much.

CHAIR—Can we move on to outcome 3? Not quite? I thought I had a chance!

Senator HERRON—It is Ms Halton that I probably should address this question to. I refer to the health work force national training. I understand that you are doing a medical work force study. Is the department doing that or do you have an outside consultant doing that?

Ms Halton—Are you referring to the work that is done under the auspices of ARMAC?

Senator HERRON—I was wondering if ARMAC is doing one.

Ms Halton—That one?

Senator HERRON—No, not this one; a parallel one. This one is the Aboriginal task force.

Ms Halton—There is a whole committee structure set up under the auspices of ARMAC. I will not bore you with the acronyms, but essentially there is a very detailed process of looking at the whole issue of the medical work force.

Senator HERRON—That is in process at the moment?

Ms Halton—That is right.

Senator HERRON—Who should I write to about that? I want to have a bit of input on that specific question.

Ms Halton—Either the chair of ARMAC, Dr Rob Stable, who is head of the Queensland health department—

Senator HERRON—Okay. I will write to him as chair of ARMAC. Thank you.

Senator McLUCAS—Could you update me on the process for the next round of MRI licences, please?

Mr Maskell-Knight—As a way of circumscribing the scope of the question, I am tempted to ask, 'What would you like to know?' The monitoring and evaluation group has its next meeting scheduled for Tuesday in Melbourne. The agenda for that meeting is to try and resolve the issue of advice to the minister on where the next areas of need are. After that, it will be a case for the minister to consider that advice and decide on how she wishes to proceed.

Senator McLUCAS—Do you expect that, at that meeting on Tuesday, the committee will come to a view about where the areas of need are?

Mr Maskell-Knight—I would hope so. You can never predict what a committee will do, but it will have a wealth of information before it which has been asked for at previous

meetings. I imagine that it will come to a view. It may be that it will want to go away and think about it a bit more, but I am reasonably hopeful that it will come to a considered view.

Senator McLUCAS—How many licences are being considered in this process?

Mr Maskell-Knight—That is one of the issues. What the committee does is to provide advice to the minister. It says, 'It looks to us as though there are gaps in the provision of MRI services in these areas.' It does not have any riding instructions about whether it should find two gaps or 10. I do not know where it will come out.

Senator McLUCAS—And there are a set of criteria that the committee is obviously working to; is that public information?

Mr Maskell-Knight—It is not. I guess it is in the process of evolving. The main criterion is access to MRI services. The committee has before it details about things like the number of services provided to patients in an area by providers in that area, and information about the cross-border flows. For example, there are no MRI services for people in north-western Victoria, so the committee has information about where those people go to receive MRI services and the level of MRI services they receive relative to comparable populations.

Senator McLUCAS—So you are saying that it is actually not a discrete and clear formula to this point?

Mr Maskell-Knight—It is not a formula, and I do not think it ever can be. I think one of the issues is that, while you may have an area where there is no MRI machine, there may be actually nowhere you could sensibly put one, because you need to have a reasonable level of specialist referral base in an area to make having a machine there worth while. There is no point having a machine if the patient actually has to go somewhere else to see the specialist to get the referral to get the scan. The patient may as well get the scan while they are away there.

Senator McLUCAS—Your point is well made; I think that is real. But you can quantify remoteness or difficulty of access.

Mr Maskell-Knight—Yes.

Senator McLUCAS—Those sort of things you can quantify. I think the point you make about the capacity of a certain community to have an MRI is the other part that you add to that equation.

Senator CHRIS EVANS—With the issue of the criteria to be applied by the committee in their considerations, what weight or emphasis or reference has been given to the question about public or private provision of those services? That has certainly been one of the strong issues in Western Australia, as you know. We raised with you on a few occasions that, while they may be physically located in a town, region or city et cetera, there is a question about whether they are located in public hospitals or in private clinics or whatever. What criteria are applied in that argument.

Mr Maskell-Knight—I think there is a distinction between looking at where facilities are and looking at the process of deciding who should get a facility if you decide that there should be one somewhere. In terms of where facilities are, we do not have information available to us on the level of service which is provided privately and not paid for by Medicare, nor do we have access to information on the level of service provided by ineligible machines located in public hospitals—although I do not think there are any in that category. The first issue—what level of service is being provided by private non-Medicare funded machines in a particular

area—is one that the committee is cognisant of, and we will have to think of how to factor that into the information we have.

In terms of whether the machine should be in a public or private facility, I think the tender process we went through last time was essentially agnostic about that. At the end of the day—I cannot remember the precise numbers—six or seven licences emerged from that process, and I think they were split reasonably evenly between public facilities and private ones. But the criteria we looked at went to patient affordability, geographic access, the existence of a suitable specialist referral base in a particular area, opening hours and things like that. There is nothing in those criteria which appears to me to confer a benefit on a public or a private organisation.

Senator CHRIS EVANS—The corollary of that is that you take no view about whether or not there should be provision of these services in Australia's public hospitals.

Mr Maskell-Knight—We take the view that, if there is a need for a public hospital to have an MRI to provide inpatient services, that is largely a matter for the state government to concern itself with. What we fund through Medicare are largely services for ambulatory patients. We are not in the business of funding machines in public hospitals to deal with in-patient work.

Senator CHRIS EVANS—So the answer is that you are agnostic about the location of the machines licensed under your regime?

Mr Maskell-Knight—That is right. The private sector would argue that the public sector have an advantage because they do not have to make a profit and therefore do not have to make patient charges. The public sector would argue that the private sector probably have an advantage because they can levy charges to help pay for the cost. So I think it is six of one and half a dozen of the other.

Senator CHRIS EVANS—That is if you are only interested in the argument between them. I was more interested in whether you had a public policy view; but the answer to that it is no.

Mr Maskell-Knight—I think we have the view that if there was a pressing need for a public hospital to have a facility to provide in-patient services, that is a matter for the state governments.

Senator McLUCAS—I have a last question on outcome 2. On page 78 of the PBS under the program 'Better Treatment for Cancer Patients', there is an allocation of $72.7 million over four years for radiation oncology services. I understand that you are doing an analysis at the moment of where the services are going to be located. Where is that up to?

Mr Maskell-Knight—The government has commissioned an inquiry into the whole issue of radiation oncology service provision, workload, access and various dimensions. Professor Peter Baume is conducting that inquiry. At this stage, we expect the report will be available to the minister later this month. We will, of course, have to take into account the findings that Professor Baume has reached, in deciding where the machines are to be located.

Senator McLUCAS—But he has been asked to provide advice?

Mr Maskell-Knight—He has been asked to advise, not so much on the details of where they are but on the structure within which you should think about that.

Senator McLUCAS—$13 million dollars is allocated in this budget. What do you imagine that will be spent on?

Mr Maskell-Knight—Certainly part of that money, we expect, will go into work force measures to improve the supply of the staff to run these machines. Beyond that, I think, we still will have to work out the details, once we know what Professor Baume's advice is.

Senator McLUCAS—But we will be identifying locations in this next financial year?

Mr Maskell-Knight—I would imagine so; but do not hold me to that.

Senator McLUCAS—I do not know how we can spend $13 million if we do not know where we are going to do it yet.

Mr Maskell-Knight—I think it will be easy to spend a considerable amount of money on a whole range of things including capital equipment, work force, and a range of measures that could be taken. I think it is premature to speculate, ahead of seeing what the report says and what the government's response to it is.

Senator McLUCAS—Thank you. We will pursue that.

Ms Halton—Senator Denman had asked yesterday for a copy of the National Alcohol Strategy, which was endorsed by the Ministerial Council on Drug Strategy and which I would like to table.

[5.08 p.m.]

CHAIR—Thank you. I thank the officers associated with outcome 2. It has been a long day for them. We are now moving on to outcome 3, Enhanced quality of life for older Australians. Senator Evans has questions.

Senator CHRIS EVANS—I want to go through a couple of the budget measures and get some explanation. I start by noting that the capital funding for rural and regional aged care areas is $100 million, but then you put it in the budget figures as only $78.8 million and claim that it is really $100 million. It looks a bit cute to me, to be honest, but I guess it could have gone on the contingency funds. But we are only spending $78.8 million over the outyears, aren't we?

Dr Graham—The $100 million will flow; it is just a matter of the way the money will be paid. The capital money is paid at a slower rate and so, although it will be passed out, it reflects how it is going to be utilised. It will be $100 million but it will be over more than four years.

Senator CHRIS EVANS—Why?

Dr Cullen—It is important to note that each year there will be an additional $25 million worth of grants actually awarded, and so over the four years $100 million worth of grants will be awarded. But those grants will only be paid out as buildings are built: it would be improper to pay money to providers before they had built the buildings. Obviously, with the $25 million in grants awarded in the fourth year, the buildings will not be built immediately and will be paid out in years 5 and 6.

Senator CHRIS EVANS—So wouldn't that mean that your entry for this year would be zero? I presume you have not awarded any yet; or have you?

Dr Graham—The money will be built into the capital funding for the next allocations round, which is under way at the moment—the level 1 funding has been announced. There will be some money passing out in the next financial year; there have been some commitments made through those capital grants.

Senator CHRIS EVANS—I do not understand that. We have a lag in the fourth year but we do not have a lag in the first year.

Dr Cullen—We do have a lag in the first year, because the amount of money paid out in the first year is not $25 million but, I believe, something like $7.5 million. The assumption is that, of the $25 million worth of grants which will be awarded in 2002-03, 30 per cent of that building work will be done within the first year, and therefore $7.5 million will be paid out within the first year.

Senator CHRIS EVANS—Is that the figure of $8.3 million?

Dr Cullen—The measure is $8.3 million but there is $7.5 million worth of capital grants. The $8.3 million also includes departmental costs.

Senator CHRIS EVANS—So how much of the total $100 million is departmental costs versus capital grants?

Dr Cullen—There is $100 million in total in capital grants, and additional departmental costs on top.

Senator CHRIS EVANS—So is the $8.3 million the total in capital grants or is it $7.5 million?

Dr Cullen—The $8.3 million in the first year is the total; it consists of $7.5 million in capital grants and $0.8 million in departmental costs.

Senator CHRIS EVANS—So the $78.8 million is not all capital grants then?

Dr Graham—No, there is $1.7 million of departmental costs and $77.1 of administered funding.

Senator CHRIS EVANS—So you are telling me, Dr Graham, that the first grants will be paid out in the capital allocation round? Can you explain that to me?

Dr Graham—In the allocations round we call for applications for capital grants as well as for places.

Senator CHRIS EVANS—So you have just combined it with your annual places round?

Dr Graham—Yes.

Dr Cullen—In the annual places round at the moment, around $10 million annual of capital grants are made, and this $25 million will mean that we will be advertising $35 million.

Senator CHRIS EVANS—That was limited to rural and regional areas, wasn't it?

Mr James—That is correct.

Senator CHRIS EVANS—Is this all limited to rural and regional as well?

Mr James—That is correct.

Senator CHRIS EVANS—Are the grants linked to new places, or can they apply even if they are not applying for new places this year?

Mr James—You do not have to be applying for new places as such.

Senator CHRIS EVANS—So they might have places that they are trying to get built?

Mr James—It could be for restructuring, for example, rebuilding, certification requirements and things of that nature. Just to clarify on targeted capital—that is a priority for

rural and special needs. It is not restricted solely to rural areas. That is the standard capital program, the $10 million a year indexed.

Senator CHRIS EVANS—Is the additional $7.5 million targeted purely at rural and regional areas?

Mr James—Correct—and remote areas.

Senator CHRIS EVANS—And you will pay that out as they incur expenses?

Mr James—That is right. It is also for urban fringe, for that group.

Senator CHRIS EVANS—That is exactly the opposite of what you just told me—that that group was purely for rural and regional.

Dr Graham—To clarify: the measure covers rural, remote and urban fringe.

Senator CHRIS EVANS—And the original $10 million in the ongoing program only covers rural and regional?

Mr James—No, the original $10 million that is continuing covers urban, rural and regional. However, the priority is rural and other special needs groups like Aboriginal and ethnic, for example.

Senator CHRIS EVANS—So you have not combined them; you are running them as separate programs?

Mr James—The residential capital grants program is under the Aged Care Act. The other program is not. So the residential care capital grants are subject to the act criteria, whereas the regional funds are not against those criteria. Their criteria are to be determined by the minister.

Senator CHRIS EVANS—Thank you. I am interested in the increase in residential aged care subsidies and how that is to be applied and then, obviously, linking into the pricing review initiative and how that is to operate.

Dr Graham—The intention is that the $50 million per year in the residential aged care subsidies will be paid through the subsidies by a percentage increase, with most of it being targeted towards the high care end.

Senator CHRIS EVANS—So you are basically going to add a figure at each RCS to the subsidy paid that equates to $51 million per year?

Dr Graham—Yes, that is the intention. We have had some discussions with the industry and the peaks are supportive of this approach. The way it would be structured is that, as I said, most would go to high care and about $2 million of that money would go to low care.

Senator CHRIS EVANS—So the vast majority of the $49 million is going to go into the high care end?

Dr Graham—Yes. The purpose of the measure was to reflect, to some extent, the pressure from wages—nursing wages particularly. That is why much of it is directed towards the high care end.

Senator CHRIS EVANS—Have you worked out the increases by RCS yet?

Dr Cullen—The intention is to provide an additional 1½ per cent increase in each of the RCS1 to RCS4 rates, on top of normal indexation and other measures, and a ¾ per cent increase in the RCS5 to RCS7 rates.

Senator CHRIS EVANS—RCS8 has disappeared.

Dr Cullen—RCS8 is a zero rate, so I chose not to put a percentage on top of that.

Senator CHRIS EVANS—I knew we did not have many left. It is one of the great unexplained mysteries of Australia. All those old people disappeared overnight. That does not sound clear cut. I know the rate is lower, but you say, Dr Graham, that in the end that effectively means $49 million to the higher end and only $2 million to the lower end; is that right?

Dr Graham—That is correct, yes.

Senator CHRIS EVANS—From when will that be applied?

Dr Graham—It will apply from 1 July.

Senator CHRIS EVANS—Is that on top of normal indexation?

Dr Graham—That is correct.

Senator CHRIS EVANS—What adjustment has been made in relation to indexation?

Dr Graham—That is to be announced.

Dr Cullen—We are in the process of determining precisely what that is and gathering the parameters that we need to know for the answer to that.

Senator CHRIS EVANS—So you have not actually struck the rates to apply from 1 July?

Dr Cullen—Not at this stage.

Senator CHRIS EVANS—Is that 1½ per cent or ¾ per cent applied to the current rate or to the indexed rate?

Dr Cullen—The effect is the same whether you index first and then apply 1½ per cent or apply 1½ per cent and then index. It is a multiplicative effect and therefore it would be the same.

Senator CHRIS EVANS—I will take your word for that. What is happening with the pricing review?

Dr Graham—The minister has announced that he will be making an announcement on this on 1 July or thereabouts, when the money starts to flow. At this point in time the appropriation is not available, but he will be ready to make an announcement of how that pricing review will be conducted at that time.

Senator CHRIS EVANS—I do not quite follow that. What is the linkage between the payment of the money on 1 July and the pricing review?

Dr Graham—The process is being planned but the minister is proposing to announce the conduct of that pricing review at about the beginning of July.

Senator CHRIS EVANS—I see. He has determined to announce it in conjunction—

Dr Graham—With the availability of the funding to support it.

Dr Cullen—The budget measure which provides funding for the pricing review provides $3.7 million in the first year, but that money is not available until 1 July.

Senator CHRIS EVANS—Yes, sorry. I was thinking of the $211 million but you are talking about the actual funds to pay for the pricing review process. I notice that that is $7

million over two years or something like that. Is that money to pay for wages and consultants, et cetera, to do the review?

Dr Graham—That is correct.

Senator CHRIS EVANS—But there has been no announcement yet on the structure of that or on who is to do it?

Dr Graham—That is correct.

Senator CHRIS EVANS—I presume that means that there are no terms of reference yet?

Dr Graham—Nothing has been announced at this point.

Senator CHRIS EVANS—I think I saw somewhere that the minister had announced that it would be completed by September 2003; is that right?

Dr Graham—Yes. The aim for completing that review is later in 2003.

Senator CHRIS EVANS—But there is no particular deadline in the sense that there is nothing financial that kicks in or fails to kick in that is linked to that, is there? This $211 million increase is just administered, as you say, as a percentage on the rate that will then flow through each of the out years automatically, so the pricing review does not—

Dr Graham—The two are separate. They will come together at that point of time, but that is the estimate of what it will take to do a complex review of the cost structures and pricing.

Senator CHRIS EVANS—I do not know about the complexity of it. So you are just applying it as a percentage rate to the RCS and then next year, when you index, it will just keep flowing through in the sense that that rate will be indexed against the rate of inflation?

Dr Graham—Yes.

Senator CHRIS EVANS—I was a bit intrigued with the reference in the budget papers that there was a decrease in residential aged care subsidy estimates, which was 'because of a fall in estimated demand for residential aged services and a downward revision to estimated dependency levels'. Could somebody explain that to me? It seemed a bit counterintuitive in terms of the demand question.

Dr Graham—It is not an unusual event that forward estimates are adjusted for actual experience. In fact, under the department of finance requirements, we are required to keep the forward estimates as accurate as possible. The other consideration is that, with the reforms to aged care, it has been somewhat difficult to be completely accurate about forward estimates. What this represents is that, with experience, we are now adjusting it to actual use. For instance, the proportion of concessional residents was increasing at a fairly rapid rate and that has now started to plateau, so that reflects, to some extent, the adjustment.

Senator CHRIS EVANS—You have a budget measure on that, haven't you?

Dr Graham—Yes. That is another aspect of it but, in terms of forward estimates, the frailty and the number of concessional residents are two factors that affect it.

Senator CHRIS EVANS—What is your percentage concessional resident rate now?

Dr Graham—It is close to 50 per cent.

Mr James—Nearly 50 per cent, yes.

Senator CHRIS EVANS—The original estimate was in the 20s, as I recall.

Dr Graham—There is a target in the way the pricing is structured at around 40 per cent, so we would have expected at least 40 per cent.

Dr Cullen—The original estimate in the 20s that you were referring to was an estimate made before the amendments which introduced the 40 per cent target were put through, so those original estimates are really not of value.

Senator CHRIS EVANS—No, but they were of interest in that they underpinned the financial expectations. Are you saying, Dr Graham, that now you are finding that that has plateaued at around 50 per cent?

Dr Graham—I do not know whether I would call it a plateau, but it is stabilising at around that 50 per cent mark.

Senator CHRIS EVANS—It had been steadily increasing.

Dr Graham—Yes.

Dr Cullen—There is a sense in which the steady increase was an artefact of the way in which the concessional proportion is calculated. When you work out the percentage of concessional, you only divide by the number of new residents, not by the total number of residents, because we have residents who entered prior to 1 October 1997. As the denominator has become larger, as we have captured more and more of the population, the figure becomes more statistically reliable. Some of the movement in the concessional ratio in the early years is just an artefact of the fact that we were not capturing a large part of the population.

Senator CHRIS EVANS—And, as is shown by the budget measures, you also have other issues about classification of concessional that you are looking to address?

Dr Cullen—Yes.

Senator CHRIS EVANS—I take your point about projections and estimates, Dr Graham, but the budget papers read as though there has been a decline or a decrease in demand for aged care. I have to say that is a little bit counterintuitive from anything else I have ever read.

Dr Graham—It is not a decrease in demand; it is a decrease in, perhaps, the rate of increase of frailty and also that concessional status. The other point to make is that, in terms of outlays, this is unrelated: we pay according to the resident profile. So if the resident profile increases, the payments against the program increase. It in no way limits the amounts that we would need to pay out according to the number of residents.

Senator CHRIS EVANS—I took that to reflect more the success of your campaign to try to address the RCS classification levels. Is that fair or not?

Dr Graham—No.

Dr Cullen—That measure is already built into the forward estimates. Therefore, the decrease of the subsidy level that we are talking about is on top of savings which were taken there.

Senator CHRIS EVANS—I thought you might have been more successful than you had found, and I was giving you credit for that.

Dr Cullen—I think we were less successful in predicting the expenditure that we expected for this year. The reason for that was that it is a very complex model which we use to predict how this money will be expended. Certain of the trends that we were mapping, in particular

the trend in ageing in place, have flattened out since the data that we had to predict trends from. Frailty did not increase as much as we expected it to.

Senator CHRIS EVANS—Does that mean that the rate of increase in the frailty level has started to slacken?

Dr Cullen—That is correct, and that is an artefact of the fact that ageing in place is a phenomenon which has now worked its way into the system and is in a steady state phenomenon, whereas over the last three years, it was working its way into the system and increasing the rate.

Senator CHRIS EVANS—How much in that saving was also due to having fewer beds online than you had anticipated?

Dr Cullen—I do not have a breakdown of that number.

Senator CHRIS EVANS—Can you take that on notice for me? I presume that was also a factor.

Dr Cullen—As I understand it, the principal drivers were the frailty and the concessional.

Senator CHRIS EVANS—I would be interested in the comparison between your estimates and what we ended up with with beds online. I notice that eventually we got a lot of the answers to those questions. I had only waited two or three years for them. But it is amazing; after the election they seemed to become available in formats that actually allowed us to assess those issues.

Senator WEST—Were you right?

Senator CHRIS EVANS—I think it is fair to say that we were a bit closer than some of the minister's statements were. I want to ask about the initiative for nursing and personal care workers. I see that the nursing one is about rural scholarships.

Dr Graham—Yes, the measure has been allocated $26.3 million over the forward years. That will provide up to 250 scholarships per year in rural and regional universities. Each of those scholarships would be worth up to $10,000. Within the department we have an aged care work force committee. We do not have final details on how these initiatives will be implemented, because we are seeking the advice of that work force committee, which includes employee and industry people, to provide advice on how we can best apply that measure. But the intent is that it would provide some scholarships for undergraduates, some opportunities for nurses to return to the work force, and some postgraduate scholarships. Within that process, too, we are learning from the experience of the rural health scholarships and using their knowledge to make sure that we get maximum benefit out of this program.

Senator WEST—Does this mean that there are an additional 125 or 250 places in rural universities for undergraduate nurses, or even for people taking postgraduate nursing qualifications? Are there an additional number of places in the rural universities?

Ms Bailey—The universities have shown a great interest in offering places to match theirs. We have had discussions with the council of deans. I think our current view is that there will be an opportunity for scholarship holders to find places in regional universities.

Senator WEST—That did not answer the question. Are there going to be additional places at universities, or will this 250 come out of the existing pool of places at the universities, with which there is already an oversupply of people wishing to undertake these courses?

Ms Bailey—This initiative is about funding scholarships for nursing in the rural and remote areas. What the universities do about offering the capacity to pick those up and to broaden the scope is a matter—

Ms Murnane—This policy does not entail the funding of additional nursing places from the Commonwealth.

Senator WEST—So there are no additional nursing places in the universities in rural Australia. From my contact with Charles Sturt University, I know that the Bathurst campus had at least 18 or 19 people they could not fit in—and that was with TERs in the very high 70s. So there are no additional university places. That is the problem.

Senator CHRIS EVANS—Is this purely aimed at registered nurses, or is there any provisions for enrolled nurses?

Ms Bailey—There will be some opportunity for re-entry and retraining, and the other initiative envisages career pathways for other workers in aged care as well.

Senator CHRIS EVANS—It seems to me that one of the key employment groups in aged care is the enrolled nurse, and there are enormous issues in a number of states about loss of training opportunities—

Ms Murnane—We would agree with that. The issue of enrolled nurses is very important and, in the short and medium term, assisting with vacancies is very important. That is why we have been working with various parts of the industry to encourage and assist where we can in the development of enrolled nurse courses in TAFEs and universities. We have also been talking to the states about their regulations on enrolled nurses, which differ from state to state and provide real difficulties for the enrolled nurse work force to be used to its full capacity in all states. We are conscious of that.

Senator CHRIS EVANS—I note that they are not mentioned at all in either of these budget initiatives.

Senator WEST—Yes, they give you the impression that it is all RNs.

Ms Murnane—I think it comes into the second one in the sense that we are talking about pathways. Somebody in the system or not in the system who wanted to avail themselves of the second measure to improve their qualifications from AIN to enrolled nurse would be able to proceed down that pathway with assistance from this measure.

Senator CHRIS EVANS—I was going to come to that, but I note that it is not specifically referred to. I take it then that the $26.3 million and the scholarships are purely directed at registered nurses?

Ms Bailey—But, of course, many enrolled nurses may wish to avail themselves of that opportunity, too: they might decide to upgrade their qualifications to become registered nurses.

Senator CHRIS EVANS—Which will add to your column-cutting.

Ms Bailey—But articulated pathways are important.

Senator CHRIS EVANS—I have always argued and tried to encourage that progression. I am not saying it is a bad thing. It also adds your backfilling problem, effectively.

Ms Murnane—It does. We have been talking to the states in various work force forums about initiatives to increase the training and supply of enrolled nurses.

Senator WEST—There are two universities in New South Wales which specialise in offering courses for upgrading from EN to RN. One is in Sydney and one is in rural New South Wales. They do not have any shortage of takers for the courses; the problem is in the places at the universities.

Ms Murnane—The government is trying to concurrently address all these issues, as all are recognised as contributors to the current difficulties in finding enough nurses—and nurses broadly defined as including enrolled nurses—right through the sector. The review into nursing education sponsored by the minister for health and the minister for education is nearing completion, and that provides an opportunity to go down that path. This may be reckless of me, because I have not got the figures before me, but the actual enrolment numbers in nursing courses are pretty volatile. While most courses were oversubscribed last year, that has not been the trend. I am not saying that we are hoping that will be the case; it is not. The other fact when you look at nursing is that there is a lot of leakage: the retention rate through the course is not high. It is quite reasonable to argue that the scholarships that we are putting in place for people from rural Australia to study nursing will help with that retention.

Senator WEST—I am not opposed to the scholarships. My problem is that we are not actually increasing the number of nurses, because they cannot get into the places to begin with.

Senator CHRIS EVANS—I think it also begs the question that, as I understand it, the nursing crisis in aged care is not limited to rural and regional. I notice this measure is wholly targeted at training in rural and regional universities.

Ms Murnane—Yes, that is true.

Senator CHRIS EVANS—I am wondering why. I am not saying there is not a problem there but it is a general aged care nursing work force issue, I think.

Ms Bailey—It appears more acute in these areas. It would be feasible to imagine that people going through training may not always stay in rural and regional areas. They may move to metro and metro may move out. So it is a way of increasing the quantum overall and then hoping they will disperse across the entire sector.

Dr Graham—Another challenge in aged care is to expose the nurse during his or her training to aged care or to have some exposure to residential aged care. So one of the outcomes of this will be to give nurses more opportunity in that area.

Senator CHRIS EVANS—In terms of the support for the aged care training initiative, do you have any more detail about how that will work?

Ms Bailey—It is still a matter that is being considered by the work force committee. I think there is a hope that it will start an adoption of a minimum qualification for the work force. That would certainly be one major rural initiative we would hope that the work force committee and the industry would endorse. The minimum qualification would be a certificate 3 at least for workers in aged care.

Senator CHRIS EVANS—Hasn't that happened in a number of states already?

Ms Bailey—It is an issue to endorse that nationally as an industry position and to use this initiative to promote that. But other details are still being considered by the work force committee.

Senator CHRIS EVANS—So no detailed work has been done yet on how that money will be applied over the next three or four years?

Ms Bailey—No. The current thinking is to determine a framework for what are the priorities and how to address it and the rollout of the next year.

Senator CHRIS EVANS—Will that be driven largely on advice from the work force committee?

Ms Bailey—Yes.

Senator DENMAN—I have a few brief questions and they mainly relate to Tasmania, of course. Can you tell me how much additional funding there is in the budget for respite care centres?

Mr Bruen—There were a number of new budget measures with support for carers that contained respite care. But overall there was an increase of some 20 per cent in the respite for carers budget overall nationally—an increase of some $15 million. How that will break up across the states has not yet been determined.

Senator DENMAN—You have anticipated my next question. I was going to ask you what proportion of that would go to Tasmania—

Mr Bruen—I thought you might.

Senator DENMAN—and whether you could specify where in Tasmania it goes to.

Senator CHRIS EVANS—Particularly the north-west coast of Tasmania?

Senator DENMAN—There is an issue where I live about a respite care centre.

Senator CHRIS EVANS—Where do you live?

Senator DENMAN—Devonport. I just wanted to put that on the record.

Mr Bruen—I can assure you that when the minister does make that decision it will be fully publicised where these extra funds will go.

Senator DENMAN—People are playing politics with it. What I also need to know is whether respite care centres are accredited in order to receive Commonwealth funding.

Mr Bruen—They have to be approved by our department. The word 'accredited' is not used but they are approved.

Senator DENMAN—Could I have the guidelines for the approval? Is that possible? I do not want them now.

Mr Bruen—Yes, I can get them.

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

Senator CHRIS EVANS—What is the increase in the HACC budget this year?

Mr Bruen—The Commonwealth contribution to the HACC budget will increase by 9.5 per cent.

Senator CHRIS EVANS—So the six per cent real growth has been maintained?

Mr Bruen—That is correct, yes.

Senator CHRIS EVANS—So is it exactly that? Was there 3.5 indexation?

Mr Bruen—The breakdown between real growth and cost indexation, which is passed on to the states, has not yet been determined. That is a matter for the minister. What we get is the total growth in the program. That is 9.5 per cent. But, on my arithmetic, that certainly includes six per cent real growth at least.

Senator CHRIS EVANS—Thanks for that. I have no further questions on aged care.

CHAIR—Are there any further questions on outcome 3?

Senator WEST—I have some to go on notice.

CHAIR—Are you wishing to go on to outcome 4?

Senator McLUCAS—Just before we do move on to outcome 4—

CHAIR—Before we move on to outcome 4, Senator McLucas has one final question.

Senator McLUCAS—It is more advice. Has this section received any request for a psychogeriatric support service? Would that fit within this section?

Dr Graham—Yes, it does. There is a budget measure. I would have to find the amount, but in the budget there was an amount put aside for psychogeriatric care centres. Part of that will be a review of the current centres with some additional money. How that will be spent will depend, in part, on that review.

Mr Bruen—In fact, the budget measure doubles the money available for the pyschogeriatric units, which is what they are actually called. To answer your question, yes, we have had interest from a lot of people wanting more of these units. This budget measure will enable us to do that.

Senator McLUCAS—Can you just tell me which page of the budget that is on and how it is described. It obviously did not jump out at me.

Mr Bruen—It is on page 107 of the portfolio budget statements under the heading 'More support for carers of people with dementia'. It comes in there. There are two elements to that, as the text points out. The second element is as follows:

The measure will also provide for the expansion of Psychogeriatric Care Units to provide quality national coverage under a Commonwealth only program.

Senator CHRIS EVANS—How many units do you think that will fund?

Mr Bruen—Probably double what we have now. We have one in each state at the moment and in the Northern Territory. We would probably be able to double that number, I would think.

Senator CHRIS EVANS—How does the finance of that work? I am not belittling it, but on $5 million—and that is only half the measure—it does not sound like it would fund those. What do you actually fund for those units?

Mr Bruen—It varies from state to state. We tend to fund consultancy units with groups that have expertise in dealing with people who have dementia. They basically act as consultants to other aged care providers, residential care providers and community care providers. So when they have difficult clients with dementia and difficulty working out a care management plan, these units come in to help with those particular problems.

Senator CHRIS EVANS—So you are providing specialist backup advice rather than facilities or infrastructure?

Mr Bruen—That is correct. It is specialist backup advice, not front-line service provision.

Senator McLUCAS—I understand there is one in Adelaide which is funded by the Commonwealth.

Mr Bruen—Yes.

Senator McLUCAS—And it is an institution rather than the model you have just described. Is that correct?

Senator CHRIS EVANS—I think you will find that it is a facility.

Senator McLUCAS—A facility.

Mr Bruen—No, we do not fund any facilities under this program. That must be another program. We do fund a psychogeriatric care unit in Adelaide, but it is as I have described.

Ms Halton—Senator, there are a number of units around the country, some of which have chosen to specialise in the care of people with dementia. There are, to my knowledge, a couple of specialised state based units in a couple of states that have dealt historically with particularly difficult cases. So unless we knew which facility it was, it would be very hard for us to say on what basis it was financed.

Senator McLUCAS—When will applications open for the next round?

Mr Bruen—Very soon. We do not have the appropriation yet, but it will be very soon.

Senator McLUCAS—Early in the financial year?

Mr Bruen—Yes.

Senator McLUCAS—Terrific. Thank you.

[5.50 p.m.]

CHAIR—I thank the officers from outcome 3. We can move on to outcome 4, Quality health care.

Senator CHRIS EVANS—Can someone explain to me the withdrawal of funding for the GP House measure. I understood from the Prime Minister's announcement that the funds taken from the Asthma Management Program and the Medical Specialist Outreach Assistance Program have gone back into those accounts.

Dr Morauta—Yes, that is correct.

Senator CHRIS EVANS—I think it was $2 million and $3 million. I forget what the break-up was.

Dr Wooding—The break-up was $4 million for outcome 5 and $1 million for outcome 9.

Senator CHRIS EVANS—Thank you. Can you explain to me what that means in practice? This decision was announced around budget day, so it was fairly late in the piece. Obviously we are nearly at the end of the financial year. Will they be rolled over in those programs?

Dr Wooding—They have been rephased into 2002-03.

Senator CHRIS EVANS—But they will not show up in the budget as expenditure for the coming year; they will be expenditure from this year just rolled over. Is that right?

Dr Morauta—Page 24 of the PBS describes the movement of the money in summary. It is a little bit obscure, but withdrawal of funding for GP House is not shown there. That is where it is minus five in the current year, and it is plus four for medical specialist outreach and plus one for asthma management in the coming year.

Senator CHRIS EVANS—Thank you. Can I just ask about what other expenses might have been incurred. I understand there was some talk about the possibility of compensation to the RACGP—I think it was in the Prime Minister's statement. Is that issue being progressed?

Mr Stuart—Yes, it is. That matter is being progressed. The department have written saying that we are willing to consider the matter, and we are dealing with the RACGP on it.

Senator CHRIS EVANS—So a process of negotiation has commenced on that issue?

Mr Stuart—A process of consideration has commenced. We have invited the RACGP to provide information which we will, of course, need to assess very carefully.

Senator CHRIS EVANS—Are you able to tell us what your letter to them said and what areas you are prepared to consider? What are you considering compensation for?

Mr Stuart—The letter said, 'reasonable costs unavoidably incurred by the RACGP and directly attributable to this termination'.

Senator CHRIS EVANS—What is your sense of what that might mean or include?

Mr Stuart—I could not speculate on that. We need to have a close look at what they might provide us.

Senator CHRIS EVANS—You must have speculated, otherwise you would not have bothered writing to them. If you had not thought there were some costs involved, why would you have sent them the letter?

Mr Stuart—I thought you might be asking me about an amount.

Senator CHRIS EVANS—No, I am asking what we are considering compensating them for. Obviously they would have to specify the costs incurred so that you could make some assessment. I understand that. What sorts of things are we talking about considering? Pain and suffering?

Mr Stuart—I would not like to speculate on that. We are talking about financial costs incurred unavoidably by the RACGP which are directly attributable to the termination.

Ms Halton—Not pain and suffering.

Senator CHRIS EVANS—Exemplary costs—is that the term?

Ms Halton—I am not a lawyer; I would not comment.

Senator CHRIS EVANS—I presume pain and suffering is not the right technical term. Is 'exemplary costs' a better way of describing it?

Ms Halton—I do not think you have a lawyer in front of you.

Senator CHRIS EVANS—That is unusual.

Mr Stuart—We are simply talking about costs incurred, not any additional costs of any kind.

Senator CHRIS EVANS—Costs they might have incurred in progressing the proposal?

Mr Stuart—Yes.

Senator CHRIS EVANS—What would that be? Architectural fees, borrowing costs or what?

Senator TCHEN—Are you thinking of sharing the costs, Senator Evans?

Senator CHRIS EVANS—As a taxpayer I will be, yes.

Mr Stuart—They would need to be costs directly related to this initiative.

Senator CHRIS EVANS—I am trying to get a sense of what they could be.

Ms Halton—I think Mr Stuart is saying that he does not want to speculate. We agree and are quite clear that this is in relation to actual costs incurred and they must be demonstrated. Mr Stuart is trying to say that it is premature to speculate as to what they might be until we get into a detailed discussion with the RACGP.

Senator CHRIS EVANS—It is about actual costs. Mr Stuart, you keep using the words 'in the termination of the matter'. I presume you mean the costs they may have incurred in advancing the proposition to the stage it had reached when it was terminated. Is that right?

Mr Stuart—Yes.

Senator CHRIS EVANS—So that would be the costs they may have incurred in planning or progressing the proposed building from their point of view. Would it include things like their legal advice?

Mr Stuart—If they are costs directly related to their work in relation to this proposition, we would examine that. I am trying very hard to avoid stating any particular kinds of costs. As you can imagine, we will want to look at these issues very carefully as to whether they bear directly on the issue of the establishment of GP House.

Senator CHRIS EVANS—I do not want to do anything that would add to the scope of the application. I will leave that line of questioning there. Have you sought legal advice about what the Commonwealth liability to compensation might be?

Ms Halton—Yes.

Senator CHRIS EVANS—Who provided that advice?

Mr Stuart—We have advice from the Australian Government Solicitor.

Senator CHRIS EVANS—Obviously, I will not ask you for a copy of that advice, but it went to the question of your legal liability. In terms of negotiating an outcome, who has to approve any decision, if there is one, to pay compensation?

Mr Stuart—My understanding is that it is a matter for business negotiation between the department and the RACGP.

Senator CHRIS EVANS—I meant in terms of your approval processes. Is this something that has to be signed off by the minister or is there some sort of gazettal? As a representative of the Commonwealth, can you tell me who is responsible for that decision making process? Where does the buck stop?

Mr Stuart—We will be able to answer that question for you very shortly. You may like to ask another question and come back to this.

Senator CHRIS EVANS—That was almost going to be my last question, you will be pleased to know.

Mr Stuart—There are particular considerations in relation to compensation.

Senator CHRIS EVANS—That is what I understood; that is why I asked.

Ms Halton—In relation to who has authority, there are two issues, one of which is the departmental delegation in relation to particular amounts. We do not know what that amount is yet. There is a broader question about the legal advice and broader levels of scrutiny of the amount. The short answer is, we do not have a detailed answer on who will approve it. I assure you it will receive very detailed senior scrutiny and, of course, in due course we will be very happy to tell you who approved it.

Senator CHRIS EVANS—Perhaps you would like to take that on advice, because my barrack room lawyer advice was that this question about compensation was slightly different to your normal departmental approvals, limits et cetera.

Ms Halton—We will come back to you, Senator.

Senator CHRIS EVANS—Is there a time frame for consideration of this matter?

Mr Stuart—No, the time frame is as soon as we can satisfy ourselves.

Ms Halton—The time frame is dictated by prudence.

Senator CHRIS EVANS—Are you aware whether or not the RACGP is proposing to proceed with any proposal similar to GP House?

Ms Halton—We are not aware of that.

Senator CHRIS EVANS—Thank you.

Senator McLUCAS—Can I get an update on how the uptake is going for the new general practitioner registrars that were announced and started in 2000-01. I understand there was an increase to 450 in that announcement.

Ms L. Smith—There was an increase of 50 places, and 150 of the already existing places, plus the 50, established a 200-place rural pathway—that is the 450 altogether. There are 452 new registrars on the training program in 2002.

Senator McLUCAS—We have exceeded our target—you have 452.

Ms L. Smith—Yes. That is because there are two extra. This allows for drop-out.

Senator McLUCAS—Have those 200 rural ones been allocated to regional areas? Are we quite clear that they have all gone to regional and rural areas?

Ms L. Smith—Yes.

Senator McLUCAS—Could we get a list of where those registrars are?

Ms L. Smith—We should be able to provide that.

Senator McLUCAS—Thank you. Do we have any indications about retention levels? I understand your comment about the extra two to pick up any drop-out.

Mr Stuart—Are we talking about retention levels of the new group or our experience of retention levels in general?

Senator McLUCAS—I am particularly interested in retention levels of the group who are in the regional and rural areas.

Ms L. Smith—Of the new group, we would not have an indication of retention as yet. It will be in a couple of years, really, that we will know that. They are in the placement, I understand, for the period of their training. They have only started this year. They are there now.

Senator McLUCAS—Thank you. That is all I want to know.

Senator WEST—I want to ask about the RN scholarships. How are the applications going for 2002? How many were there? How many have been given out this year—new ones and old ones? And did we ever sort out what happens about their academic results and the continuation of the scholarships?

Ms L. Smith—I will start with the numbers. Over 400 applications were received for the new scholarship places. These were the ones that were advertised in December 2001. Three hundred and fifteen of the applications proceeded to the selection phase. There are approximately 100 new scholarships that are available in 2002, and 88 applicants were advised in early May that they had been awarded a scholarship. Does that cover the first part of your question?

Senator WEST—Yes, it does.

Ms L. Smith—Sorry, what was the second bit about?

Senator WEST—How many are continuing over from last year? There are 88 new scholarships. How many are continuing?

Ms L. Smith—There are about 400 still.

Senator WEST—About 400—

Ms L. Smith—Scholarships remaining from previous years.

Senator WEST—Did we sort out the issue of academic results and continuing—

Mr Stuart—We are on our way through doing that. As you are aware, the minister took an interest in that issue at the last hearings. There has been a process of advising, and we will be advising further shortly on what will be the new guidelines in the new academic year. I really cannot expand on that at the moment because it is a matter for the minister's decision, but there has been a process of consideration about the issues that you raised.

Senator WEST—Is this the Minister for Education, Science and Training or the Minister for Health and Ageing?

Mr Stuart—This is Senator Patterson.

Senator WEST—I am sure Senator Patterson will have taken all of what I just said on notice. If some further information can come back on notice, that would be appreciated. How are the nursing scholarships going?

Mr Stuart—I thought that we dealt with the nursing scholarships under outcome 5 yesterday.

Senator WEST—Okay, I am getting confused. It is too late in the day. Now to my favourite question—numbers of doctors in rural areas.

Senator CHRIS EVANS—Senator West made a promise that the tradition will continue.

Senator WEST—Because if they do not answer it I am going to come back and haunt them. That will be enough to send Senator Evans mad. Do you have any numbers or do you want to take that on notice?

Mr Stuart—We provided a number of quite substantial tables to you in relation to questions on notice from the last hearings. That is still the latest available data.

Senator WEST—So there is no more recent available data?

Mr Stuart—No, there is not.

Senator WEST—Are we seeing a change in the work habits and work practices in doctors, in that doctors are not working the same length of hours that doctors used to work 40 or 50 years ago?

Mr Stuart—There is certainly discussion about that. The figures that we discussed at the last hearings suggest that, over the last year, we have not only had more doctors but also an increase in their labour output, because both the doctor numbers and the full-time workload equivalents have increased. There was an earlier pattern where that was not always occurring, but for the most recent there has been a increase of 6.2 per cent and an increase in full-time workload equivalents by 4.8 per cent, while the numbers billing Medicare increased by 11.5 per cent over that period.

Senator WEST—That is not the story that I am getting anecdotally.

Mr Stuart—These are reliable figures from Medicare billing.

Senator WEST—I am not doubting that for a minute; I am just saying that it is not the anecdotal story that I am getting.

Senator HERRON—Can you table those figures?

Mr Stuart—The figures that I just read out are now in *Hansard*, and the answers to questions on notice from the last hearing contain considerably more information. They are also available.

Senator HERRON—Where are they in *Hansard*?

Mr Stuart—They are in questions on notice from the last hearing.

Senator WEST—It is answer No. EO82 from March 2002.

Senator HERRON—Are they the latest available figures?

Mr Stuart—That is right.

Senator WEST—I will hand you a copy, Senator McLucas. When will there be another set of figures put out?

Mr Stuart—At the end of the financial year we will see a new set of figures become available around August-September.

Senator WEST—Senator McLucas, you will be able to follow it up at supplementary estimates.

Senator McLUCAS—My question may be able to go on notice. It has to do with rural doctor numbers. Can you provide a breakdown of the money we have spent on GP retention in rural areas and what programs that expenditure is attributed to? How do you measure the success of those expenditures? Is it simply on a straight line number of GPs in rural areas?

Mr Stuart—Thank you for flagging this interest yesterday. We have some numbers here. Under the Rural Retention Program, for the two years 1999-2000 and 2000-01 there was a total of $23,820,000 under the retention payments.

Senator McLUCAS—Just to be clear, Mr Stuart, are you saying that that $23 million was for each year?

Mr Stuart—No, for those two years taken together.

Senator McLUCAS—And that was all under the GP retention program?

Ms L. Smith—Yes.

Mr Stuart—Yes, that was under the GP Rural Retention Program.

Senator McLUCAS—And what about the issue of measuring success?

Ms L. Smith—At the moment, we measure the success by the increasing numbers of doctors, because the payments for rural retention are made depending on how long a doctor has remained in a particular area. So while the numbers are increasing it means that people are not leaving.

Senator McLUCAS—And you are meeting your targets?

Ms L. Smith—I believe so, yes.

Senator DENMAN—I have a question about the positron emission tomography scanner. There were seven funded publicly, with Tasmania being excluded. What provision is being made for Tasmanian patients needing a PET scan? Presumably they will have to travel to Melbourne.

Ms Halton—At the risk of giving Senator Evans some glee, this is, unfortunately, outcome 2; so we cannot deal anymore with the needs of north-west Tasmania.

Senator DENMAN—I was told yesterday it was outcome 4.

Ms Halton—PET?

Senator DENMAN—Yes.

Ms Halton—I am sorry about that.

Senator DENMAN—Never mind. I will put it on notice. That will please him.

Senator WEST—While they are going to get that additional information, we had a briefing from the department and we indicated at the time that we would like that briefing to be made available on the public record. I think it was being sanitised into an appropriate form so that it could be. Could we have that information, please.

Ms Halton—We will chase that up, Senator.

Senator WEST—Thank you.

Ms Halton—Senator Knowles, if this is a sensible juncture, Senator McLucas asked us a couple of questions yesterday. She asked how many Aboriginal health workers are employed in Commonwealth funded community controlled health services. The answer is: in 1998-99 there were 523 full-time equivalent Aboriginal and Torres Strait Islander health workers. They were employed in 110 Commonwealth funded Aboriginal primary health care services. She also asked: 'What is their training level?' Unfortunately, the service activity reporting date, which is what we use to measure what is going on, does not collect data on the training levels of those workers.

Senator Crowley—notwithstanding she is not here—asked us, 'Do any of the funds provided for eye health go to providing community education?' The answer is: no funds are specifically allocated for community education under the national Aboriginal and Torres Strait Islander Eye Health Program. However, regional eye health coordinators—I think we talked about those yesterday—employed under the program have community education as one of their roles. In 2000-01, $2.1 million was expended on regional coordination.

Senator HERRON—Are they listed according to location?

Ms Halton—No. I do not have that detail.

Senator HERRON—Thank you.

Senator McLUCAS—Has the evaluation of the round 1 trials now been completed?

Mr Broadhead—Yes, it was completed some time ago and published on our Internet site over a year ago, I think.

Senator HERRON—Could I just follow up on that Aboriginal work force. You said there were 500—

Ms Halton—There are 523 full-time equivalent—

Senator HERRON—But you have not allocated those to either state or—

Ms Halton—That is the total number of full-time equivalent workers employed in the 110 Commonwealth funded primary health care services.

Senator HERRON—So they are full-time equivalents. Do we know whether they are male or female?

Ms Halton—I do not have information that tells me whether we actually collect gender. Frankly, I would be surprised if we collected gender about those workers. I might be wrong.

Senator HERRON—Do we know the status of the training of those as you mentioned before?

Ms Halton—No. That was the question that Senator McLucas asked yesterday. She explicitly asked what was the training level and what I have reported back is that our source of information, which is the service activity reporting data, does not collect the training levels.

Senator HERRON—Where was that data obtained from?

Ms Halton—The service activity reporting data is information that is collected from each of the services that we fund. The 1998-99 data—

Senator HERRON—That is what I am getting at: is that purely Commonwealth funded services?

Ms Halton—Yes. This is information that we collect in respect of services that we fund. I could not say with any categorical assurance whether they have other sources of funding, but we have standard information that we collect from them for the services that we provide funding for. It is contained in this service activity reporting collection and that is what I relayed to Senator McLucas.

Senator HERRON—So that does not take into account any state or territory funded services?

Ms Halton—No, not if they are not funded by us. This is information we collect about what we fund.

Senator HERRON—Those figures seem very low to me, that was all—528 overall right throughout the Commonwealth. Could we obtain other figures—that is, if Senator McLucas wants them?

Ms Halton—I am very sympathetic to Senator McLucas's interest and, Senator Herron, you know this well: the difficulty in getting data about services that we do not have a direct relationship with can sometimes be problematic. The other thing about this would be that the service activity reporting data is a very particular data collection and whether or not there would be any comparability with those other sources I think would be hard to determine.

Senator HERRON—They could be obtained from the states and territories if we wrote to them and asked whether it was possible. I am trying to get some handle on this because, as you know, we are all concerned about it. Yesterday, we discussed the things that go into

Aboriginal health and the educational programs and all that. It has been static for so long. We trot out the figure of the disparity between life expectancy and, as I mentioned, 70 per cent of life expectancy is to do with lifestyle and the rest is to do with genetic background and so on. Really, the key to it is education. I think these health workers do a terrific job and I do not think it is essential that they have a necessary level of qualification so long as they communicate and do educate particular communities. As you are aware, it is extraordinarily patchy and I think it is the explanation overall as to why there has been no improvement in this regard. We have not coordinated this in any sort of fashion. We cannot even find out—as Senator McLucas asked—how many health workers are in this field, what is their standard of education and so on.

Ms Halton—As you know, the question of education for Aboriginal and Torres Strait Islander health workers has been something of a difficult issue over the years, as much as anything else. If they are individuals who live in remote communities even getting access for those workers to education can be quite a challenge and very often the people who are going to be well placed to provide services to those remote communities are going to be people who come from those communities. The minister mentioned to me today her visit to the Northern Territory and noted problems even with issues around facility with English. If you are going to be doing training, particularly in biology—

Senator HERRON—Yes. I think that one I mentioned to you was Lajamanu where they went out with laptop computers and CD-ROMs in language. Minister, has the Commonwealth got a role in this in terms of funding health workers apart from the ones that Ms Halton mentioned? What is the role of the Commonwealth in relation to health workers?

Senator Patterson—Senator, as Ms Halton said, I observed some issues surrounding this, especially when people were doing courses like nursing or the Aboriginal health workers programs. We have actually had some discussions about possibilities. I do not want to do policy on the run, but I think there are some issues that can be discussed. Minister Ruddock has actually formed a working group of senior departmental officials from every portfolio that has got any connection with indigenous communities—for example, Dr David Kemp, Minister for the Environment and Heritage—to try to bring together all these areas. Some of them may not necessarily be health responsibilities, and that may not be one of them. We also need to look at whether it is something that Dr Nelson needs to do in conjunction with the relevant states. I think there are a lot of things still left to do.

Senator HERRON—Yes, and you welcomed the Northern Territory government initiative, did you not, in terms of regionalisation?

Senator Patterson—There was an article on the front page of the *Australian* saying that I welcomed it. I did welcome it, because it was a Commonwealth program. I think the *Australian* got it slightly wrong. It was to do with the coordinated care trials. I did not make a song and dance about it, but it really was more—I stand corrected—a federal initiative. Look, far be it from me to argue about whose it is, as long as we are getting some outcomes.

Senator HERRON—That was Commonwealth funding?

Senator Patterson—Yes. It was the coordinated care trials which, as we mentioned before, have now been extended from Katherine West to Katherine East. There is also one in Bunbury and another in Kimberley, as well as one in Tiwi. They are feeding each other and sharing information with each other, so there is real learning going across particular groups as well.

Senator HERRON—Congratulations.

Senator Patterson—I have just been carrying on the good work that we started, Senator.

Senator HERRON—Thanks very much.

Senator McLUCAS—Can you tell me what the current status of round 2 is?

Mr Broadhead—We are finalising contract negotiations at the moment for the establishment of six trials. This was announced a little while ago by Senator Patterson. Subject to those contract negotiations coming out satisfactorily, we will establish six trials.

Senator McLUCAS—When do you think they will start? How long will the process take?

Mr Broadhead—Somewhere between days and weeks. We are days away, in some instances. So it will be quite shortly.

Senator McLUCAS—Thank you.

Senator FAULKNER—Could the department confirm that it sought advice from the Department of Prime Minister and Cabinet on 1 February this year about a request from former Minister Wooldridge for access to his email records?

Ms Murnane—Yes, Senator.

Senator FAULKNER—Could you provide for us, please, the background to that request?

Ms Murnane—The background to the request was that one of our officers in IT was contacted by our Melbourne office and asked to confirm that the former minister did not have a right to access facilities. After that, the IT officer approached the head of our legal services, asked her, and she rang PM&C the next day and received advice that it was indeed right that, under certain conditions—subject to the Archives Act—former ministers do have access to material that they would have had when they were ministers.

Senator FAULKNER—And that request went through to either Ms Belcher—anyway, to the Government Division in Prime Minister and Cabinet?

Ms Murnane—A formal request from Dr Wooldridge did not ensue.

Senator FAULKNER—So Dr Wooldridge contacted the Melbourne office of the department about access?

Ms Murnane—Yes.

Senator FAULKNER—Do you know the date on which that occurred?

Ms Murnane—The Melbourne office contacted our IT officer in Canberra on 29 January.

Senator FAULKNER—This year. So the IT officer sought further advice?

Ms Murnane—Yes.

Senator FAULKNER—As far as your department is concerned, both internal and external?

Ms Murnane—Yes. Our legal officer sought confirmation.

Senator FAULKNER—The Melbourne office contacted the IT officer and the IT officer contacted your legal officer. Is that how it worked?

Ms Murnane—Yes, that is the sequence.

Senator FAULKNER—The legal officer contacted the Government Division of the Department of the Prime Minister and Cabinet?

Ms Murnane—That is correct.

Senator FAULKNER—Was any other contact made by any of those officers as this developed?

Ms Murnane—Your question to me was in relation to our contact with the Department of the Prime Minister and Cabinet.

Senator FAULKNER—Yes, in the first instance it was.

Ms Murnane—At that time, without the knowledge of our legal officer, our internal IT people, the executive of the department—the secretary and the deputy secretaries—and the relevant people in our Corporate Services Division, the former minister had access to our computer system. He had access to his emails, for example.

Senator FAULKNER—I do not know whether you know the background to this, Ms Murnane. I asked some questions in the Department of the Prime Minister and Cabinet estimates hearings last week and received an answer which was subsequently corrected. I do not know whether you have seen a copy of the letter from Ms Belcher, which is as it should be, as we would all appreciate. The matter led me to ask some follow-up questions at the Defence estimates. I suspect there was a misunderstanding at some level between Defence and your department. So, yes, my first question did go to just confirming the corrected advice from the Department of the Prime Minister and Cabinet about this access. Do you know whether the request for access from the former minister was limited to electronic records?

Ms Murnane—The request from the former minister did not come directly.

Senator FAULKNER—He made no request, really, did he?

Ms Murnane—It did not come in writing. The former minister's question was to a person in our Melbourne office. The minister rang him and asked whether he would be able to have access. That provided our Melbourne office with the catalyst to ring our internal IT people, and I have gone through the sequence of events. I should say one thing: you said before that there had been a misunderstanding between us and the Department of Defence. We have had no contact at all with the Department of Defence on any matter connected with this.

Senator FAULKNER—No, I am sorry. I thought you may have seen—this is not particularly important—

Ms Murnane—Yes, I do know about that.

Senator FAULKNER—Yes. I had asked a question in Prime Minister and Cabinet and I had received an answer that related to the Department of Defence. I suspect the answer would have been accurate if you had actually substituted your department for the Department of Defence—and that was corrected, as is appropriate, and obviously I have got no complaints about that at all. It caused me to follow this matter up in the Department of Defence and I was able to be informed that, in the case of former minister Reith, there was no email access from when he had ceased to be a minister. But what you are saying to me is Dr Wooldridge did have unauthorised access—

Ms Murnane—No, I am not saying it was unauthorised. It was authorised.

Senator FAULKNER—You are saying that he had authorised access to his email account?

Ms Murnane—He had access. A request was conveyed to IBM GSA, by an officer who was authorised to make that request, that he should have access.

Senator FAULKNER—And this was a Melbourne based officer, was it?

Ms Murnane—No, this was not.

Senator FAULKNER—This was a Canberra based officer?

Ms Murnane—Yes.

Senator FAULKNER—Hence the point that you are making that you, Ms Halton, were not aware of that request.

Ms Halton—No. I have not made any points but, no, I was not aware of the request.

Senator FAULKNER—The point that was made by Ms Murnane you were not aware of?

Ms Halton—Absolutely. That is quite correct. I was not aware of it.

Senator FAULKNER—And your legal officers were not aware of that?

Ms Murnane—No.

Senator FAULKNER—No-one on the executive was aware of that?

Ms Murnane—No.

Ms Halton—No.

Senator FAULKNER—No-one in corporate services was aware of that?

Ms Murnane—To my knowledge, no. There are a number of officers on leave that we have not been able to speak to yet.

Senator FAULKNER—So have you since been able to establish what records were made available or what records were accessed during this period of improper access?

Ms Murnane—Concerning improper access, I have said that the former minister's access was continued subsequent to a legitimate request—instruction, probably—from an authorised officer to IBM GSA. Yes, we do know what the former minister had access to—

Senator FAULKNER—When was access stopped? Do we have that date?

Ms Murnane—Access was stopped on 13 March 2002.

Senator FAULKNER—Why did it take so long?

Ms Murnane—Because we were not aware that the former minister had access. As a result of housekeeping it became apparent to somebody employed by IBM GSA that the former minister still had access. That person checked with our IT person whether this was proper. The head of our IT said no, it was not, and the former minister's access should be disconnected. Our IT officer rang me and I said, 'Yes, that is right,' and the access was terminated. I told the secretary—the secretary knew nothing about it. She knew when I told her.

Senator FAULKNER—Now you have managed to lose me in the dates because I do not really understand how there was a six weeks break. I know from a corrected answer from the Department of Prime Minister and Cabinet that on 1 February 2002 an officer in the Department of Health and Ageing contacted an officer in Government Division for advice—and you have been able to confirm that to me tonight.

Ms Murnane—That is true.

Senator FAULKNER—Prior to that occurring—and I want to be absolutely clear on this—an IT officer in your department was contacted by an officer in Melbourne. The IT

officer contacted someone in the legal division and the legal division made this contact with the Department of the Prime Minister and Cabinet.

Ms Murnane—Correct.

Senator FAULKNER—What can you say occurs after the officer in your department contacts Prime Minister and Cabinet?

Ms Murnane—I think the cause of your getting lost is probably because you may be assuming that our officers at that stage knew Dr Wooldridge did have access. They did not. They assumed that he had no access. That is why there was no instruction put to IBM GSA, because it was assumed there was no need to put any instruction. The point that I am making here is that we were not aware of the fact that, through another sequence of events that I have described, the former minister retained his access.

Senator FAULKNER—I did not actually realise that there were two separate sequences of events. I now understand that there are two separate sequences of events, and the second sequence you might describe to me more fully. I have understood the first sequence: I think I have just outlined the first sequence to you. You have indicated that at the conclusion of that sequence of events there was not an awareness at a departmental level that former minister Wooldridge had access to the email account. So does that first loop close effectively when the Department of the Prime Minister and Cabinet provide advice?

Ms Murnane—Yes, because they confirmed what we thought to be the case.

Senator FAULKNER—So how does the second sequence begin? Does the first sequence begin with a request from Dr Wooldridge or does the first sequence begin with one of your officers, either in Melbourne or in your IT section, taking an initiative?

Ms Murnane—I think we had better clarify what we mean by the first sequence. By the first sequence you mean the actions that led to us seeking advice from PM&C?

Senator FAULKNER—I thought that Dr Wooldridge made contact on 29 January.

Ms Murnane—That is right.

Senator FAULKNER—What does he ask on 29 January or what was the point of this contact?

Ms Murnane—He asked an officer in our Melbourne office if he could come into the office and have access to his former office and the computer there.

Senator FAULKNER—So it is not just emails: he wanted access to his former office.

Ms Murnane—For the purpose of reading his emails and not for any other purpose—I am assuming that.

Senator FAULKNER—I always try not to make too many assumptions. He wanted access to his former office and he wanted access to his emails?

Ms Murnane—That is right.

Senator FAULKNER—Is there anything else that he wanted access to?

Ms Murnane—Not that I am aware of. What the officer in the Melbourne office has reported to people here who followed this up with him is that Dr Wooldridge said he would like to come in and have access to his former office and to the computer in the office.

Senator FAULKNER—Yes, and that sets in train the officer he contacts in Melbourne contacting someone in IT and then the officer in IT contacting someone in legal and someone in legal then contacting the Government Division of the Department of the Prime Minister and Cabinet—

Ms Murnane—That is correct.

Senator FAULKNER—which PM&C have advised me of.

Ms Murnane—Yes.

Senator FAULKNER—Okay, I am clear up to that point. I am not clear as to what happens then, so you can help me.

Ms Murnane—As to what happened then, essentially nothing happened: the status quo prevailed—the status quo that our internal IT people, our corporate area and the executive of the department were not aware of—that he continued to have access to the system. On 13 March an IBM GSA officer was doing a housekeeping check and saw that there was still an active log-on for the former minister. He then rang the head of our IT and asked should that be the case. He was told no and that he should disconnect him immediately. The head of our IT rang me, and I confirmed that Dr Wooldridge should be disconnected and not reconnected.

Senator FAULKNER—If Dr Wooldridge continued to have access to his email account for a month and a half via the Melbourne office, did anyone establish why he asked originally on 29 January if he could have such access?

Ms Murnane—You said that we should not assume, but it would, I think, be reasonable to conclude that he was actually asking for access simply to the office and the computer in the office. It was taken by our officer and our IT person that he was asking for access to IT, but he was not, because he had that.

Senator FAULKNER—Have there been any other requests in relation to access to emails from Dr Wooldridge?

Ms Murnane—Dr Wooldridge was not terminated on 26 or 27 November; he ceased to be minister on the 26th. A former person in his office who is an employee of the department was presumably contacted by him and contacted our priority client person, or the IBM GSA priority client officer, and asked if he could continue to have access to tidy things up.

Senator FAULKNER—How was that request made?

Ms Murnane—This was all verbal.

Senator FAULKNER—Who made that request?

Ms Murnane—We think it was an officer who was a DLO in Dr Wooldridge's office. We have not been able to talk to that person because that person is currently out of Australia on leave. I do not really want to say any more at this stage except that we know who we will talk to when we are able to get in contact.

Senator FAULKNER—So you do not want to name the former DLO in Dr Wooldridge's office, because—

Ms Murnane—No, I do not.

Senator FAULKNER—let us be clear—neither you nor anyone else has been able to check. What you have told me in relation to the contact by a former employee on 27 November has not been confirmed directly with the employee?

Ms Murnane—I have just been advised that there were a number of contacts. I was right, one is in relation to a DLO, but the very first one is in relation to a DLO, too, but a more junior DLO, who is on leave in Australia. I have not personally spoken to her. Somebody has spoken to her. She is on compassionate leave now; her husband is very sick. She is a junior officer. She was doing what she thought was right. I would really rather not mention her name.

Senator FAULKNER—I am not asking you for the name.

Ms Murnane—Good.

Senator FAULKNER—I did ask you the name of the other officer—that is all I have done—and I have heard you provide an explanation to the committee which is in the case of the other officer. You have provided an explanation to the effect that you have not been able to check with that officer whether there is any basis to the story that you have heard; what you believe to be the case, but you want to check it with the primary source.

Ms Murnane—It may not be absolutely exact, but, on the basis of what we know, we can certainly reconstruct events. You asked me who that officer was, and I said that I did not want to name them.

Senator FAULKNER—Yes, but this is a different officer from the other officer, whom I did not know about. Given that the chronology starts before I thought it did, can we work through this sequentially? I will not be asking for the name of the junior officer that you refer to.

Ms Murnane—Thank you.

Senator FAULKNER—The reasons you have given for not providing that name are adequate, as far as I am concerned, at this point. Obviously, I could ask for that name and, if I did, it would be required to be provided.

Ms Murnane—Yes, I agree with that.

Senator FAULKNER—But I am not going to ask you that. I understand that you know how this system works. Let us go back to the first contact and try to work through it sequentially. Is that junior the first contact?

Ms Murnane—The starting block is after Dr Woodridge ceased to be minister and Senator Patterson became minister. I stand corrected on what I said last time: the junior DLO in Minister Patterson's office—who was also the junior DLO when Dr Wooldridge was minister—rang our IBM GSA priority client liaison officer and asked him to not disconnect Dr Wooldridge from the computer system because there were some things to tidy up. He passed on that request to access control, which is outsourced to IBM GSA. Note that we were not in the department, we were not aware of that and more senior people in Senator Patterson's office were not aware of that. When they found out, the department was contacted.

Senator FAULKNER—When did they find out?

Ms Murnane—On 15 January. The department was contacted on 15 January by Senator Patterson's staff and asked to disconnect Dr Wooldridge immediately. This was actioned immediately by access control, which, as I have said, is run by IBM GSA.

Senator FAULKNER—Let me put it into my words because I want to be very clear on this. Senator Patterson's more senior staff find out about this original contact the best part of a

couple of months earlier. A couple of months? I suppose it would be a couple of months. Do we know?

Ms Murnane—No, I do not know when—

Senator FAULKNER—Do we know when the original contact was made with the junior DLO?

Ms Murnane—It was on 27 or 28 November.

Senator FAULKNER—All right; six or seven weeks. When senior staff in Senator Patterson's office find that out, they contact your department and ask that that be disconnected?

Ms Murnane—Correct.

Senator FAULKNER—Senator Patterson, were you aware of that at any stage? You may not have been, of course; your staff may not have drawn it to your attention.

Senator Patterson—I was aware and I asked my senior staff member to have it disconnected immediately, as you would expect me to do.

Senator FAULKNER—As I would expect you to do, yes. So there is that level of contact but, obviously, that does not work. That junior DLO that you are speaking about was the one that you mentioned for a reason—

Ms Murnane—That was the one that asked for connection to be retained for a short period to enable him to tidy up either on the day Minister Patterson was commissioned or the day after that.

Senator FAULKNER—You have mentioned to me that you do not want that DLO named, for family reasons. That is fine. Let us move on to the next step. What is the next step?

Ms Murnane—The next step is that on 17 January access was restored to Dr Wooldridge.

Senator FAULKNER—When the request was made by Senator Patterson's staff, on behalf of Senator Patterson, actual email access was terminated?

Ms Murnane—That is right.

Senator FAULKNER—I think that is a crucial part of it, thank you.

Ms Murnane—I had said 'disconnected' but—

Senator FAULKNER—Yes, 'disconnected'. It is much better to deal with this chronologically, Ms Murnane, or it becomes extremely complex. It sounds like it is an extremely complex story anyway, but let us see if we can work through it. It was disconnected on the 15th—is that right?

Ms Murnane—That is absolutely correct.

Senator FAULKNER—It was disconnected on the 15th and it was re-established on the 17th?

Ms Murnane—Yes.

Senator FAULKNER—Can you explain to me why and how on earth it is re-established?

Ms Murnane—Again, the IBM GSA liaison officer for ministers' offices was contacted, this time by the former DLO to Dr Wooldridge—a more senior person—

Senator FAULKNER—This is a former DLO in Dr Wooldridge's office who is a non-continuing DLO in Senator Patterson's office and has become a departmental officer. Is that right?

Ms Murnane—No, they are a continuing DLO in Senator Patterson's office.

Senator FAULKNER—You have a lot of DLOs, Senator Patterson.

Ms Murnane—It is quite usual for a cabinet minister.

Senator FAULKNER—Yes, I know.

Senator Patterson—I have two. I need about 22, I can tell you; maybe 42.

Senator FAULKNER—As you would appreciate, I do not treat seriously any complaints from government ministers about staffing levels, so let us move on.

Ms Murnane—I am waiting for your next question, Senator.

Senator FAULKNER—On 17 January a senior DLO in the current minister's office takes some action that causes reconnection. Is that right?

Ms Murnane—Yes.

Senator FAULKNER—Can you explain that to me?

Ms Murnane—The absolute facts are that Dr Wooldridge was reconnected—his access was re-established—and this was on request. There is no written record of this, but the IBM GSA liaison officer recalls that it was Dr Wooldridge's former DLO, now Senator Patterson's DLO, who made the request that Dr Wooldridge should have access re-established for a short period of time.

Senator FAULKNER—Were you aware of that, Senator Patterson?

Senator Patterson—No. I had asked for it to be disconnected, on whatever date it was.

Senator FAULKNER—The 15th. Yes, I know you had asked that but I was asking whether you were aware that it had been reconnected, which is a different issue.

Senator Patterson—I did not know it was reconnected.

Senator FAULKNER—And that was asked of IBM GSA. Are they effectively your email service provider?

Ms Murnane—IBM GSA are our provider of IT.

Senator FAULKNER—IT provider in the broad.

Ms Murnane—The provider of our hardware.

Senator FAULKNER—And after receiving that request, it is acted upon?

Ms Murnane—Yes. The department and IBM GSA endeavour to give and are committed to giving a good service to ministers and their staff in relation to IT because it is so critical to business functions. When the request came from a departmental liaison officer in the minister's office to IBM GSA Access Control, it would have been reasonable for them to assume that that was perfectly legitimate.

Senator FAULKNER—Yes, because, if you like, it has got some ministerial imprimatur—the person is a staff member of the minister's office. Anyway, access is re-established but the department does not know that?

Ms Murnane—No.

Senator FAULKNER—Minister Patterson does not know that?

Ms Murnane—That is right.

Senator FAULKNER—Does that take us then to 29 January?

Ms Murnane—It does.

Senator FAULKNER—I see, and it is at that point when Dr Wooldridge asks your Melbourne based officer about access rights to email.

Ms Murnane—He asks him about access.

Senator FAULKNER—He asks him about access—can you tell me precisely what he does ask?

Ms Murnane—No, I cannot, because I was not there.

Senator FAULKNER—But this has all been investigated hasn't it?

Ms Murnane—No, we have not had time to do what you would call a full and final investigation. What we have done is reconstruct events. The nature of events, it seems to me, permits the inference that our officer in Melbourne, and indeed the head of our IT here in Canberra, believed Dr Wooldridge was asking for access to IT as well as to the department. But he was actually asking for access—and probably just for a very limited period; a couple of hours, maybe—to his former room in our Melbourne office.

Senator FAULKNER—You have said before he was asking for access to his former office and access to his email.

Ms Murnane—If I said that, I was wrong.

Senator FAULKNER—I thought you did; I wrote that down.

Ms Murnane—What I think I said is that he was asking for access to his former office and facilities, and our staff in Melbourne and the person that was contacted in Canberra assumed that that included access to email. We discovered later he already had access to emails. I think it is then reasonable to infer that, in Dr Wooldridge's mind, the only thing he was actually asking for was access to the room. But there is a degree of surmise in that.

Senator FAULKNER—Because he already had access to the emails?

Ms Murnane—Correct.

Senator FAULKNER—And the room is an office in the department?

Ms Murnane—It is an office in the department that is used by the minister, by visiting staff and for meetings. It is not just sitting there waiting.

Senator FAULKNER—If you like, it is more a general-purpose office; it is not exclusively used by the current minister—the sort of arrangement that seems to happen in most departments?

Ms Murnane—That is right.

Senator FAULKNER—That is 29 January?

Ms Murnane—That is correct.

Senator FAULKNER—This access in relation to the email account continues right through this period to 13 March?

Ms Murnane—That is correct.

Senator FAULKNER—Does access to the ministerial and general-purpose office also continue through to 13 March?

Ms Murnane—He had access to his current emails. He had access to a U-drive, which is essentially his personal archive.

Senator FAULKNER—What is a U-drive?

Ms Murnane—Could you repeat your question, please, Senator?

Senator FAULKNER—I first asked: 'Did he have access to his email account?'

Ms Murnane—Yes; that is correct.

Senator FAULKNER—You indicated that he had access to his U-drive.

Ms Murnane—What was your next question?

Senator FAULKNER—You blinded me with science when you answered that, but I was terribly impressed. I would be even more impressed if I knew what a U-drive was.

Ms Murnane—I thought that you asked: 'What did he have access to through general purpose office files?'

Senator FAULKNER—Yes.

Ms Murnane—He had no physical access to an office.

Senator FAULKNER—He did not have physical access to the office? I am sorry, but I misunderstood you. I thought he had access to an office that was used as a general purpose office.

Ms Murnane—No. I think I have made it absolutely clear that he did not have access to that office and that he was told that he could not have access to the office or to his emails.

Senator FAULKNER—But when? There is this question of when he was told that. He was told that on 13 March.

Ms Murnane—No. His emails were cut off on 13 March. After ringing our Melbourne office on 29 January, he was told that he did not have access to the office and he did not come into the office. He did not avail himself—

Senator FAULKNER—With respect, what occurred after 29 January in terms of feedback has not been cleared up. It is not clear to me. I am not being critical. Understanding that access to emails stopped on 13 March, my follow-up question—which I think you are answering now—was: 'When was access to the general office stopped?'

Ms Murnane—He had no access to the general office after 26 November. Once he ceased being minister—

Senator FAULKNER—Are you saying that the request went in about access to the office but, because it was not granted, there was no access to the office? That is what I am trying to nail down.

Ms Murnane—That is right. I have said—and I think I more than implied it before—that he had no access to the office.

Senator FAULKNER—In terms of an email account or access to emails, if he had access to a physical office—and I appreciate that this was not the case—would there be greater access to any IT function?

Ms Murnane—What do you mean by that?

Senator FAULKNER—In other words, could he effectively have had the same level of access to IT functions whether he accessed his email account from a physical office in the department—which did not happen—or, say, from a home computer?

Ms Murnane—Dial-in access was available.

Senator FAULKNER—This is what I am trying to understand. In other words, in terms of access to the IT network, there is no particular advantage in being physically located in, say, a departmental office?

Ms Murnane—Unless you are in the precinct of the office and you want to go in, then, no, that is true.

Senator FAULKNER—That is the point of the question. So you actually get access to your IT network via a home computer or via any computer?

Ms Murnane—Only if you have dial-in access. You could not, for example, get access.

Senator FAULKNER—No. I am sure that is a great relief! And if is not to you, it is to me! But he did have dial-in access until 13 March, didn't he?

Ms Murnane—That is correct.

Senator FAULKNER—Okay. Thank you for that. Were there any broader requests in relation to other cabinet or departmental or related documents? As you know, there is clear advice in relation to former ministers that they can access material that they are likely to have sighted. I, for example, could apply for access to material that I was likely to have seen while I was a minister. That access, in the ordinary course of events, would be granted. Putting aside the email issue and the electronic records issue, did Dr Wooldridge apply for, or was he granted, any other broader access to that sort of material—to non-electronic records?

Ms Murnane—He asked me after this if, as a former minister, he could have access to material he would have seen as minister. I said yes. He asked for access to some material. I said I would send him the relevant section of the Archives Act, together with some legal advice that interpreted it for him, and information on what he should do to activate that access, which was essentially to write to the secretary and indicate why he wanted the material. If it was cabinet material, the approval would be from the Secretary of Prime Minister and Cabinet. To my knowledge, I do not think that that was followed up.

Senator FAULKNER—Only the one request?

Ms Murnane—That is the only one that I know of, and I think I would know.

Senator FAULKNER—I accept that. So do you know when that request was made?

Ms Murnane—I would have the approximate date, because I have the date that I faxed him the Archives Act. Sorry; I cannot recall it.

Senator FAULKNER—You do not know that date tonight?

Ms Murnane—I do not know that date tonight.

Senator FAULKNER—Do you know what the material related to?

Ms Murnane—He mentioned a number of things. I think he was basically thinking through how he would narrow it down. So it was pretty general.

Senator FAULKNER—Did any of those things—which you might take on notice for me if you are not able to say what they are tonight—relate to the building for the Royal College of General Practitioners?

Ms Murnane—No, they did not—absolutely not. They did not relate to that in any way, shape or form.

Senator FAULKNER—Dr Wooldridge by this stage, of course, is no longer a minister. He has another role, as a consultant, doesn't he?

Ms Murnane—I think he has a number of other positions, yes.

Senator FAULKNER—In relation to these physical records, did you consider it important in terms of access to give consideration to any possible perception of conflict of interest or to any actual conflict of interest?

Ms Murnane—Yes, I would have if the request had come, but it did not.

Senator FAULKNER—It came in general terms.

Ms Murnane—It came, and it was not. A number of areas were mentioned by him, but there was nothing around GPs, GP House or the Royal Australian College of General Practitioners in the conversation I had with him. If that had formalised into a request, I would have, in preparing advice for the secretary, looked very carefully at the purposes for which material was available and looked to exclude any possible conflict of interest. My memory is that the Archives Act might talk about other things in terms of pecuniary awards or something.

Senator FAULKNER—So the situation, as I understand it, is in relation to the email account. What precise day did former Minister Wooldridge cease to be a minister?

Senator Patterson—I am not sure what time it happens on the day—whether it happens when you are sworn in. I was sworn in on the 26th.

Senator FAULKNER—You were sworn in on the 26th?

Senator Patterson—I think it was Monday, 26 November.

Senator FAULKNER—Obviously, the election was on the 10th—that I do remember, unfortunately. From 27 November to 15 January former Minister Wooldridge, after he ceases to be a minister, has access to his email account.

Ms Murnane—Can you say those dates again, please, Senator?

Senator FAULKNER—Yes. From 27 November to 15 January former Minister Wooldridge has access to his email account.

Ms Murnane—Correct.

Senator FAULKNER—He then loses access to his email account for two days and he has access re-established to his email account on 17 January, and that goes through to 13 March 2002.

Ms Murnane—Yes, that is right.

Senator FAULKNER—Another way of putting it would be to say that he has access to his email account from 27 November 2001, after he ceased to be a minister, through to 13 March 2002, except for one day, 16 January.

Ms Murnane—Yes.

Senator FAULKNER—In your investigations into this matter have you established what the former minister accessed?

Ms Murnane—He was able to access his current emails and make use of email communication. He was able to access his personal email archive. He was able to access the shared drive, the archive of his former office. That is fundamentally it.

Senator FAULKNER—So you were able to establish what he had the technological capacity or capability of accessing. Thank you for that. My next question goes to whether you have established what he actually did access.

Ms Murnane—We have a capacity. It is not an exact science. Yes, we can establish that—broadly anyway.

Senator FAULKNER—You can establish it. Have you established it?

Ms Murnane—No, not in great detail. You used the word 'investigation'. There was not an investigation into Dr Wooldridge and I saw no reason to have an investigation into Dr Wooldridge. The issue here was that there were some real difficulties in communication at a number of levels, but all the evidence points to that fact that Dr Wooldridge thought he was proceeding in a way that he was granted authorised access. He had made the requests, the requests were passed on to access control, and access control acceded to those requests.

Senator FAULKNER—So if they are not investigations what am I best describing them as, do you think? I want to be fair about this, as always.

Ms Murnane—I think we did want to know. I certainly asked at the time what he had access to and what he availed himself of.

Senator FAULKNER—Who did you ask that of—Dr Wooldridge?

Ms Murnane—No. I asked that of our IT people.

Senator FAULKNER—What was the answer?

Ms Murnane—The answer was that he had access to his current emails, both receiving and sending; he had access to the Internet, through the department's intranet; he had access to the archive—that is, the stored record of emails that he had previously generated and received; and he had access to documents that were on a shared file in his former office. That is fundamentally what he had access to.

Senator FAULKNER—I know those are the broad parameters of what he had access to, but did anyone in the IT section check precisely what was accessed?

Ms Murnane—No; and I did not ask them to.

Senator FAULKNER—Can you explain to me why you did not?

Ms Murnane—Because Dr Wooldridge was not under any form of investigation. He had no access to protected material. He had no access to current departmentally generated material. His access was almost exclusive to material that he had generated or had been generated by his office. The only current access—the only real-time access—he had was to receiving and sending emails. I just did not think it was appropriate to go back and look at all he had done in relation to maintaining communication with a variety of people. It could have been done, but I did not ask for it to be done.

Senator FAULKNER—How did you satisfy yourself, for example, that there was no conflict of interest or even a perceived conflict of interest?

Ms Murnane—I satisfied myself that he could not have had access to documents that were created in the department in relation to GP House and he could not have changed, modified or deleted any of those documents that were pertinent to the inquiry that we were doing into the processes around the allocation to GP House.

Senator FAULKNER—Did you receive a written brief on that?

Ms Murnane—I did not receive a written brief. I received briefs and I was satisfied that that was the case—and I still am.

Senator FAULKNER—Who provided these briefs?

Ms Murnane—The briefs were provided by the head of our contestability branch who is, among other things, responsible for the IBM GSA contract and interface and interaction with IBM GSA.

Senator FAULKNER—But you did not think it was of sufficient significance for any further investigation? You did not think the capacity for Dr Wooldridge to dial in and use his email account and other IT functions warranted any further investigation in terms of actually checking what took place?

Ms Murnane—Not in terms of checking what documents he created when he had access to the computer or what documents he had created and stored in an archive. No, I did not think it was necessary to establish that.

Senator FAULKNER—What are on these shared files and archives that we are talking about?

Ms Murnane—The only material that Dr Wooldridge could have had access to was material that was generated by him or in his office. He did not have access to general departmental material. He had no access to protected material. He had no access to any budget documentation. He had no access to any email discussions or correspondence in the department in relation to GP House or any other matter. He had no access to the email or documents being generated and shared in Senator Patterson's office. Apart from the real-time access, the only access he had was to material that related to the time when he was minister.

Senator FAULKNER—Who have you reported to on this? There was no investigation into this?

Ms Murnane—No, there was not an investigation.

Senator FAULKNER—There have been inquiries, and they have been conducted by you?

Ms Murnane—There were inquiries into how this happened, yes. I did make inquiries into how it happened. I made inquiries into whether—and I am not saying that I was entertaining any suspicions of him at all, but I thought that the question could be asked—it was possible for him to have had access to documents relating to GP House.

Senator FAULKNER—But we do not know what he has had access to because nobody has checked.

Ms Murnane—We know the number of times he has accessed the computer.

Senator FAULKNER—How many times is that?

Ms Murnane—From 17 January to 13 March, it was over 100 times—I think 106.

Senator FAULKNER—From 17 January to 13 March, he has accessed this computer—

Ms Murnane—102 times, I am told.

Senator FAULKNER—What about from 27 November through to 15 January?

Ms Murnane—I do not have those numbers.

Senator FAULKNER—It does not give me any confidence in the thoroughness of any investigation.

Ms Murnane—I have said that there was not an investigation into Dr Wooldridge.

Senator FAULKNER—There has been no investigation. All we know in relation to the second period of access, when it was improperly restored—that is, from 17 January to 13 March—is that the computer was accessed 102 times. He dialled in 102 times.

Ms Murnane—Yes.

Senator FAULKNER—Were there any costs that the department bore in relation to this?

Ms Murnane—There would have been costs, yes.

Senator FAULKNER—What were the costs?

Ms Murnane—We can investigate that; we have not done that yet.

Senator FAULKNER—Nobody has investigated the costs in the first period of access from 27 November to 15 January.

Ms Murnane—No.

Senator FAULKNER—Nobody knows even how many times the computer was accessed during that period.

Ms Murnane—We do not know now; we are looking to see whether we can re-establish that.

Senator FAULKNER—There is an awful lot that no-one knows.

Ms Murnane—About most things, I think, there is an awful lot that we do not know. My concern was, as I have told you, access he may have had to any current files or any departmental files, particularly in relation to GP House. I ruled that out.

Senator FAULKNER—We do not know that either. We do not know about these 102 times in the second period after access was improperly restored.

Ms Murnane—Those 102 times were access in relation to him reading or generating his emails, in relation to Internet accounts or in relation to going back and surveying historically not what was in the department but what he created or what was created in his office. That is all. He could not have had access to the current material the department was generating or to the past material the department had generated and was now searching through in its inquiry into GP House. I have just received the times of access from the earlier period.

Senator FAULKNER—That has suddenly been done, has it?

Ms Murnane—Yes.

Senator FAULKNER—When was that done?

Ms Murnane—Some time this afternoon.

Senator FAULKNER—What is the figure?

Ms Murnane—From 11 November to the end of November, 14 times, but during that time he was minister until the 26th.

Senator FAULKNER—From 11 November to what?

Ms Murnane—To the end of November; that is, from the day after the election.

Senator FAULKNER—How many times?

Ms Murnane—Fourteen.

Senator FAULKNER—That is a very small proportion of even that first period when he had access, isn't it? It did not start until 27 November.

Ms Murnane—I agree with that, but I have not got—

Senator FAULKNER—In other words, when you say 11 November to the end of November, it is 27 November to the end of November, isn't it?

Ms Murnane—No, it is not. The count I have got is from 11 November.

Senator FAULKNER—So the statistic is meaningless, basically.

Ms Murnane—We can get precise—

Senator FAULKNER—I do not blame you for not providing it before because it is a nonsensical statistic.

Ms Murnane—I did not have it before. In December 2001 he accessed the computer 17 times. From 1 January 2002 to 16 January 2002 he accessed 30 times. The next figures I have got take into account the other numbers I gave you, so the total of his access—I agree with you it is not exactly from the 27th, it is from the 11th, and we will see what we can do about that—is a total of—

Senator FAULKNER—I suggest the thing to do here is to put November aside in its entirety. We know he improperly had access from 27 November, but put it aside; say that there are 149 occasions from 1 December 2001 until the time access was finally stopped on 13 March 2002—unless my maths are wrong.

Ms Murnane—No, they are right.

Senator FAULKNER—And I think my maths are right.

Ms Murnane—That is right.

Senator FAULKNER—Judging from what you say, that is not too far off it. Probably somewhere a little over 150 will be the final figure, if that pattern is repeated. Have you thought, Ms Halton, about what is appropriate here in terms of a more formal investigation of these issues?

Ms Halton—The advice from the technical people in relation to what Dr Wooldridge had access to is quite clear. In relation to how this happened and the authority on which the access was granted, yes, I have had further thought about that, and there are two issues that I think are relevant. Firstly, as Ms Murnane has indicated, one of the officers concerned is out of the country and is not contactable and the other is on compassionate leave due to the grave illness of her husband. We have not been in a position to speak to them. It is our intention to speak to both of those officers to ascertain the reasons for their behaviour. As you would appreciate, this is a serious issue in terms of—

Senator FAULKNER—I certainly do appreciate that.

Ms Halton—What action I would take as secretary of the department in relation to any further action in respect of these two officers would clearly depend on what they said, based on discussion with both of them when they return from leave.

Senator FAULKNER—But you are directing your attention to the question of the officers.

Ms Halton—Can I go on? That is step 1. Step 2 is in relation to the controls around how access is actually given, and there have been a number of discussions about how access arrangements are appropriately controlled. I can say that we have already removed authority from DLOs in ministers' offices to actually provide instructions to our outsourced provider. There are a number of other steps that we are considering taking, but I have not actually received a final version of what those arrangements would look like.

Senator FAULKNER—Do MOP staff have authority?

Ms Halton—No.

Senator FAULKNER—The interesting thing here is that DLOs are departmental staff. Do you know if MOP staff have authority in your department?

Ms Halton—No, that is not my advice. My advice is that the DLOs had authority as in fact divisional liaison officers have authority.

Senator FAULKNER—Departmental liaison officers?

Ms Halton—Yes, I am saying that in the department there are divisional liaison officers. The point I am making to you is that that authority in this particular case has been exercised inappropriately. I think, because the nature of the tasks in minister's offices is not the same as in the divisions, that it is appropriate that function return—and has returned—to the core department so that control can be exercised over this sort of access. As I have said, the whole question about whether or not access control should continue with the outsource provider is something which is receiving very active consideration.

Senator FAULKNER—What about the question of costs?

Ms Halton—That has to be investigated. Until I have advice on all of those elements, I will not take a decision. But I will take a decision on those things.

Senator FAULKNER—What about conflict of interest concerns or perception of conflict of interest?

Ms Halton—I think Ms Murnane has gone to the advice about what could have been accessed. I will take further advice on this, but I do not believe that there is any demonstrated conflict of interest. Your point is about perceived conflict of interest.

Senator FAULKNER—I said both: either conflict of interest or a perceived conflict of interest.

Ms Halton—I think there had been a view that there was not either of those things. You are suggesting to me that perhaps that view is not correct, and I will take some further advice.

Senator FAULKNER—No. I do not make outlandish allegations or suggestions. I just want to know how you are satisfied on these issues. I am a politician. People say that I am partisan and that I do not have a great deal of time for Dr Wooldridge anyway. All that would be true. You are the departmental secretary.

Ms Halton—Yes. I am satisfied that an authorised officer of the department, without the knowledge of people inside the department who were appropriate to know of such things,

granted Dr Wooldridge access to his email account and to historical material which was the province of his former office. I am satisfied that that was not appropriate. I am satisfied that he was, based on legal advice, technically an authorised user because he was granted access by someone who had authority to do that. I have told you what I will do, when both officers are available, about the fact that that authority was not appropriately exercised in this particular case. In terms of how this happened and the nature of the control, I have outlined to you the change in who is an authorised officer to actually make such decisions. As I have indicated, the role of IBM GSA and core departmental officers is under active consideration. You have asked the question about costs. Yes, the question of costs needs to be considered but only when all of those issues have been considered and advice received on them.

Senator FAULKNER—You said you sought legal advice. When was that sought and why was it sought?

Ms Halton—I sought the legal advice today in respect of the definition of an authorised user. I think there had been an assumption about what constituted an authorised user, but I was concerned that that assumption be tested properly.

Senator FAULKNER—Why did you seek it today?

Ms Halton—Because in reviewing this issue and knowing that it was going to be the subject of questioning, I was reviewing in my own—

Senator FAULKNER—I think we should note here that I had raised with the committee yesterday that I would be raising these matters.

Ms Halton—That is correct. I was reviewing in my own mind some of the assumptions that were implicit in particular parts of the chronology, which Ms Murnane has gone through with you. I asked whether it was legally correct about being an authorised user.

Senator FAULKNER—That is a nice way of saying you have sought legal advice on whether Dr Wooldridge broke the law.

Ms Halton—I sought legal advice on whether he was an authorised user.

Senator FAULKNER—And I said, 'That is a nice way of saying you sought legal advice today on whether Dr Wooldridge broke the law.' I suppose one of the issues here—it is a serious point and I would ask you to address it—is that this has been an issue that has faced the department now for a considerable period of time. I do not know when it came to your attention; I probably should ask you that. Let me ask you that first: when did it come to your attention?

Ms Halton—I was completely unaware of the issue of Dr Wooldridge's access until 13 March, when his access was notified and the fact that he had been discontinued was also notified.

Senator FAULKNER—What action did you take when this issue hit your desk?

Ms Halton—It did not physically hit my desk. Ms Murnane told me and the range of discussions around that issue were, as we have already discussed, what he had access to. That was the first question: what had he had access to? There were a range of other things which have led to the chronology which we have outlined.

Senator FAULKNER—But isn't it true that most of these other things took place very recently?

Ms Halton—Not all of them—

Senator FAULKNER—Most of them.

Ms Halton—some of them in terms of clarifying a particular detail, such as the access issue over the period.

Senator FAULKNER—But I indicated to the committee here yesterday morning that I was going to progress email issues. That of itself obviously has caused some departmental activity. I am not critical of departments preparing themselves for Senate estimates hearings. Good departments do that. I have said that at any number of estimates hearings. But I would be critical if action was taken in relation to a matter like this because of likely questioning at an estimates committee that had not been taken at a more appropriate time, which in my view, frankly, was right after 13 March.

Ms Halton—A number of actions were taken at that time. There was, for example, the unavailability of some of these officers. There are a number of elements to this which still cannot be resolved. We have indicated to you that it is our intention to resolve them.

Senator FAULKNER—These officers have all been unavailable for 2½ months, have they?

Ms Halton—No, but some of them have—

Senator FAULKNER—That is the thing, you see?

Ms Halton—No, let us be clear. In terms of actually working out the detailed chronology around this, that has taken some inquiries, as you could probably well imagine. In terms of getting to the bottom—if I can put it that way—of all the details of this, that has been occurring and will in due course be finalised. You have asked a question about when the legal advice was sought. You have rightly made the point that it is prudent to check one's assumptions prior to coming to provide evidence. That was done.

Senator FAULKNER—It was done today.

Ms Halton—Yes, that is right, because an assumption had been made and that was—

Senator FAULKNER—But the only legal advice that has been sought in relation to Dr Wooldridge's misuse of this email account was asked for today. I assume it has not yet been provided, given that it was only asked for today.

Ms Halton—It was asked for. It was not asked for in writing.

Senator FAULKNER—It was asked for telephonically, was it?

Ms Halton—Verbally.

Senator FAULKNER—Verbally. Have you got it?

Ms Halton—Yes.

Senator FAULKNER—I hope it was not provided verbally.

Ms Halton—In fact, I think it was provided to Ms Murnane.

Ms Murnane—It would be fair to say that I had always taken the view that there had been officers who had worked for Dr Wooldridge, and who were now working for Senator Patterson, who basically were doing what they thought was the best they could by their former minister. The immediate action that was taken, once it was found out that he had this access, was that it was discontinued and not re-established. What I did today was confirm—I knew; but, as you said, you know you are likely to be questioned on something and so you

confirm it—that the two DLOs had the authority to make a request for access to IBM GSA access control. That was confirmed.

Senator FAULKNER—Some of these people are unavailable, and I accept that. But I do not think they have been unavailable for 2½ months, have they?

Ms Murnane—No, they have not.

Senator FAULKNER—It begs the question: what would have happened if it were not raised at a forum like this?

Ms Murnane—There are various ways of knowing. I knew why those officers did what they did: they did it to be helpful. They were asked favours. They would not have thought they were doing anything wrong.

Senator FAULKNER—They were asked favours by the former minister. We all know what the power relationship is there.

Senator Patterson—I would not use the word 'favours', because that puts a—

Senator FAULKNER—That was Ms Murnane's choice of word.

Senator Patterson—I know. They were asked to be reconnected.

Senator FAULKNER—Ms Murnane used 'favours'. I suspect she is right.

Ms Murnane—When I say 'favours', what I mean is to be the conduit for that request. The important thing was that Dr Wooldridge was disconnected and could not have been reconnected. I did speak to both of those officers around the time and told them that, if any further approaches were made to them, I wanted them to let me know straightaway. They conveyed to me that they had told Senator Patterson's chief of staff of Dr Wooldridge's disconnection from the system and of my confirmation that that was to stay in place; he was not to be reconnected. I then got a message back from the chief of staff that that was entirely the appropriate thing to do from their point of view and that would be the stand they would be taking should he ring them.

Senator FAULKNER—Yes. He was disconnected on 15 January, as he should have been. He was reconnected on 17 January and he should not have been. He should not have been connected from 27 November to 15 January—we all know that. He was disconnected finally on 13 March, which he should have been. The point is, Ms Murnane, that it is a complete fiasco.

Ms Murnane—You present it that way. What you have left unstated is that, in the period between 27 November and 13 March, nobody at a senior level in the department had any knowledge that this was the case.

Senator FAULKNER—I accept that. You have told me that and I absolutely accept that; I know you would not mislead the committee. The problem that I have is that I am not satisfied that we do not face a situation here where this improper access continued for an extraordinarily long period of time. It includes a disconnection and then a reconnection for a former health minister who gets a job in the health industry the day after he leaves office. He may have had access to commercially sensitive and security sensitive information, and there has been no thorough investigation. I hear what Ms Halton says about the issues that are being investigated, but there is so much detail we do not know. This long after the event, we ought to know a lot more.

Ms Murnane—You said he could have had access to commercially sensitive, protected information. I have said to you: only if that had been accessible to him when he was minister.

Senator FAULKNER—Given that no-one knows the details—

CHAIR—Senator Faulkner, could I interrupt please. You said that you were going to be here for 10 minutes and I am worried now that it is getting beyond the dinner break time.

Senator FAULKNER—I will conclude my questioning—I don't want to see the officers stay hungry for too long. The point I would ask you to consider, Ms Halton, is that there has been no investigation of this. I understand what is occurring at the moment. I have heard what you have said. We have gone into a whole range of issues such as costs—no-one knows what costs are being borne by the department in relation to this. We now have some detail about the number of times this has been accessed in this period—approximately 150. I am not satisfied in any sense about commercially sensitive information and I think we ought to be. You are not satisfied and I am not satisfied about whether there is a breach of the law and a range of other issues. They will be revisited, but I say again that this has been an absolute fiasco for the health department. Frankly, in my view, it is an outrage that Dr Wooldridge could do this.

Senator McLUCAS—I have some questions in that overarching area.

CHAIR—How long are you going to be? I am concerned that meals finish at 8 o'clock.

Senator McLUCAS—I flagged earlier today that we wanted to ask some questions about the Intergenerational Report. Given the time, I will put those on notice.

Senator Patterson—Thank you, Senator McLucas.

Senator McLUCAS—They go to the issue of what informed both departmental decision making processes and the IGR. Yesterday, we were talking about the electorate profiles that were on the web site. I think someone said that they had been on the web site only once. I do not know whether that is correct.

Dr Wooding—I will check that. I thought that it was only once, but I will take that on notice and provide the correct answer.

Senator McLUCAS—We are talking about a document called *Electorate profile for Queensland*, with the electorate number and name. It is produced by the Portfolio Strategies Division. I am advised that they go back to 1993.

Dr Wooding—On the web site?

Senator McLUCAS—They were being produced.

Dr Wooding—Sorry, on the web site I think it was once. They have been produced for some time.

Senator McLUCAS—We forget that we did not have web sites. I understand that they were produced every two years, but that does not make sense because 1993 was odd.

Dr Wooding—We have collected information in the department for a long time. We can split it into various geographical units. By electorate is one possible way of doing that. I suspect that we have been doing that sort of work for a lot longer, even before 1993.

Senator McLUCAS—Do you intend to publish another electorate profile this year?

Dr Wooding—At this stage, no. As I said yesterday—I think the secretary said it also, if you look at the transcript—we are working on finding a range of ways of cutting up our data in a geospatial sense that will be useful for a broad range of people, and by electorates is one

way of doing it. Though, to be honest, in terms of the health programs, as a general rule, by electorate is not a very helpful way of geospatially splitting information about our programs. We are currently reviewing the way we do that. We will certainly be looking to put out information in the future which is split in various geospatial ways, but I cannot say exactly how we are going to do that yet.

Senator McLUCAS—When did we make the decision not to do it by electorate?

Dr Wooding—As I said, we have not made a specific decision not to do it by electorate; we are examining the way we do it, and we have not released any since June 2000.

Senator McLUCAS—I would like to know why we are not going to do it by electorate. I take your point that doing health planning by electorate is not the way you make decisions, but there are a whole lot of other reasons why you would want to have information by electorate. The Senate especially is interested in reviewing information that is collected by electorate; it is part of our role.

Dr Wooding—Excuse me, Senator, but I did not say that we are no longer going to produce it by electorate; I was saying that we are in a phase at the moment where we are looking at how we produce information in units, and there has been no decision made specifically that we will not do it by electorate.

Senator McLUCAS—If you make a decision one way or the other, can you inform the committee?

Dr Wooding—Absolutely.

Senator McLUCAS—I will put this question on notice: I would like the advertising allocation for each of the outcomes for the budget 2002-03; and how the advertising and promotions—however you describe it—will be allocated to each of the outcomes, or whether it is collected centrally—

Dr Wooding—We do not have a specific advertising budget for the portfolio. We report on the money spent on advertising in the year completed in the annual report. The next annual report, which will come out later this year for 2001-01, will show advertising as spent by outcome—that is my recollection—and it will show how we have spent advertising money in the 2001-02 year. For the forthcoming financial year, I will have a look and see what I can provide. We may be able to provide something on specific initiatives, where we have identified in the PBS or some other document that we are going to spend money on advertising. But we do not have a specific advertising budget as such.

Senator McLUCAS—So you do not have any communication plans or things like that?

Dr Wooding—We have had communication plans about the way we communicate, but we do not have an annual budget where we say, 'We are going to spend this much on communications in these outcomes in this year.' We announce in certain places that we have budgets for specific campaigns and communication activities, and I will have a look and see what I can provide in relation to that. But it is not a formal document in the way that you are suggesting.

Senator McLUCAS—I will put those questions on notice.

Dr Wooding—We will have a look and see what we can provide.

CHAIR—There being no further questions before closing, I would like to thank the minister and Ms Halton, all the officers of the department, the secretariat and Hansard, and I

would also like to recognise that it is Senator West's and Senator Crowley's last foray into estimates. While we may not have agreed on a lot of things over the years, I am sure that it has been both challenging and rewarding for all of us, and I take the opportunity of wishing you both exceptionally good fortune for your retirement, and I hope we will see you from time to time.

Senator WEST—Thank you very much, and thanks to the department also: there have been occasions when I have given you a hard time. Believe me, I will still continue to be a ghost, haunting you whenever there are nursing issues!

Senator Patterson—Senator West, Senator Herron asked me if I was going to say something to you, and I said that I thought that I had to both of you; but he said that he did not think so. So, just in case you feel left out of my comments earlier, I want to say thank you very much, and I hope that you will write a book on how to retire from politics—tell us all so that we know.

Committee adjourned at 7.59 p.m.