COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Reference: National Health Amendment (Prostheses) Bill 2004

MONDAY, 7 FEBRUARY 2005

CANBERRA

BY AUTHORITY OF THE SENATE

INTERNET

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **http://www.aph.gov.au/hansard**

To search the parliamentary database, go to:
http://parlinfoweb.aph.gov.au

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Monday, 7 February 2005

Members: Senator Knowles *(Chair)*, Senator Greig *(Deputy Chair)*, Senators Barnett, Denman, Humphries and Moore

Participating members: Senators Abetz, Allison, Mark Bishop, Boswell, Buckland, George Campbell, Carr, Chapman, Colebeck, Collins, Coonan, Crossin, Eggleston, Evans, Faulkner, Furguson, Ferris, Forshaw, Harradine, Hogg, Lightfoot, Ludwig, Lundy, Mackay, McGauran, McLucas, Moore, Nettle, O'Brien, Payne, Robert Ray, Tierney, Watson and Webber

Senators in attendance: Senator Knowles *(Chair)*, Senators Allison, Barnett, Denman, Humphries, McLucas and Moore

Terms of reference for the inquiry:

National Health Amendment (Prostheses) Bill 2004.

WITNESSES

Committee met at 12.16 p.m.

SCHNEIDER, Mr Russell John, Chief Executive Officer, Australian Health Insurance Association

CHAIR—The committee today is taking evidence on the National Health Amendment (Prostheses) Bill 2004. I welcome Mr Russell Schneider, representing the Australian Health Insurance Association. Witnesses are reminded that the giving of evidence to the committee is protected by parliamentary privilege. However, the giving of false or misleading evidence may constitute a contempt of the Senate. Mr Schneider, we have before us your submission. I invite you to make an opening statement, at the conclusion of which senators will ask you some questions.

Mr Schneider—All I would like to say really, as we say in our submission, is that the great challenge facing health systems both in the public and the private sector is the challenge of modern health technology—which brings about enormous benefits to people and allows things to be done which were just unthinkable only a few years ago. The challenge to both the public and private sectors and the community as a whole is whether we can continue to afford to pay for the benefits of modern technology. Unfortunately, miraculous devices do involve very substantial costs, so it is incumbent on all of those involved—whether they be governments, insurance funds, hospitals or indeed the providers of medical devices—to ensure that, in the interests of the community, any avoidable or unnecessary costs in that technology system are reduced to the barest possible minimum, because every health care dollar spent that could be better spent on something else is a dollar lost; and the dollar is ultimately finite.

The current legislation moves, I think, in a very effective way towards attempting to introduce some elements of more effective pricing for prostheses without compromising the integrity of the system and without denying patients access to the most appropriate technology for them without cost, other than the cost they must pay for their premium. I would make the point that today prostheses represent 12c in every dollar of health insurance premium, and that is a figure that is growing each year. The intention of this legislation as we understand it is to move towards a system in which the price paid for prostheses is more related to their relative clinical benefit than has been the case before and to ensure that that relationship is determined by expert clinicians not by insurers, not by governments and indeed to some extent only in part by suppliers—who will be subject to far more competitive strains that has been the case in the past. The intention of the legislation as we understand it is to ensure that all devices are fully covered. There has been a lot of discussion about possible gaps and copayments. It is true that the legislation does make it possible in certain circumstances for some devices to have a patient copayment, but that would only occur in circumstances where the supplier of the device has chosen, for whatever reason, to insist on a higher price than that sought and available for a clinically equivalent product.

All patients will always be able to receive a clinically appropriate device for their care without a copayment. It has been said in some of the debate about this legislation that it is going to mean that patients will only be able to get a Holden rather than a Rolls-Royce and if they want a Rolls-Royce then they will have to pay for it. That is not true. The way the system is going to work is that if there is a Rolls-Royce product in the form of a prosthesis—that is,

the very best prosthesis which clinically establishes it is the very best to the satisfaction of experts—then that will be fully covered. The only area where there would be a gap would be—to continue with this analogy—if you have a Holden which is seeking a Rolls-Royce price but is still a Holden. In those circumstances I think the community would expect it to be only reasonable that the person who is encouraging somebody to buy that Holden at a Rolls-Royce price should point out that there will be a cost involved.

The legislation has a number of safeguards for consumers and for clinicians but, very importantly, it also offers us an opportunity as a society to make sure that we can continue to access the best of technology at prices that people can afford to pay. I will now illustrate the impact of technology on health insurance premiums over the last few years. In 1988 the most expensive device on the cardiac prostheses list was a pacemaker. That pacemaker cost about $4,000, which was the equivalent in those days of 10 single person premiums. So it was relatively affordable. Today the most expensive cardiac device is a defibrillator pacemaker, which is light years ahead of that which it replaced—there is no doubt about that; it is a vastly superior device to the other—but the cost is $50,000 or the equivalent of 50 single premiums. In other words, whereas we needed to have 10 people who did not claim paying for one cardiac device a decade or so ago today we need to have 50 people who do not claim to cover that same device. At that sort of cost explosion we will rapidly run out of enough people in the Australian population to be able to cover devices without enormous price inflation coming into the system.

There are a number of reasons why the cost of prostheses goes up, and one of them is technological innovation itself. There is no doubt at all that improved devices do improve our standard of living and allow people to enjoy a quality of life that was unheard of a few years ago. But, equally, if they are to be able to afford that, we have to ensure that any unnecessary cost pressures in the system are minimised. This legislation is, we believe, a very significant step towards achieving that.

Senator DENMAN—I had better declare a vested interest here. I have a prosthetic knee and two hips.

Mr Schneider—I hope you do not go through the metal detectors!

Senator DENMAN—I do.

CHAIR—Senator Denman was brought along today to provide the props.

Mr Schneider—I should have brought some myself.

Senator MOORE—And yourself, Madam Chair.

CHAIR—And the screw in my foot, yes.

Senator DENMAN—In point one you state that you believe the legislation will ensure that the rate of growth in the cost of modern technology is tempered by market forces. What leads your association to this conclusion? Do you see the provisions of the bill which will protect consumers from competitive pricing being limited to just the standard listed devices?

Mr Schneider—I will explain how the system will work rather than simply pointing to clauses in the bill because I do not have all of those in my head, and the way the system will work is predicated on how the bill has been put together. At the moment we have in effect a

seller's market. The sellers may dispute that, but when you have a situation where you have to cover everything at a price that effectively has to leave the patient without any gap, it is very difficult to achieve much in the way of competition.

This system is based very much on the Pharmaceutical Benefits Scheme arrangements, which are intended to encourage competition between suppliers to be listed, because if they are not listed and there is a copayment, there is a likelihood that they may not be attractive in the marketplace—that both clinicians and consumers will choose to have in most circumstances access to a generic product or an equivalent product which does not have a significant price copayment for it. My understanding is that, although there may be the occasional hiccup with the PBS, that system does work very well and has led to reductions in prices of pharmaceuticals.

We expect that much the same thing will take place within the prostheses area, because suppliers will have a very strong interest in their being priced at a price equivalent to the benefit so that there is no gap. We expect that both the consumer and the clinician will tend to move that way, given the fact—I think this is very important and cannot be stressed enough—that the clinical equivalence of the devices will be assessed by expert clinicians who work with those devices all the time. They, in effect, will be saying: 'Of 10 devices, five are exactly the same, and therefore they should be grouped together and priced accordingly.' They will not actually make decisions on price—that will be negotiated by someone else—but within that group there will be no reason at all why one device should have a different price from another.

Senator DENMAN—So the patient is very much at the mercy of the clinician as far as the device is concerned; is that right?

Mr Schneider—I am not sure whether I would say 'at the mercy'. The objective of this exercise will be to have no device with a copayment. We expect that in most cases the clinicians will choose to have those devices. If there is one that does have a copayment, the clinician will be expected to inform the patient in advance of the copayment. Indeed it would be very difficult to convince a person that they should be paying something out of their pocket which is not clinically appropriate. We expect the clinician to advise the patient that there are other devices which are clinically appropriate and can be provided at no cost.

Senator DENMAN—What happens, then, if you are in theatre and something goes wrong, and they have to use a different product from the one they have discussed with the patient and there is a cost difference?

Mr Schneider—In our submission we have a process which was in broad principle agreed by the various parties as to how it would work. I understand that some of the other parties may have modified some of the precise words, but inherently the principles are still agreed. I think in those circumstances either the health fund takes the responsibility for meeting the cost or it is shared between the parties—the hospital and the fund. I do not recall exactly, but we do have a specific provision to deal with that. While we do not invite legislation to do this, we have taken the view that, provided the principles are embraced by all, if it has to be done by regulation or legislation, we would live with that, but we would not want to be the only ones.

Senator DENMAN—And that situation probably does not arise all that often—or it might, more than I realise, perhaps.

Mr Schneider—Well, it may. One would hope that in the best of worlds it would not occur more than very occasionally.

Senator DENMAN—Your association and others who have commented on the bill believe that public hospitals in particular but also private hospitals and even doctors are able to buy prostheses more cheaply through volume discounts. On the other end, you say that the funds, as those who are paying for the prostheses, do not have this opportunity. I am a bit unsure about why that is.

Mr Schneider—It is largely because, if you are a hospital or a doctor, you determine which prostheses you are going to buy. A hospital, for example, can say in negotiating with a supplier that it will buy 10,000 whatsits and demand a price based on the volume that it is providing. It may not only be for that particular whatsit; it may be for a whole range of equipment that the supplier provides. The health fund cannot negotiate that. The health fund cannot say, 'We are going to buy this many of these,' because it cannot control the use of them or the selection of them.

Senator DENMAN—So those costs are not passed on to you?

Mr Schneider—No. We would like them to be passed through but they are not. I will give you an example. I asked my funds to do some work comparing prices paid in the public and private sectors. A device called a drug-eluting stent is a tiny little piece of metal—like a little pipe—that goes into your veins. It saves people's lives. In a Melbourne public hospital, the price for that device was $2,400 and the price funds had to pay in the private sector was $3,220—a difference in price of $820 for that device. What is disturbing about that is that this is one area where the public sector probably does not have more volume than the private sector, because most drug-eluting stents are provided in private hospitals. We find it rather difficult to come to grips with the fact that there is that price differential and we would hope that this new system would at least reduce the difference between the two.

Senator MOORE—I have a couple of questions. I was taken by those last figures. I am trying to get my head around what kind of money we are talking about. The legislation cannot determine the money; it is talking about theory and process. The example you gave was that in the public system the piece of equipment was $2,200-odd and it was $3,000-odd in the private system. Do you have other data on those particular issues? This bill covers so many things. Can we get hold of any of those calculations? I am trying to work out exactly what the dollar saving is.

Mr Schneider—Yes. It is very difficult to work it out across the board, and I cannot really predict at this stage what the savings will be. Perhaps I will use another example. If we take cataracts and lenses, the public sector price was $135 per lens and the private sector price was $290.

Senator MOORE—That is an even bigger gap.

Mr Schneider—Yes, it is. On our calculations, which I have to qualify by saying that they might not be 100 per cent accurate, if the same price were paid in the private sector as is paid

in the public sector—and, again, volumes work the other way; that is, most cataracts are done in the private sector rather than the public, so volume should work in favour of the private sector—there would be a saving of around $12 million. That is in just one area of the schedule. If we flow that through the whole system—where we pay almost $700 million for prosthesis—one would expect or hope that there would be millions to be saved. But I must make the point that savings in the health insurance dollar are important but equally important is ensuring that we tie as much as possible the cost of the benefit to the relative benefit of the device—and we get a bit more science, I suppose, into the relationship between the price paid and the actual clinical benefit or clinical appropriateness of different devices.

Senator MOORE—And that kind of science is not there at the moment?

Mr Schneider—It has not been applied to date. It is now being applied within this system. I understand that the clinical advisory groups, as they are described, have begun a review of some devices. I am not a party to that; it is commercial-in-confidence. As I understand it, the clinicians themselves are favourably impressed by the fact that this new system is being worked and there is actually an official sanction for doing this, which has not been the case in the past. The devices have been subject to TGA approval—you cannot get them in without that—but that does not go into the same sort of rigorous examination of relative benefit.

Senator MOORE—It is more about whether it is safe, as opposed to whether it is cost effective?

Mr Schneider—Yes. If it meets certain safety criteria it is okay. But they do not concern themselves at all with the price or the relative benefit of one device compared with another, to my knowledge.

Senator MOORE—I am intrigued by your comparison to Holdens and Rolls Royces. I know there is a big gap there. But you gave the example of a particular heart device and the enormous growth in the science and the cost. Would a device like the second one you mentioned, costing about $50,000, be a Rolls Royce or a Holden pretending to be a Rolls Royce?

Mr Schneider—That would be a Rolls Royce, and it would be paid for as a Rolls Royce. If the old pacemakers were still around—and they are probably all worn out by now—you would be paying a Holden price for those. If they asked for a Rolls Royce price I do not think anyone would think that was appropriate. To some extent—though I do not make this the substance of our argument—in circumstances like that, the price is probably for the benefit of the patient more than anything else, I would hope that that sort of thing would not happen within this new system. The device that is clinically regarded as being superior to anything else, or superior for a particular application for a patient, should be fully covered.

Senator MOORE—I have only two more questions at this stage. I am very fond of tables. I find them useful to read, and you have one in your submission. I am interested—and it follows on from Senator Denman's question—in the 'what if' idea that you think you are covered and then something happens whereby you do not have the ability to make a decision. You speak there of shared responsibilities in terms of liability at that stage. Is that shared responsibility absolutely agreed or is it based on goodwill at the moment?

Mr Schneider—My understanding is that it has been agreed. But I guess different people will have different views about that. Certainly, as far as the health insurance industry is concerned, the commitments imposed on the health funds, via those tables, are accepted by us. As I said, if it is necessary to enshrine that in regulations it would—

Senator MOORE—It makes a big difference; 30 per cent as opposed to the whole buck.

Mr Schneider—I cannot speak for the others. That is the only point I make. My understanding is that it was agreed. I believe that it has gone through the various decision-making councils of the various groups. But I cannot speak for them, and it would be quite improper for me to attempt to do so.

Senator MOORE—The other point is the amount of information you give to people who are looking at taking up private insurance about what they are covered for, in order to provide a clear understanding. People have a wide range of understanding and knowledge when they are signing up for a product. At the moment they are pretty safe because most full funds cover the whole lot, so they know they are covered. What kinds of processes are your members considering putting in place to ensure that, when they are giving guidance to consumers about which package will suit them—amidst all the other information that people are weighing up—they point out that this is a new one that they might have to consider?

Mr Schneider—Apart from the commitments that are in the submission, we are currently finalising a code of conduct for health fund staff which is very similar to the provisions in the legislation for insurance brokers and advisers, and which is intended to ensure that all staff provide people with appropriate information, particularly in relation to any limitations on policies. That will be, in effect, a binding code to which I think all health funds are committing themselves to. We have simply got some minor processes to go through, I believe, with Treasury to ensure that it is consistent with what their wishes are in relation to insurance generally, as it applies to advice. I think that should go a long way towards making sure that people are adequately informed. Again, we are also working further with the AMA and the department to ensure that we get a very effective, informed financial consent process so that people are not only informed at the time they take out the health insurance product but also informed at the time they go to use it, and often there is a big delay between the two.

Senator DENMAN—You talk about people taking out health insurance and so on. Young people probably would not think that at their age they would need to cover themselves for this. Is that a problem? I am thinking about elite athletes and people like that.

Mr Schneider—The biggest problem with young people is that they do not believe that they should be insured for virtually anything, including their health but not just their health. They should be equally protected.

Senator DENMAN—Yes, I realise that, but do they realise that? Obviously not.

Mr Schneider—I wish I could say they did, but my own personal experience suggests to me that it is very difficult.

Senator DENMAN—What about elite sportspeople?

Mr Schneider—I think they would be more sensitive to these sorts of things, by their very nature.

CHAIR—The teams generally cover them, though.

Mr Schneider—Yes.

CHAIR—That is at the elite level.

Mr Schneider—I think their coaches, managers or teams would make absolutely certain that they were totally protected.

Senator BARNETT—Thanks, Mr Schneider, for your submission, which is very informative. I must just declare a vested interest, as somebody wearing an insulin pump, as you are aware. I want to go to the points that you made about safeguards for consumers. You mentioned earlier the example of everyone having access to a Holden rather than free access to a Rolls Royce, and I think that is a fair comment. The main point to make, though, as a person who is perhaps familiar with the consumers, is that it is the latest model Holden and not a 1970 version. You know that there are a number of insulin pumps and Sof-Sets, but one, I am advised by people in the diabetes community, is actually uncomfortable and at times painful. That is readily available for access by consumers.

In terms of consumers being aware of the gap, you mentioned earlier that the access to that information is through the doctors and also through the health funds. Can you just flesh out exactly how that is going to happen? In the submission you say that you are hoping that, through the AMA and through the doctors, all reasonable endeavours will be made to get information to the consumer. How can we guarantee that that is going to happen?

Mr Schneider—Working through the process, I think at first instance it is incumbent on the funds to make sure that their members are fully advised of how the new arrangements will work. We are yet to finalise this, but we have been talking with the various groups involved. Doctors, hospitals, health funds and the Department of Health and Ageing have been discussing the form of an appropriate education campaign which would be targeted at the various audiences—the patient, the doctor and the health fund staff themselves. I would expect that we would have to make quite sure that any constraints were identified to people via brochures and other material so that we can make them aware that this is the case. We could also perhaps suggest to them that if they are going to go in for an operation and need a device they should ask the doctor, if there is to be a gap, for the reasons why and whether there is not a clinically appropriate device as an alternative. They can then make an informed decision. I think that the AMA itself would think that it is very important that patients are informed in advance of any gaps.

Senator BARNETT—I am sure they do, but do patients have to sign a form of some sort to say, 'Yes, I consent to the paying of the gap,' or are they just informed?

Mr Schneider—No. It has been proposed, and I cannot impose this on the medical profession, but I understand that the AMA has already constructed an informed financial consent form. That form will quite specifically provide information in relation to any possible gap. My recollection is that that will actually have to be signed off by the patient and the doctor.

Senator BARNETT—That is on page 8 of your submission in the paragraph under the heading 'Doctors'. Maybe we need to ask the AMA and the department whether there is a

requirement for the consumer to sign that consent form. It seems like a good idea to me, but that is what I am seeking clarity on.

Mr Schneider—I cannot speak for them. We would certainly hope that they would be fully informed about that, but there are two other fail-safes or supports. One of them is the hospital. When the person books into the hospital, other than in an emergency situation—and let us face it, there are nowhere near as many emergency situations in the private sector as the public sector—at the stage of that elective booking, one would expect that the hospital would have a very strong interest in ensuring that the device that they were going to order and supply was fully covered. If it was not, they would be wanting to tell the patient at that stage of any gaps. That is a second protection.

We cannot force consumers to contact health funds in advance. We do certainly encourage people and will continue to encourage people to check with their health fund before they go into hospital so that they can be advised of any gaps, co-payments or limitations to the products.

CHAIR—They are already advised of gaps in co-payments now by doctors, surgeons, anaesthetists and hospitals. I cannot imagine that for some reason the fitting of prostheses would somehow be excluded from that informed consent. As recently as last week I had to sign all those consent forms, and I cannot imagine that they would say, 'We're just going to leave one bit out.'

Mr Schneider—It is not in the interests of the hospital, apart from anything else, to leave that out.

CHAIR—Exactly.

Mr Schneider—They would prefer you to know in advance if you have to pay anything, rather than wait and cross their fingers and hope that you agree to pay after the event. They have a very strong interest in ensuring that the patient is informed, as does the health fund and the doctor. The other thing about this is that, if I understand the way most of these things work, although there are about 5,000 items on the list, most specialists or subspecialists would only use a relatively small number of devices. One would expect that they would be aware in advance of those few, if any, that may have a co-payment. One would hope that the devices they use would have no co-payment at all, but they would know in those circumstances. So it is not as though the doctor is not going to know whether this has a co-payment or not.

Senator BARNETT—Going back to my first point, are you confident that they are going to access the most recent Holden, not the 1970s model, through the systems that we have in place in this legislation?

Mr Schneider—That is my understanding. Let us be honest: something might come onto the market that has not had time to be examined by the clinical advisory groups. There is provision for that to be fully covered, but that is a matter for the manufacturer. There is an incentive for the manufacturer or supplier to actually list it at the price of notionally equivalent devices so they can build up some track record and then put it into a clinical advisory group to see where it is rated, if I may use that term. Other than that, my understanding is that, if it is the most up-to-date Rolls Royce and the clinicians agree that it

is—that is the important thing: it is not my decision, it is not the suppliers'; it is the clinicians'—then it would be fully covered.

CHAIR—We are running short of time, but I have one basic question about putting a brake on the practices of, for example, some orthopaedic surgeons who might put a prosthesis worth $20,000 into a patient who is aged 90-odd where a lesser prosthesis would do exactly the same job for the equivalent benefit. Do you believe that this legislation will also put a brake on the practice by some—and I do not say by any means by all—of always going for the top of the range when an equally effective prosthesis is available?

Mr Schneider—That would depend a little bit on the findings of the clinical groups. What I think it would do over time is concentrate the attention of clinicians as the clinical advisory groups review items more and more. One would expect that they would be making it clearer that certain devices were appropriate for certain people and others were less appropriate for them, even though the device might be clinically appropriate.

That would put a signal out to the medical profession that some intelligence and logic should be applied to the decisions they make—horses for courses. One would hope that that would be the outworking of it. That is not to say that there should be any denial of the most appropriate device for a person based on age. In fact, in early discussions on this subject the health insurance industry decided that under no circumstances would we be seeking to relate the availability of a device to a person's age or for that matter their sex or their state of health.

CHAIR—I want to make it crystal clear that I am not suggesting that, either. There was no hint of a suggestion in my question about that. In fact, my question was quite specific. It said that sometimes a very expensive product is placed in a person where an equally effective product at a much lower cost would have been sufficient. However, the choice is always to go for the top of the range instead of something that is equally efficient.

Mr Schneider—I do not believe there is anything in the legislation that would impose that on doctors.

CHAIR—I am not suggesting there should be, either. I am asking you whether or not you think this legislation might put a brake on that practice of some clinicians always opting for the top of the range and bring a touch of reality into play.

Mr Schneider—Focusing on the clinical appropriateness of the devices will, one hopes, start to not so much change behaviour but at least alert clinicians to the potential inappropriateness of using certain devices for certain patients. I suspect the profession would probably deny what both of us believe to be the case. But I am pretty confident that the more information you provide people in the medical profession the more it tends to influence their behaviour. Not so much the pricing aspect of the legislation but the simple fact that it is going to subject devices to clinical assessment—

CHAIR—That is right.

Mr Schneider—must have some impact on the way doctors decide they are going to use devices.

CHAIR—With all the support assessments that can be done now the guesswork is greatly reduced prior to a procedure commencing, so surely this would be of benefit.

Senator McLUCAS—Thank you for your submission. You make a point under 'Possible Problems' where you say that where there are a group of prostheses that are similar the competition that exists among the producers will reduce prices. But you identity that where there is essentially a monopoly provider there will be no controls. Can you explain that a little further. In how many circumstances do we have monopoly providers?

Mr Schneider—In most cases, my understanding is there are a number of competing devices. However, with new technology, obviously the first person to the starter's gate is the one who gets an advantage and they will keep that advantage for a while. The drug-eluting stent was one example of that. It was unique to one company and for quite some time the price was in our view excessive but there was no way of comparing it because there was nothing to compare it to. A competing device came onto the market and the moment that happened we discovered that the original supplier was much happier to negotiate lower prices than had been the case before. That is what I expect will happen here. I think we have to accept the reality that where there is a monopoly, as with drugs, any manufacturer who has a sole device is going to have control of the market for a period of time and then sooner or later someone will come up with a competitor or something superior so we will have a sort of leapfrog situation. If we can find a way of dealing with that I can assure you I will be back in here at the first opportunity.

The other area of concern is the possibility of some minor tweaking taking place so that of the five devices all nominally in the same area something is suddenly found that puts one there and one there and one somewhere else. Again, I think it is a matter of vigilance and proper clinical assessment. The feedback I have suggests that the clinicians involved in this process are doing an extremely ethical, proper and responsible job. I guess the only thing we can do there is monitor that and if there does appear to be a problem perhaps we will actually have to open up discussions with the department, the government and the parliament to see what can be done.

Senator McLUCAS—Further on you talk about alternative solutions and I think you are alluding—without saying the words—to the need for some sort of review. Is that the view of the AHIA?

Mr Schneider—Of this process, this legislation?

Senator McLUCAS—Of the legislation.

Mr Schneider—It is not a formal view in the sense of saying that there must be a review of this legislation within a certain period of time, although I think that probably all of the groups involved would say that they believe it should be reviewed. Speaking perhaps more for myself than all the other members, I think it is probably better to do it on an iterative basis and just see what the problems are and identify those and try to deal with them as they occur. But it would not be illogical to keep the process under review and if the idea is that it should be looked at in 12 months, two years or five years time, we would have no objection to that at all.

Senator HUMPHRIES—There are 9,000 prostheses available on the schedule at the moment. Do you know how many companies supply those devices? How many suppliers are there in the marketplace?

Mr Schneider—I am sorry, I do not have that in my head, Senator. I think there are probably about a dozen really big ones. It is probably pretty much the same as the health insurance market where you have a number of big ones and a whole range of very small suppliers or importers. Some may deal with only a couple of small devices, and they may be for a niche market. But I cannot give you the exact number.

Senator HUMPHRIES—When you referred to a 'seller's market' is there any danger of cartel behaviour—suppliers getting together to ensure that what is submitted to this committee is a very small range of price difference?

Mr Schneider—I think everyone would be very disturbed if that were to take place. It is something that we would have to monitor. I think that if it were to become a serious concern—and I am not suggesting that it is—we would have to start thinking about putting evidence before the ACCC or some other agency. But in fairness to the suppliers, I have no evidence that that would take place at the moment. Indeed, it is our hope that we will actually get competition among the suppliers because there will be an interest in being listed. Let me assure you, it is something we will be keeping an eye out for.

Senator HUMPHRIES—I am sure you will.

Senator MOORE—I only know my own fund so I do not know all the different funds, of which there are so many. Is there any suggestion that there could be some kind of limitation on the number of these devices that patients could access? Most of these things have a time line and I have heard of cases of people having to have similar surgery time after time. Do any of your funds think that there will be a limit or is it uncapped at the moment?

Mr Schneider—I do not believe that anyone could do that. In effect, we pay for hospitalisation, unless the product itself specifically excludes some things, which it can do. Provided the operation is covered, we pay for it. Take pacemakers, for example. What I did not realise until recently is that when they go in they do not go in forever. When they wear out they have to be replaced. We pay for them without any question about how many times. I have heard of cases where there have been a number of hips paid for, for example. In fact, one of the things that I understand is taking place at the moment that is having an impact on price is hip revisions—the generation of hips that were planted perhaps 10 years ago—

Senator MOORE—Twenty years ago!

Mr Schneider—are wearing out and so there are all these people going back and having new ones put in. They are better hips.

Senator MOORE—We hope so, Mr Schneider.

Mr Schneider—Knowing what a hip replacement operation is like, not having had one, I would certainly hope so. I would not like to have more than one in my lifetime if I could avoid it.

CHAIR—Thank you very much for your submission, Mr Schneider.

[1.00 p.m.]

GILHEANY, Dr Mark Francis, President, Australasian College of Podiatric Surgeons

PRICE, Mr John, Chief Executive Officer, Australasian College of Podiatric Surgeons

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

CHAIR—I welcome representatives from the Medical Industry Association of Australia and the Australasian College of Podiatric Surgeons. Witnesses are always reminded that giving evidence to the committee is protected by parliamentary privilege. However, the giving of false or misleading evidence may constitute a contempt of the Senate. We have before us your two submissions. We invite you to speak to your submissions, at the conclusion of which I will invite senators to ask any questions.

Dr Gilheany—On behalf of the Australasian College of Podiatric Surgeons I would like to thank the committee for allowing us to provide a submission and, furthermore, for allowing John Price and me to attend today. Our submission to this committee is about achieving amendment to this legislation to remove inequities and confusion for patients. We are not concerned about the specifics within the list of item numbers; on the whole, we believe that this is a valuable reform. As a matter of courtesy, I would like to thank the government for recognising podiatric surgery during 2004 for the purposes of private hospital insurance in relation to foot surgery performed by podiatric surgeons. That legislation will compel health funds to pay for hospital services in association with a surgical procedure performed by a podiatric surgeon.

Our issue with the National Health Amendment (Prostheses) Bill relates to the potential for the insurance industry to avoid paying for prostheses if implanted by a podiatric surgeon. Prostheses are essential to our work, and the same devices are used by podiatric surgeons as by any other provider of surgical services. Within the draft prostheses bill, payment for prostheses is specifically linked to Medicare payment. The door is therefore open to avoid payment for prostheses implanted by podiatric surgeons as podiatric surgeons at this point in time do not attract a Medicare benefit for their services.

To date it appears that the insurance industry is reluctant to pay for these prostheses, which is leaving the community substantially out of pocket when the whole intent of the legislation in 2004 was to encourage competition in provision of surgical services and to ensure that the consumer was not disadvantaged. As a final statement to the submission, we have a clear understanding from the office of the Minister for Health and Ageing that amendments to the legislation as we have suggested would be considered favourably by the government—which does encourage us. I did not want to take a lot of time, so I am open to questions now.

CHAIR—Pardon my talking to my colleague but it was about this exact issue. I want to clarify with you your knowledge of the health funds and their commitment to pay for the prostheses. When I read your submission I was a bit concerned about that and I sought assurances that a patient would be treated the same way regardless of whether they went to an orthopaedic surgeon or to you. I was given that assurance. Do you have something that is quite contrary to that?

Dr Gilheany—Unfortunately, yes. I have approached the health insurance industry in the past few months in relation to providing the reform that last year's legislation enabled, and I have it in writing from one major health fund that they will not pay for prostheses or theatre fees for surgical events provided by a podiatric surgeon simply because under the Health Insurance Act they are forced to pay for hospital services but not necessarily prostheses. Under the prostheses bill, as it is currently written, they are still not forced to pay for the prosthesis if it is put in by a podiatric surgeon; it is their choice. But one major fund has told us in writing that they will not pay. Another major fund, in a minuted telephone conversation I had with their public officer, has indicated the same thing. Thus far, approaches to the peak bodies in respect of private health insurance, such as the Private Hospitals Association and Mr Schneider's group, have also failed at this point to produce responses.

CHAIR—We will just leave that there for the moment and I will come back to it because we have not yet heard from Mr Ross. I think that certainly needs more clarification.

Mr Ross—As a representative of the suppliers of medical devices in Australia, I appreciate the opportunity to speak to the committee today. I do so, having been involved in industry advocacy since the time these reforms were first proposed some years ago. I am also a member of the Minister for Health and Ageing's Prostheses and Devices Committee and the department's prosthesis policy advisory group, although I am not here in that capacity. The overwhelming theme of the submissions to this inquiry is in support of the legislation and MIAA shares this approach. However, like others, suppliers have reservations and our concerns are that although the intent of the bill is to restrict premium growth it may produce unintended consequences for patients.

Our submission to this inquiry has focused on the terms of reference and I will highlight several points. We believe that the outcomes of the reforms are uncertain. Like the Australian Consumers Association, we are sceptical of the capacity of these changes to bring about a long-term slowdown in premium increases. While we agree that these reforms are likely to place pressure on prosthesis prices, we believe that the real driver of expenditure is utilisation, which is not addressed by these measures. I also note the observation by Catholic Health Australia that the ageing of the privately insured population is likely to result in continuing growth, which will limit cost savings even if prices fall.

The reforms have the potential to impact on patient choice on two counts. Firstly, patients who cannot afford to pay gaps will have the breadth of prostheses available to them reduced. The Private Health Insurance Ombudsman notes in his submission:

> Many consumers might see the introduction of a patient gap for prostheses that would otherwise have been available with no gap, as a reduction in patient choice.

As an aside, MIAA would prefer to see situations avoided where surgeons felt pressured to use less familiar prostheses based on financial considerations rather than clinical considerations. Secondly, prostheses subjected to gap payments may no longer be commercially viable and may not survive in the marketplace. We have no idea at this stage what the extent or size of gaps resulting from reforms will be, but if it is large in both respects it has the potential to limit patient choice as well as impacting the range of products available within Australia.

While suppliers are not in the front line of health care professionals dealing with patients on the issue of informed financial consent, MIAA and its members will support the process in accordance with accepted practice. Suppliers are not represented on the government's IFC task force and I note in the ombudsman's submission that he too does not see suppliers as essential to resolving IFC obligations to patients. We accept this approach and have appreciated consultation commensurate with our role.

I spoke of the uncertainty of outcomes, and I believe that this also relates to the lack of reliable data that has been available to stakeholders in designing reforms. On page 11 of its submission, the Health Insurance Association proposes the next round of alternate solutions. It is our hope that, if we are required to enter into consultations on significant changes to the reforms some time in the future, we will be in possession of data that will better inform our decisions than the data we currently possess.

We support the need for the draft key performance indicators and the collection of data against which those measures can be assessed from the outset of implementation. MIAA appreciates the minister's commitment to review reforms two years after introduction. For our part, MIAA plans to continue to participate actively and positively in the reform processes, hopeful that in two years time we will be able to make an informed judgment on the impact. We support the passage of this legislation.

CHAIR—Thank you, Mr Ross. Dr Gilheany, I would like to come back to you for a moment to pursue this issue a little further. Are you able to provide the committee with the names of the funds and copies of the correspondence that you have had?

Dr Gilheany—Yes. I have information here. The correspondence is from HBA. Conversations with the public officer of MBF have indicated the same thing and conversations with Medibank Private are indicating the same thing. We have not had anything in writing from either MBF or Medibank Private. The impression that we have at the moment is that it is a bit of a one-in all-in and that unless there is specific legislation that says 'You must pay' they will not pay. I think that is particularly reprehensible in terms of community responsibility.

CHAIR—Particularly given the role that podiatric surgery plays in society—and I have to declare a vested interest with my bung foot. I might add that it was operated on by an orthopaedic surgeon, but the toss-up was very clear and I do not think there should be any discrimination. Suffice to say, leave it with us, because I think discrimination of that nature is certainly undesirable. So I would appreciate it if you would leave that with the committee as a work in progress.

Dr Gilheany—Thank you.

Senator DENMAN—Does the college have any figures on the number of procedures involving the use of prostheses performed by your members on an annual basis in recent years?

Dr Gilheany—It would number in the thousands, but I do not have specific figures. Essentially, almost every foot operation has a requirement for some form of prosthesis. Often they are very simple things like small pins that may cost only $5 each; however, they are integral to the process. Currently, insurance will not pay for those and patients are being billed

separately. Of course, it can run to quite expensive implants for joints as well. Prostheses vary dramatically in the foot. There are screws, plates, pins—a whole range of things. Virtually every operation I do requires some form of prosthesis.

Senator DENMAN—Your operations are not always done in a hospital, are they? I live on the north-west coast of Tasmania, so I know this.

Dr Gilheany—They are always performed in a fully accredited facility—either an accredited day surgery centre or a hospital. In fact, one of the benefits in choosing to pursue podiatric surgery rather than the alternatives is that internationally podiatric surgery historically—over the last 30 to 40 years—grew out of the use of local anaesthesia rather than general anaesthesia and the concept of ambulatory surgery rather than inpatient surgery. So before the concept of day surgery and the reduction in the average length of stay was even discussed podiatric surgeons were performing far and away the majority of their work on a day patient basis. Today, I perform a very wide range of complex and simple procedures and my average length of stay is one day. That in fact has positive implications for general health as well. If we can get you up and mobile, you are going to get better quicker. So we are quite comfortable in either the hospital setting or the day procedure setting as long as the facility is properly accredited.

Senator DENMAN—Are you barred, for want of a better word, from using your skills in any hospital? Is that a problem?

Dr Gilheany—It can be. Admission to hospitals and day surgery centres is controlled at the end of the day by medical advisory committees. The decision to allow a practitioner of any discipline into a hospital depends upon the acquiescence of the medical advisory committee. If a medical advisory committee chooses not to allow podiatric surgeons into that facility, it is difficult to get round, and there are sometimes competing interests involved there. Gaining access to some facilities has been difficult. Tasmania is a classic case.

Senator DENMAN—I realise, from where I live, that it is a difficulty there, most definitely.

Dr Gilheany—It has been a problem nationwide. However, barriers are coming down. As I said when I was thanking the government earlier, the legislative change last year in respect of professional attention is already bringing barriers down in that sense. I believe the recent changes in Tasmania are a direct result of the legislative reform. So positive public outcome is being seen already from that, and I just do not want to see that watered down by not being treated appropriately within the prostheses legislation.

Senator DENMAN—On another issue, can you explain to me the reasons why there is a reluctance to require the funds to reimburse people with your skills using devices and so on?

Dr Gilheany—I have had many conversations with many people in funds and I do not understand it.

Senator DENMAN—You have got no clues at all?

Dr Gilheany—I have personal theories which cannot be substantiated.

Senator DENMAN—Is it a competitive thing?

Dr Gilheany—I do not think it is fair for me to say.

Senator DENMAN—Okay.

Mr Price—I think there is a historical situation. One of the reasons why we are here on this previous legislation is to introduce a little competition into the system. If you mention the word competition—that is one way of putting it—and certainly that is an international situation, and there are barriers. The public hospital system is certainly a barrier at the present time. We have got entree into several public hospitals but not enough. The bed stay costs have been proven to be lower in the case of podiatric surgery in some situations.

Senator MOORE—Is that in every state, or does it vary from state to state?

Mr Price—In most states, there is still that barrier in the public hospitals.

Senator HUMPHRIES—I agree with your submission overall. I think you make a very good point, but at the beginning of the first dot point you say:

To the insurance industry the impact is cost neutral.

That is, the impact of this legislation. How did you come to that view? If prostheses are to be included in the schedule and are to be claimable against health funds, surely they are not cost neutral any longer.

Dr Gilheany—If I perform the operation and put the pin in or if an orthopaedic surgeon puts the pin in, the cost is the same.

Senator HUMPHRIES—But at the moment if the orthopaedic surgeon puts it in it is claimable. Is that what you are saying?

Dr Gilheany—At the moment, if an orthopaedic surgeon puts the pin in, the health funds will pay for that service. At the moment, they will not pay for it if I put the pin in. So you are right that, in pure dollar terms, it is an increase; but we would argue that the consumer is being driven to sit on an orthopaedic waiting list because of the building cost barrier, and the prosthesis is just another component of that cost barrier. So either they are staying with me and paying more money than they realistically should have the pay—and I feel strongly about that—or they go elsewhere, sometimes to their second choice of provider. And this is another thing about choice: if a patient has chosen to seek my advice and would like to have me perform the surgery—and I have even had words with the health industry people about this—when they go to the health fund they are often advised by clerks at the desk that they should not come to me but go to an orthopaedic surgeon because they will get their money back. So the health funds are quite happy for individuals to trot off to an orthopaedic surgeon who, as I say, is not necessarily their first choice and pay those costs. This is the point I make about it being cost neutral. That component of the cost of the whole exercise should be cost neutral; the differential should not be there.

Senator HUMPHRIES—There are long waiting lists for some orthopods in Australia these days, aren't there?

Mr Price—Yes.

Dr Gilheany—And foot surgery, of course, historically has not been particularly glamorous. However, with an ageing population and the importance of mobility, if your feet

are not working you are in real trouble. That is going to become a bigger and key issue over time with an ageing population. So we should not be putting extra barriers in front of well-trained expert people. I do not want to compete with the orthopaedic community; I do not want to compete with anybody. I have skills to offer the Australian community. I want to have the ability to offer those skills on a slightly more level playing field. That will reduce the overall burden on the health sector.

Senator HUMPHRIES—Mr Ross, I think you heard my question to Mr Schneider about the potential for cartels to develop where there are a limited number of suppliers in the field. Can you assure the committee there is not any danger of that happening in the Australian market?

Mr Ross—I think the ACCC is concerned across all industries, and ours is no different. I am also aware that in the 3½ years I have been involved in this industry there have been no particular cases raised in relation to prostheses. We discourage the collective discussion of pricing issues amongst our members, and I have heard no murmurs to the effect that this happens. I note that Mr Schneider supports that.

Senator DENMAN—What is the difference in your training to become skilled people and the training of orthopaedic people to become skilled people?

Dr Gilheany—The best way to describe it is a different paradigm. There was a review by Queensland Health a year or two ago with respect to the regulation of health practitioners in which they looked at this issue. They had an independent facilitator look at the training background of podiatric surgeons to perform foot surgery compared to that of orthopaedic surgeons. They literally stood in front of a whiteboard and asked, 'What do you do, what do you do and what do you do?' The result of that is that we are essentially trained as well as, or better than, orthopaedic surgeons to do the work we do. The training program is extensive; it is detailed. Although we come from a slightly different paradigm, it is a little like the oral surgery argument where you are dealing with dentists who specialise in reconstructive surgery—and that is where they have come from, and we are the same sort of people. I can go into specifics if you wish.

Senator DENMAN—No, it is okay.

Dr Gilheany—I would argue that we are better trained to perform foot surgery.

Mr Price—I would like to add a further point. These days the postgraduate theoretical work—additional pharmacology, medical science and so on—is done at master's degree level at university and then the practical for orthopaedic surgeons is done in hospitals, in our case essentially in private hospitals, unfortunately, because we do not have access to the public system.

Dr Gilheany—And/or international rotations.

Mr Price—Yes, as well.

Dr Gilheany—We are sending people to England to work in the NHS.

Mr Price—That is a postgraduate program beyond general podiatry.

Senator DENMAN—I am not sure whether you would be prepared to answer this—you probably would not be and I should not ask it: do you think that perhaps the AMA, or somebody, are ganging up on you people so that there is no competition?

Dr Gilheany—I do not believe that is likely. To be honest, I think that we are of small interest to an organisation as large, complex and responsible as the AMA. There may be individual bias coming through at a local level, and that is inescapable, but I do not believe that there would be anything systemic. I certainly would hope that there is nothing systemically against us.

Senator DENMAN—Yes, I would too.

Senator McLUCAS—Mr Ross, in the opening comments of your submission you talk about a lack of reliable data. In your submission you talk about Mr King from the Australian Health Service Alliance and his explanation of what the drivers are. Do you concur with that?

Mr Ross—For want of better information, I think his conclusions are quite credible. Certainly post-market surveillance that we have done would suggest that the CPI is probably about right for the increase in the price of prostheses, but it is certainly not in the order of 18 or 41 per cent. That is the increase in expenditure that may have been referred to, but it is certainly not the increase in price.

Senator McLUCAS—Did you look at the Private Health Insurance Association's submission?

Mr Ross—Yes, I did.

Senator McLUCAS—I refer to page 4 of their document. I think this refers to just the private sector. The way I read the graph is that the number of services is about the same, but the cost is increasing.

Mr Ross—I would like to make a few comments on the data that we have on the number of services. Firstly, I would like to quote from the AOA National Joint Replacement Registry 2004 report, which advises:

... data for the last eight-year period demonstrates that hip and knee joint replacement surgery has increased by 74.5% ... an average annual increase of 7.2% ... As in previous years there has been a greater increase in the private sector. 6.6% private ...

Hip and knee surgery, anecdotally—certainly amongst our members—seems to be happening with increasing frequency. The use of cardiac devices and stenting has increased as the utilisation of coronary artery bypass grafting has decreased. So our information is that the number of procedures is on the rise.

I will go back to the Private Health Insurance Administration Council figures. Their 2002-03 report says:

PHIAC does not collect data on the types of prostheses for which benefits were paid. Reference to trends in average prices do not take account of any change in technology or types of prostheses used.

Further in the report they go on to say:

While the number of prosthetic items appeared to fall over the last two years, there have been coding changes to prostheses that artificially decrease the number of items recorded in 2001-02. This trend may have continued through 2002-03.

What I would be saying is that the protocols for reporting the number of prostheses used do not appear to me to be clear, and there is certainly some divergence of opinion as to what the situation is.

Senator McLUCAS—Essentially you are saying that the reason we do not have the data is that it is not being collected.

Mr Ross—It is not being collected in a sufficiently refined manner, yes. I believe that some health funds have it—for instance, the Health Services Alliance, and they are not afraid to speak about it. I understand that AHIA as an association does not yet have all this aggregated information. What we are saying is that, if we are going to look at the effects of these reforms in a couple of years time, we need to know comprehensively what prostheses are being used. We will know what the individual price of those prostheses will be because the minister will determine that. But we need to have a report that indicates to us what the utilisation is by billing code, and I think that would better inform our judgment on the success of the reforms.

Senator McLUCAS—Who should collect that data in your view?

Mr Ross—This is an issue that is still a bit of a policy void. I have discussed this in the past with PHIAC staff, and they do not believe that it is their responsibility. I think they are probably the closest to actually collecting that data. To be fair, though, the funds already have comprehensive requirements for data reporting, and some of them might see this as being rather onerous. But, on the other hand, there are considerable issues here with regard to expenditure. As I see it, it would be quite worth while to go to the trouble of collecting the utilisation by individual billing codes. There is a billing code for every individual prosthesis—and there are approximately 9,000 of them on the list—so that would tell us the frequency with which they are being used and perhaps the trend in movement from one prosthesis to another, and it would allow for some very informed analysis.

Senator McLUCAS—You talked about the review, and I think you were agreeing with the two-year review period. It would seem to me that it would be fairly hard to review something if you did not know what the baseline was.

Mr Ross—It is indeed. This has been a concern that we have long held. We are trying to contribute to this process as positively as we can, but it does not take away from the fact that we are to a certain extent travelling blind in this regard. A number of stakeholders want pressure placed on the actual price of prostheses, and this will do that. But there are other issues which need to be attended to. Come the time of review when we would expect that expenditure would have continued to rise, we would like some informed judgment about why that has occurred. When you look at the increase of membership of private health insurance—an increase of about 13 per cent over the last few years—which has brought an extra 2,800,034 members into the fold, it is highly likely that it is going to cost more because you have more people drawing on it.

Senator McLUCAS—It would have been nice if we had had the figures before we had Lifetime Health Cover. It actually makes some real analysis of what is happening.

Mr Ross—Yes.

Senator McLUCAS—I have one further question. From the point of view of MIAA—and you may not have a view on this—how do doctors currently make choices about which prostheses to prescribe?

Mr Ross—I am assuming that they make a choice based on the circumstances of the patient, which are unique to that patient, and the clinical outcomes that they seek. We have a large range of prostheses to address a very large range of conditions. I would make the point that I do not think in terms of Rolls-Royces and Holdens; I think in terms of extra health outcomes required for severe clinical conditions which might otherwise not be treated. I think that is an approach that we would take on that matter.

Senator McLUCAS—In your understanding, do certain manufacturers of certain types of prostheses market directly to, say, orthopaedic surgeons?

Mr Ross—They will certainly provide material to surgeons which advises them of the health outcomes available with prostheses. Because devices are very different from drugs—it is not just a matter of popping a pill; it is a matter of surgery and inserting a device—there are training responsibilities for the medical device suppliers in informing doctors on and training doctors in the use of medical devices. So of course there is some very close contact in providing the briefing material and in the training that is conducted. They do market to the surgeons. I mentioned our second line role in IFC, informed financial consent. Our members do not on the whole market to patients. We certainly would not see that changing.

Senator BARNETT—Dr Gilheany, thank you very much for your submission. From a first reading of it, it seems quite persuasive. I want to confirm that you see the gap in the legislation as an anomaly. Is that the way you see it?

Dr Gilheany—Yes.

Senator BARNETT—We will look at it very carefully. Thank you. Mr Ross, how many members does your association have?

Mr Ross—Approximately 140 medical device suppliers, of whom about 60 are involved in prostheses.

Senator BARNETT—Would that include the major suppliers of prostheses in the country?

Mr Ross—Yes. I would estimate that, of the volume of prostheses listed on schedule 5, probably of the order of 85 to 90 per cent is supplied by our members.

Senator BARNETT—I think we heard earlier today that there were some 9,000 suppliers.

Mr Ross—There about 8,700 items on schedule 5.

Senator BARNETT—Items, yes. Excuse me.

Mr Ross—I have not done a check on the last schedule 5, but I think there are about 120 device suppliers, of whom approximately half would be our members. The remainder are small companies, on the whole, although there are some exceptions.

Senator BARNETT—What reasons do you give for the view that the Health Insurance Association gave in their submission that there has been an increase in prostheses benefits? They had it at 12 per cent in 1999 and at 28 per cent in 2003. What is the reason for that?

Mr Ross—Firstly, I think there is confusion between the cost, price and expenditure. The figures that we have from the Private Health Insurance Administration Council deal with expenditure. Some stakeholders will try to translate expenditure into cost, and therefore prices, going up by that amount. That is not the case. As I mentioned before, I think the CPI is probably a reasonable estimation of the amount of increase of devices. That has been suggested by the Health Insurance Association.

Senator BARNETT—Over what period of time?

Mr Ross—I would say, on average, over the last few years. The other elements of the increase in expenditure are utilisation and the shift in technology, where you move from a less expensive prosthesis to a more expensive prosthesis because it offers more in the way of health outcomes. Technology is improving and the health outcomes available to patients are improving, but it does come at a cost.

Senator BARNETT—Do you have confidence that under this system consumers can access—as Mr Schneider said—the latest model Holden? Do you have confidence that that can happen? You made a comment earlier that you would prefer not to use that analogy.

Mr Ross—Yes, I prefer not to use that analogy. I think there are some devices that have different clinical outcomes because the particular device has a different capability or marked capability in a particular area. As regards your point about whether the full range of devices will be available to patients, this is a concern that we have, and I think only time will tell. We have been reasonably happy with the reform architecture as it has been developed, but until the first new schedule 5 is published and we know the extent of devices in the gapped area and the size of the gaps it is very hard to make a judgment on the overall impact. If those quantities and amounts are reasonably modest, I think the impact on patient choice will be relatively low.

Senator BARNETT—So that will be monitored over that period of time by you, the industry and others and then at the two-year review.

Mr Ross—Indeed it will. We note that the minister has made a commitment to this review in two years, but I certainly would hope that other stakeholders will be interested to watch it evolve, certainly over the embedding period, to make sure that there is sufficient clinician choice in the process.

Senator MOORE—Dr Gilheany, you mentioned a Queensland health review that came up with considerations. Did that have any impact on your access to public hospitals in Queensland?

Dr Gilheany—No.

Senator MOORE—I will follow up on that. Mr Ross, you heard previous evidence from Mr Schneider where he described 'possibly' the current environment being a seller's market. Do have any comment on that?

Mr Ross—I suppose that is his perspective. It is not particularly our perspective because, in the current environment, we are finding that some funds are refusing to negotiate. Others are continuing to negotiate in good faith, and the competitive processes are operating. But we do find too that, in some cases, funds are attempting to impose on clinician choice in the selection of devices. If that is the case then it makes it difficult for some of our members to actually supply their devices, so I would have to say there are opposing views as to it being a seller's market.

Senator MOORE—Is that one of the reasons that you are hopeful that this process could bring more openness? You said in your opening statement that, despite some concerns, you were supporting the legislation. Is that hope one of the reasons for that?

Mr Ross—Yes. The centralised negotiation of benefits, whilst it holds some risks for our members, simplifies the process and means that there will only be one benefit per device as opposed to at the moment, where there could be eight benefits negotiated with the eight different funds and groupings in determining a benefit. So it is going to simplify that process. We are reasonably happy with the clinical evaluation. We have been pleased with the way that the clinicians have been dealing with that process and we have similar levels of satisfaction to AHIA in that regard. We are also more optimistic because, certainly in the last couple of years, we have been much more involved in the reform process. I think that it is much more attuned to providing a better outcome than we had thought when we were initially invited into the fold to discuss these reforms.

Senator DENMAN—In your submission on page 3 you say:

High technology prostheses that cannot be commercially sustained are unlikely to remain available in the Australian healthcare environment.

Do you mean available or not available at all?

Mr Ross—If a prosthesis cannot be commercially viable then it probably will not remain on the market at all. There are circumstances where, because of some costs in getting to the Australian market at the moment, there are devices that are not available within Australia and they do not get marketed here. Australia represents about one to two per cent of the world's consumption of medical devices. We compete amongst the world's markets for the supply of these devices and if they are not viable here they will be taken to other markets where they are viable. That is not a desirable situation from our perspective.

Senator DENMAN—You are basically saying that we have access to the stock standard stuff mainly, but what about a broader range? Are you saying that we could be denied access to a broader range of products?

Mr Ross—To the higher technology devices, yes we could. What I am saying is that could be an unintended consequence of this process that we need to monitor. Overall it is not the circumstance at the moment.

CHAIR—Mr Ross, isn't that somewhat alarmist? I really have to take issue with you there. We have a panel of expert clinicians who, in their right minds, would not seek to deny a patient the best possible prostheses for their circumstance. Isn't it somewhat alarmist to come in here and say that Australians will, because of this legislation, potentially be denied the best possible prosthesis?

Mr Ross—I agree with your faith in the doctors and I, too, hold that faith in their deliberations in the clinical advisory group setting. It is not the doctors who actually do the benefit negotiation. There will be negotiators involved in the centralised benefit negotiation process coming from the health funds to work on behalf of the Department of Health and Ageing in this process.

CHAIR—Yes, but there is an expert panel advising on the efficacy, effectiveness and so forth of the prostheses. That is point number one. That expert panel, in their right mind, would not say, 'We are now going to remove the availability of certain devices'.

Mr Ross—I have referred to this as an unintended consequence. I agree with you that the doctors would not wish to see that happen, and there is no doubt about that. What I am saying is that if there are some devices where the gap imposed is significantly large then the impact will be that that device will potentially not be used in sufficient quantities to make its marketing within Australia viable. I am not trying to say that that is going to happen in a large way, but I am saying that it is a possibility and that we should watch the evolution of these reforms to make sure that it does not happen.

CHAIR—I am still of the view that that type of evidence to a committee is very alarmist, because I do not believe for one moment that any advisory committee or surgeon would want to see an inferior product placed in a patient. But I want to ask you a further question: from your own personal point of view, how is the current prostheses-listing process working?

Mr Ross—I believe that there are some problems as we wait to move into the new process. The interim period that we are in now is causing difficulties for our members in their negotiation with funds. This indecision as we move from one system to another is also impacting on the private hospitals, because there is a difference in some circumstances between the sale price of a device and the amount that a fund is willing to reimburse. In some cases the hospitals are paying that amount; in some cases suppliers are taking the lesser amount. So there are difficulties currently with this process that we hope to see resolved as we move into the new reforms.

CHAIR—So looking at the clinical evidence first and foremost in considering prostheses for listing is the primary consideration, isn't it?

Mr Ross—In the new process?

CHAIR—In any process. The old process was not working as well as it should, as you have just said. So a new process should look at the clinical evidence first and foremost as the primary deciding factor on any procedure that is done.

Mr Ross—The new process through the clinical advisory groups will conduct that review and our members have been participating actively in that. As with Mr Schneider, we are happy with the way that the clinical advisory groups have been doing that. Previously, there was not a process to do such a thing. We are quite satisfied with the way that is being done at the moment and we have appreciated being included in that process.

CHAIR—So from the evidence that you have given to my colleagues I understand that you are actually in agreement that the legislation is worth while—your submission says that—

and that the setting of no gap benchmarks is desirable in helping to keep costs manageable for prostheses.

Mr Ross—There are a lot of qualifications in your statement there. We certainly concede that the new process will put pressure on prices. But the point that we have tried to make in our submission and in my opening remarks is that it will not necessarily prevent increases in expenditure. That is where I would be looking for this group to understand that when expenditure continues to rise it will not necessarily be because suppliers are putting up their prices; it will be because utilisation will be continuing and technology will be offering more in the way of health outcomes.

CHAIR—Yes and no. We had evidence earlier today from Mr Schneider, that you heard, about the sheer cost of better prostheses. So it is not just utilisation.

Mr Ross—That is right. The information provided earlier on the AHSA analysis of it identifies utilisation and increasing technology as well as the increase in price as being contributors to the increase in expenditure, with the increase in price being the lowest of all of those at roughly CPI.

CHAIR—Thank you. Dr Gilheany, there is one thing I would like to say from my point of view and from the point of view of my colleagues, although I have not had the opportunity to talk to Senator Moore or Senator Denman. There is much in what you have put to us today that we will consider very seriously because we consider the weight of the evidence that you have presented to the committee to be quite substantial.

Dr Gilheany—Thank you.

CHAIR—Thank you also for your attendance today. Thank you both.

[1.54 p.m.]

MACKEY, Mr Paul Francis, Director, Policy and Research, Australian Private Hospitals Association

SULLIVAN, Mr Francis John, Chief Executive Officer, Catholic Health Australia

CHAIR—Welcome. I remind you that the giving of evidence is protected by privilege and the giving of false or misleading evidence may constitute a contempt of the Senate. We have both of your submissions before us. Would you like to make an opening statement before we ask some questions?

Mr Mackey—No.

Mr Sullivan—I do not have an opening statement. I am happy to let the submission stand.

Senator DENMAN—Mr Mackey, in your submission you say that your association has a relatively wide range of doubts and concerns about the legislation and you list them. With such a range of concerns, is your association really comfortable with the legislation or is it more the case that you will be happy to accept anything given your concerns with the existing arrangements?

Mr Mackey—I am not sure that we listed that many concerns with the current legislation. I think we pointed out the problems with the current situation, but we see the legislation as being quite a positive remedy to a number of the problems that the current situation has caused.

Senator MOORE—We see that legislation as proposed legislation. I think Senator Denman's question was about the current situation.

Mr Mackey—I am sorry; I misunderstood. The current situation is not one that our association has ever supported. It was introduced against our express advice. Certainly, the advice was that there was likely to be a blow-out in expenditure and that is exactly what has occurred. Administratively it is a very inefficient system. It has imposed a lot of quite unnecessary costs onto hospitals. We see the proposed arrangements as a very positive way of overcoming a number of those difficulties.

Senator MOORE—We have been told that, with the development of this proposed legislation, there is a hope that there will be more openness and also a collection of data. People have been unified in their concern about the lack of accurate data. Why are you are hopeful that that will occur and do you think that is likely to occur with this process?

Mr Mackey—We certainly hope that it does occur as a fundamental element of the proposed new arrangements because, as you said, lack of data is a real problem. Without accurate data it is difficult to put the correct policy settings in place. We do not have a very clear picture—and I think Mr Ross alluded to this in his evidence as well—of just what proportion utilisation and increase in costs actually contribute to the blow-out in health fund expenditure.

Senator MOORE—You put that in your submission, Mr Mackey. That was a clear point.

Mr Mackey—Hopefully under the proposed arrangements there will be a better capacity to track that. Data is extremely important.

Mr Sullivan—I have nothing substantial to add to that. I think that is our aspiration. Obviously the greatest benefit of what is being proposed is a more administratively efficient system and a single schedule. Although that might go against the principle of competition between funds and suppliers and the underpinnings of policy previously, we think it is an improvement. If it is an improvement it may make the cooperation between the suppliers and health funds such that you will get good data.

Senator MOORE—Another point that both of your submissions make is that the administrative cost to your organisations has yet to be quantified. You know there is going to be a cost. Along with all of those forms people fill in when they go into a hospital, this is going to be another one. That was one they did not have to worry about before. You guys had to worry about the cost but the patient did not. What have you both done about issues of administrative cost and what do you think should be done in terms of looking at what one more level of administration is going to mean in your organisations?

Mr Mackey—I guess there are two aspects to that. One of them is that the present arrangements impose a wide range of administrative costs. I alluded to that a little earlier. That is mostly driven by the fact that we have eight different buying groups from the health fund point of view as well as all of the suppliers. You have different schedules and each hospital has to try and manage them administratively. It is quite a cumbersome system. We hope that will be simplified under the proposed arrangements. That simplification should occur with the minister determining a benefit for each item. So hopefully that will be the case.

The other aspect is that a lot of hospitals currently do not get any reimbursement from health funds for the administrative costs of managing prosthetics. In larger hospitals it is an enormous business to manage. There are an enormous number of operations and an enormous number of prostheses being used. Hospitals buy on consignment some items that are used a lot, so that they have them on the shelves all the time. Other procedures are done on a one-off basis. So there is quite a lot that needs to be managed. We have a great concern about trying to get some reimbursement for those costs, and that is something we will certainly be pursuing on behalf of our members.

Mr Sullivan—I think Mr Mackey is saying that, in the present arrangement, administration for hospitals is an ongoing issue—and we foresee it in the future. The way it primarily works is that hospitals and health funds negotiate about the business broadly and then specifically. Obviously it needs to be recognised that, even if we go forward with a regulation like this, a regulation brings a cost; it is just a reality.

Senator MOORE—Is there any way that, through this particular process, that could be part of the negotiation, or do you see that as being separate?

Mr Sullivan—Our position at the moment is that some of this is somewhat in the dark—the implications thereof. More broadly, the way that hospitals are reimbursed under these arrangements is through negotiation with the funder; that is how it goes for everything. Despite the fact that there would be potential for administrative costs, it is our hope that the other benefits would outweigh that cost. We are trying to be very pragmatic and realistic about this. There are aspects of this that we would prefer to be tighter at this time, but overall we are prepared to go forward because we see it as an improvement. Administrative costs is one of

the issues we would have to flag and put on the table in negotiation. To be honest, I am not sure how we could safeguard that at the moment, but it has been thought about.

Senator MOORE—Mr Mackey, do you have a comment on that?

Mr Mackey—These sorts of negotiations are between individual hospitals, or groups, and funds. Through discussion we see that as being the most appropriate place for reimbursement of administrative costs to be worked through. I think it is bit more difficult to try to do it in any sort of overall regulatory sense.

Senator MOORE—I do not know whether you were both in the room when Mr Schneider gave evidence about comparative costs of a couple of devices in the public health system and the private health system. Simplistically, that could be taken as a statement that public health is a more efficient purchaser of these kinds of implements. One of the things we need to do is work through this and quantify it. I am hopeful—and there is a lot of hope about this legislation—that this process will provide us with more information and more accurate data. Would either of you like to comment on the statement that it is costing more for this kind of surgery and these kinds of devices in private hospitals than in the public system?

Mr Mackey—I was not in the room when Mr Schneider gave that evidence, but I would like to make a couple of comments. State and territory health departments are large buying groups; when they negotiate with suppliers, they are buying on behalf of all their public and private patients. As I understand it, they tend to make a selection of devices available for their patients, so they negotiate with a certain number of suppliers and are able to get quite a good price for those devices.

On the other side you have eight health funds negotiating with suppliers. If there is one thing that is clear under the current situation it is that they are not particularly efficient purchasers of devices. One of the things that the proposed arrangements are trying to put in place is have one private buying group to negotiate with suppliers. The group will be made up of a number of negotiators. The intent, as I understand the proposed arrangements, is to enable the funds to have a greater capacity to bargain with suppliers. I think it is a little bit misleading that there is a number of figures tossed around in terms of 'This is public and that is private,' because as I understand it there is not a standard public sector price. There are different prices for different devices in different states and territories in the same way that different private hospitals purchase devices from suppliers at a variety of rates.

Funnily enough, under the current arrangements the private hospital actually bears the financial risk in these arrangements because they purchase the device from the supplier, the health fund negotiates with the supplier for a benefit, and I heard Mr Ross give evidence that that is not always the same as the price the hospital has paid. There is, certainly, one very large health fund that has refused to negotiate with suppliers for the last 18 months. As we see it, the proposed arrangements will get a greater level playing field than the current arrangements do.

Mr Sullivan—I have nothing more to add.

CHAIR—You concur?

Mr Sullivan—Completely.

Senator BARNETT— Mr Mackey, I have a quick question about your submission, with regard to the exclusionary products. I think the Australian Health Insurance Association would say that this allows for flexibility and freedom in the marketplace. What do you say to that?

Mr Mackey—As we said in our submission, we are greatly concerned about exclusionary products, because health care is one of those areas where it is very difficult for individuals to judge the sort of risk they are carrying. You do not know your chances of acquiring an injury or of getting a particular condition that will require you to get a prosthesis. I think those products have shown themselves to not be particularly popular with consumers. We do not see any place at all for them. The other aspect of this, from a hospital's point of view, is that we do not yet have 24/7 eligibility checking for hospitals to check with a fund as to a patient's coverage. If a patient is admitted through an emergency department and undergoes a procedure, it is often not known until the next day that they have a cardiac exclusion or something like that. The third problem we have with this is we do not believe they are marketed appropriately. There have been a number of instances raised by the Private Health Insurance Ombudsman of elderly people being sold products with cardiac exclusions. That is clearly inappropriate. We do not see a place for them in the current environment.

Senator BARNETT— In your submission you go so far as to say they should be prohibited.

Mr Mackey—Yes, that is certainly our position.

Senator DENMAN—Mr Sullivan, in your submission you talk about how when patients are admitted to your hospitals you are now going to go through with them the possibility that they may have to pay an increased gap. I know you do not have any choice but to do that, but do you think that because of that a patient may choose to have a prosthesis inserted that is not the most appropriate?

Mr Sullivan—We were careful about this. We stressed the point that what eventually gets implanted is as a result of the discussion with the doctor. Most people would be fairly slow to move away from that decision. I would think that the likelihood of that is small. That is my hope.

Senator DENMAN—That was my concern.

Mr Sullivan—We would not want to put in place something that is a barrier to their care. The point we are trying to make is that it is possible that on occasions the patient will face an out-of-pocket cost. What we have found in the past 15 years with out-of-pocket costs is that oftentimes the hospital is the first point at which the patient complains, even if it is a medical out-of-pocket cost. So that is the point we are making here. It is important that people understand that there will be gap payments in some cases and we are going to make that clear to the person when they are admitted, even though it is not of the hospital's making.

Senator DENMAN—Surely, one would hope, a competent surgeon would have gone through that process with them as well.

Mr Sullivan—Clearly that is our hope. I think the issue is about competency and the capacity of the individual surgeon to communicate.

Senator DENMAN—Do you want to comment on that, Mr Mackey?

Mr Mackey—I do not think I have anything further to add. Certainly our hope is that the arrangements will work in that way.

Senator MOORE—Have you seen the Australian Health Insurance Association's submission? They put a table in it—I am always drawn to tables and am very fond of them; I find them neat. The exceptional circumstances table sets out the IFC, which is a critical element of this discussion because we did not have it and now we do. The table outlines the situation variables and who accepts the liability. The third situation, which is an emergency, is where:

3. Patient capable and competent but IFC not appropriately gained (eg, due to time critical pressure) or cannot be documented or proven—

or in your case, Mr Mackey, where you have not been able to check with the health fund and the person may or may not know. As to who accepts liability, the table says:

Fund, hospital and supplier each share liability for the gap on equal basis. Each of the above parties will pay or forego 33.33% of the cost of the gap amount

That is the proposal. Is that firmly agreed or is it a hope?

Mr Mackey—I think it is more accurately contained in the AMA's submission as a draft.

Senator MOORE—So it is a proposal?

Mr Mackey—It is a proposal. It is something that was discussed by a range of stakeholders, but that did not include consumers. I think it would benefit from their input. Certainly the discussions that I was present at did not include consumers. It has not been signed off in any sense—certainly not by our association—and it would be subject to more discussion I would think. It was part of a working draft document.

Mr Sullivan—That is its status. It has not been through the major boards of the associations.

Senator MOORE—It interested me that that was the one that was shared.

Senator DENMAN—The final page of your submission says:

In those situations where informed financial consent cannot be reasonably obtained—

and so on. That is for various reasons, of course. Have you discussed with the health departments the suggestion you are putting here?

Mr Sullivan—What we have in our submission fundamentally is not news to any of the players.

Senator DENMAN—I realise that. What is their response?

Mr Sullivan—Bearing in mind that many of our major hospital groups have been discussing this issue with health funds for a good couple of years, this idea is being floated with them. The difficulty in discussing some of this is the fact that the environment in which all this occurs has primarily been around negotiation and individual price-setting accordingly. Now we are shifting to a slightly more regulated environment, so some of the questions we have about the implications or changing nature of the players are literally that—just questions.

We do not have any definite answers for you. So as with your previous question, these are proposals to demonstrate how possibly the players can work together on a certain problem. That is the status of it.

Senator MOORE—We are being asked to look at the legislation, and the success of the legislation will be determined by whether those negotiations work. I am concerned about whether we are still in that hopeful phase and how soon after the implementation hope descends to despair.

Mr Sullivan—Is that a question?

Senator MOORE—Yes. Please comment.

Mr Sullivan—My response, given my previous comment, would be that vast improvement is inherent in this regulation. The improvement is the single schedule, which means single prices, hopefully single cover and, where possible, the knowledge that you will face a gap. That is all clear. It is clearer than the present arrangement. Hopefully the administrative burden will be less for us but, as I said previously, the administrative burden is but one issue in a mess. This is better than what we have. So, although all of us probably could argue that some of this is done with our fingers crossed, the structure of the arrangements is an improvement.

Mr Mackey—I think that is a fair summation. The other aspect that is a little unknown at this stage—and this would be difficult from the committee's point of view—is that the benefit negotiation process has not really got under way in a large way, so at the moment we do not actually know what proportion of items will be available at a gap. The smaller the number is, the less of an issue informed financial consent is because it will not occur that many times. The degree of hopefulness is around those sorts of things.

CHAIR—Thank you both for giving us your time today.

[2.17 p.m.]

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

SMEAL, Mr Colin Stephen, Senior Policy Adviser, Australian Medical Association

CHAIR—Welcome. I remind witnesses that your contribution is covered by parliamentary privilege, but the giving of false or misleading evidence may constitute a contempt of the Senate. We have your submission before us. Do you wish to speak to your submission prior to any questions?

Mr O'Dea—Yes, just briefly. I think the case for some sort of reform is very strong. As we say in our submission, the expenditure on prostheses has gone almost vertically up the page, even without fiddling with the X-axis. We really need to make sure that there are some competitive forces in there to ensure that there is a moderating effect on price, utilisation and benefits. If we can get it right, if we can make sure these things are competitive, there will be more money available to spend on other prostheses and, overall, we will have a higher quality environment. I listened to your questions, which were good questions. There obviously is some risk in everything you do. You cannot foresee perfectly what the outcome will be. Sitting and doing nothing is just not an option in this case.

There is strong involvement of the clinicians, so from that point of view we are happy. The clinicians obviously dominate the clinical advisory groups—the groups that classify the prostheses into sensible groups for prices and benefits to be then set. There is strong involvement of the clinicians in that and in the Prostheses and Devices Committee. I think that is a good safeguard. The clinicians are primarily motivated by good patient outcomes. Clinicians have no financial interest in this matter at all. They do not benefit from prostheses. Obviously they charge a fee for an operation, but they do not financially benefit from the prostheses at all. It is a completely separate transaction. The issue for us is informed consent. I am happy to take questions. We have done our best to make sure that the processes that are developed are developed to inform patients adequately. We have a form, which I think we can share with you. We have consulted widely on the form.

Senator MOORE—It is evolving.

Mr O'Dea—It is.

Senator MOORE—Forms do.

Mr O'Dea—It has probably evolved to a plateau for a while. It obviously will continue to change over time, hopefully for the better. What we do not want to see is something in the legislation that puts the obligation on the doctor to inform patients about prostheses, because we think that would be wrong. It would be akin to forcing panel beaters to tell drivers of damaged vehicles what NRMA's insurance policies are. I do not think it is appropriate. But, having said that, doctors are prepared to do everything they can to make sure that patients are informed about the cost of prostheses. It is our expectation that most of them will still be no gap prostheses. You will still have a range of high-quality prostheses available to patients for each MBS procedure. If we have only one prosthesis, I think we have probably failed. We need to have a full range so that choice is still there. I think if we miss out on the last five per cent of choice then there will be some outlier doctor who has always used a particular

prosthesis, but now there is a gap involved and patients say, 'No, I will have another prosthesis.' I do not think that is a great loss overall but you do need a full range of prostheses to make sure you keep quality up. I will stop there.

CHAIR—Mr Smeal, do you wish to add anything at this stage?

Mr Smeal—No, thank you. Mr O'Dea has covered it.

Senator DENMAN—What led your association to believe that in the vast majority of situations the prostheses available will be at no gap?

Mr O'Dea—I think that largely it will come down to the fact that the manufacturers will be keen to keep their volume up. Rather than have a small gap, they will be prepared to move their price down to the benefit level so that there is no gap. So there is a downward pressure on price, which is appropriate. I cannot look at a crystal ball and say that this is how it will be. I am just saying I hope that we have a full range. If it turns out that we have just got one then we will have failed. When we review the legislation, we will have to do something about that. I do not expect that we will. For a start, initially, most of the items on the schedule will be grandfathered over. It is not as though there is going to be a cathartic change on day one. I think it is a process of change that will evolve over time and we will look at the most important ones first—the ones that are worth the most dollars—and get those right. We have no guarantee but, as I have said before, the case for change was compelling. I think that what we have here is minimal change. It has been well worked through with the players in the industry and I cannot see a better way to do it. We could not sit still, but I cannot see a better way.

Senator DENMAN—We heard from the podiatric surgeons. Does your association have a problem with them?

Mr O'Dea—I was not here when they gave evidence. There was a bill to allow health funds to pay hospital benefits to patients of podiatric surgeons and we did not oppose it. I have a view and certainly the orthopaedic surgeons have a view about whether it is appropriate for them to operate, but we did not oppose the bill and we do not oppose the payment of prostheses benefits to the patients of podiatric surgeons. To that extent, we have not got a problem with them, no.

Senator DENMAN—I had better not dwell on this but, when they were here, I asked questions about their skills and training for the work they do on feet. It seems to me that they have a very similar skill to an orthopaedic surgeon in that particular area. There seems to be a problem somewhere. Who limits their registration? Who decides whether they can be registered?

Mr O'Dea—They are not doctors. They are not seeking registration as doctors. I imagine they are registered as podiatrists, and that is regulated by the state governments. Regarding their credentials at the hospital level, where they practise, which I understand is mainly in South Australia and Victoria, where there are about 30 of them, they are credentialled by doctors—probably orthopaedic surgeons—in those hospitals. They are certainly not being subjected to a full opposition campaign by the AMA. We can do that but we do not in this case.

Senator DENMAN—Let us move to the prostheses. I do not know if you were here when I admitted I have had two hips and a knee done. Is there any requirement of an orthopaedic surgeon to declare if he has a financial interest in a particular product that is being used?

Mr O'Dea—There is if it is a hospital. If the doctor is participating in a gap cover scheme and is proposing to admit you to a hospital in which he or she has an interest, it is required. I am not aware of any requirement for the doctor to disclose an interest in a prosthesis.

Senator DENMAN—What if it is a prosthesis that he himself has helped develop?

Mr O'Dea—I would think it is wise to declare it, but I do not think there is a requirement. I personally would declare it if I was benefiting from something that I was proposing to use on a patient. Colin has pointed out to me that there is a provision in the form which I had forgotten about.

Senator DENMAN—We have just got that form guide. So there is a provision there that he or she should declare an interest in a particular product.

Mr O'Dea—Yes. That probably refers to the requirement under the gap cover legislation for the doctor to declare an interest in, say, the hospital he was proposing to admit to, but where we put it in the form it would encourage the doctor to also declare an interest in prostheses. But I think I am right when I say there is no legal or other requirement.

Senator MOORE—My questions focus on the accountability for giving advice. A lot of your submission was focused on that on the basis that that was the major thing. I am still struggling with the concern the AMA has when it says 'the doctor simply cannot be held responsible for a process in which he/she plays only a part' in terms of the doctor providing patients with information about the cost of their procedure. You have spoken to that. I have had a look at the form, and it covers everything that I think would be the responsibility between doctor and patient. I am interested to find out exactly what concern the association has with having that immediacy of link, because in talking with consumers it appears that the person that they are dependent on, and probably still trust the most, is the person doing the surgery. So I want to flesh out exactly why you are concerned about having that ownership of the responsibility of telling the patient, 'Hey, there could be a gap. We cannot guarantee what the gap is until after the surgery is complete, because things happen'—the same way you have to get them to sign a consent form before they go under things because things can happen if you are taking surgery—and also of that clear provision, which is in the draft form, that they have to go away and check with their private health provider to clarify the details. What is the concern with having that responsibility?

Mr O'Dea—I will see if I can clarify that for you. We want to make sure that the best information is available to patients in every circumstance where it can be done. Again, I do not have the crystal ball with me today, so I cannot say exactly what percentage, but I suspect that 90 per cent of prostheses will still be provided at no gap. So 90 per cent of the time it will not be a problem. The rest of the time, the doctor will probably know what the gap is and will tell the patient, but I think there will be a lot of occasions where the doctor will not know. The doctor controls, in association with the patient, what prosthesis is used, but they have no say over the price or the benefits.

What I am saying is that they will do their best in every situation, and we should make sure that there is as much information as possible out there for the doctor to use. But what we would oppose is a bit of legislation that required the doctor to do that—gave them a legal responsibility such that they might be sued, for example, if they did not do it. We would think that was wrong, because it would be analogous, as I said before, to getting panel beaters to advise patients about NRMA insurance policies. I do not think you can do it. It is like a lot of things in this area. It is worse, actually. Health is always complicated, as you know, but when you start delving around in how prostheses get from the manufacturer into the patient and then look at the insurance, it is incredibly complicated. I am impressed every time Paul and Francis and others from the hospitals can explain it.

We are not opposed to giving good quality information, as much as we can. We have done this form. We have worked with the consumers; they have said they are happy with everything we have done. This form is in existence already. It is up on our web site. It is used extensively already. We would love the health funds to adopt it, promote it and print big pads of it and hand them around. We really would like some support. But we simply oppose a legislative requirement that doctors be responsible for this, because unlike their own fees, which they do control, they do not control most aspects of this and they have no financial interest in it either.

Senator MOORE—The big issue about this particular change—and we all share the hope that it is going to be good—is that it is changing something. Patients who had private health cover had no requirement to pay. That is the change: now they do. It is sheeting home the responsibility as to how patients know to budget for surgery and what the costs are going to be. That is what we are grappling with. Certainly, your proposal is that it is a cooperative responsibility, but at the moment that cooperative responsibility is not legislated.

Mr O'Dea—That is exactly right. As I said before, when expenditure is rising like it has been, you cannot sit still and do nothing. What we have done is sensible in terms of adding the possibility of a gap. It is the only way you can have some price pressure. At the end of the day, if that works, there is volume, there is compositional change and there is price. We do not really know what is driving it at the moment—we do not have the information—but it looks to be a combination of all those things. Actually, volume is not included; volume seems flat. But there is compositional change and price. If you can make sure that that is under control and there is some competitive force, that will free up a lot of money that would otherwise be taken simply into profits or whatever. You can free that up to give more prostheses to patients or better benefits in another area. So I think that is important.

There are four parties to it. There are the health funds, the doctors, the hospitals and the patient. Giving some responsibility to the patient is completely appropriate. Telling them, 'Yes, I am going to use a particular prothesis. There may be a gap. You've got to go and find out what it will be exactly from over there,' is pretty good. Patients like that. In some circumstances it would be onerous, but by and large they do not mind making a phone call to get the certainty.

Senator MOORE—When I heard evidence from the AMA, in different places, one of the big concerns of the doctors was that their independence was being somehow regulated by changes—that they were going to lose choice or lose the ability to make independent choices. Do you see that as being an issue with this legislation?

Mr O'Dea—Yes, I do. There is some choice being traded off, obviously, but I think it is at the extreme. I do not know what the others have said in evidence, but I suspect that we will still have a full range of prostheses at no gap and others available at a reasonable gap. So I think choice will still be there but there will be a loss of some choice at the margin. Someone who has always used this prosthesis and loves it will find it is on the list now with a gap. There is going to be pressure put on them to go and use this other one over here. That will happen, but I think it will be at the margin.

There is a corresponding benefit, which is that you might liberate some money to enable more prostheses overall to be funded. Some of the new defibrillators coming through are $50,000. They are really quite a strain on the system but they stop people from dying. They reduce mortality by 30 per cent. You cannot ignore that. It would be unethical not to do something so that you can fund it, so I think we have to make sure we have an efficient system.

Senator MOORE—I notice that the AMA have been deeply involved in the discussions, as they ought to be, and the negotiations leading up to the process. Have there been any indications about how big a gap we are talking about? Certainly with the current payments we are talking about $100 or $200—that kind of thing. Was that the kind of gap that you were hearing about?

Mr O'Dea—The gaps are not going to be huge.

Senator MOORE—I am just worried about a $50,000 piece of equipment. I am sitting here thinking: one, I do not want to ever have one and, two, I am scared about a huge gap, which may actually make you need the equipment more.

Mr O'Dea—Yes, that is right. You should probably ask the department those questions.

Senator MOORE—Yes. The department know they are going to be asked.

Mr O'Dea—I do not know what the average is. There are 9,000 items on the schedule. A lot of them are just screws and brackets and things and they are not high-cost, so a small percentage gap on them would be nothing. That is true even with artificial lenses. There are lots of them but they do not have a high unit price, so you are probably talking small gaps for a lot of them. But when you are getting some of the hips and things that are getting up to $5,000 or $10,000 you have to be careful to make sure the gaps on those are not—

Senator MOORE—Just from what you have said, my interpretation is that it is kind of a balance call. You are fully aware of some of the issues like responsibility and cost but on balance the AMA is supporting the process.

Mr O'Dea—That is right. We are happy to be on the side—as usual—of progress and advancement.

Senator MOORE—I will make a note. That was the justification?

Mr O'Dea—There is a balance between unrestricted freedom of choice and being able to make sure the system is efficient so it is able to fund more and more options for patients. We have come down on that side. It has been one of the better examples of where the government has been prepared to work with the industry with lots of detailed discussions over a period of two years. It does not happen often. When it does, we thank them for it. We approve of it.

Senator MOORE—With regard to your form, I am interested to know whether you get feedback as to how many of your members who are in this field of surgery use it and whether you keep any data. From looking at it, it does spell out the various things that various people have to take into account when they are making the decision. Do you keep data about it? You have put that up as a model. You have put it out on your web site. You leave it up to your members to choose to take it up or not. How do you know whether they are doing it or not?

Mr O'Dea—We have not done a survey asking them whether they are using our form. But we have done a survey asking how often they get written financial consent from patients and I believe the government has done the same survey.

Senator MOORE—Did you get the same answers?

Mr O'Dea—I think they were not too far apart. About 80 per cent of medical services in the private system are provided at no cost to the patient at the time. They are all covered by GAP cover schemes or whatever. It has gone up from almost nothing in 1996 to about 80 per cent now. You are only really talking about the 20 per cent and what you find is that a lot of those do get written consent but there are particular problems in pathology, radiology and anaesthesia. We all understand the reasons for that and we are trying to work out ways to improve it. This will help. It is only part of a strategy, though. It is a strategy that has been going on for quite a few years and we are making progress.

Senator MOORE—Can we get the end data of your survey—not the detail.

Mr O'Dea—Yes, certainly.

Senator MOORE—That would be very useful.

Senator HUMPHRIES—Does the AMA produce any other proformas for other services that a patient might receive—say in a hospital—such as doctor services or anaesthetist services or anything of that kind?

Mr O'Dea—The proposed procedure bit at the top of this form should cover all the medical services associated with that.

Senator HUMPHRIES—I was thinking more of the front page where you give specific advice about prostheses.

Mr O'Dea—I do not think so. This is the main one, but we would certainly be happy to do it. It is an area where we are not opposed to getting better information out there for people—it is what they want. If there are particular things in mind, we would be happy to look at them.

Senator HUMPHRIES—Because, if people went for a procedure in a hospital, they would face gaps in all sorts of areas, wouldn't they?

Mr O'Dea—The other areas are mainly the responsibility of hospitals and others to inform all the gaps they might get in relation to hospital, physio or whatever. I do not think there are too many these days. They are mostly wound up into the episode benefit, the daily benefit or whatever, but most of those are the responsibility of the hospitals to inform about, and they do. We have just about got this problem covered, I think. I have been involved in it for almost the whole time, and we have gone from almost zero to almost satisfying the consumers in this area.

Senator HUMPHRIES—It has been a long time since I have been in hospital as a patient, so I am not sure what kind of volume of paperwork an incoming patient would receive. It is not likely that documentation like this—or this front page, particularly—would be lost in a mountain of other information and documents that a patient would be signing, is it?

Mr O'Dea—This form actually looks daunting, doesn't it? It is four pages. But it is all done on a screen, and it is the equivalent of carbon paper copies—it all goes straight through. So you fill out one form, and that does the lot. The patient keeps one, the doctor keeps one and another one goes to the hospitals so that, if the patient loses theirs, the doctor has got one.

Senator HUMPHRIES—There are other forms the patient fills in for the hospital, aren't there?

Mr O'Dea—There are.

Senator HUMPHRIES—And this would presumably be in among those when they came to be admitted.

Mr O'Dea—They should get it before. They should get it prior to admission, take it home and have it in their folder or whatever system they use. But it should be available at the last consult before admission.

Senator BARNETT—Just to follow on that, regarding this consumer safeguard and this particular form, you mentioned earlier that you consulted widely with some consumer groups. Can you advise us what types of groups?

Mr O'Dea—All the way through the last two years the Consumers Health Forum have been on the negotiating group, and they have been represented by a very clever woman from Western Australia who asks a lot of difficult questions. At the end of it, I think she has been satisfied that we have got an adequate process here. We had another telephone consultation about a week ago where we had two other Consumers Health Forum representatives who had been involved in the government's informed financial consent strategy. Again, that is why it has changed since we put the submission in: they made some helpful suggestions and we put those in. It has been a two-year process. Obviously, we have not talked about this the whole time but at various times along the way we have addressed it and they have seemed satisfied.

Senator BARNETT—It seems that you have done a pretty comprehensive effort, which is good. I was just wondering if you had had contact with other consumer groups such as, say, the Cancer Council, Diabetes Australia, the Heart Foundation and those types of groups or whether you had just worked through the Consumers Health Forum.

Mr O'Dea—I think the Consumers Health Forum is a peak body representing those bodies. But we did not talk to the Consumers Association, and I notice that they have been a bit vocal in the last little while. We did not talk to them but, after this, Colin and I will go and see them and see if we can help them in any way.

Senator DENMAN—The other submissions we have heard from other people have mainly been supportive of this legislation, but they have all had some concerns. Have you got any concerns at all about it?

Mr O'Dea—If I am wrong and we end up with effectively no choice: just one prosthesis per MBS procedure, then obviously we have failed. I guess that is a remote possibility. I do

not think it is a high possibility at all. No-one would tolerate that—you wouldn't, we wouldn't, the funds wouldn't. It is not in their interests, so it cannot be the outcome. There will be some loss of choice. But as long as there is a corresponding benefit, which is that we can fund a greater range of prostheses over the other side, it is worth doing. I guess that is where our concerns are.

Senator DENMAN—I thank both of you for coming today.

[2.45 p.m.]

ADDISON, Ms Linda, Assistant Secretary, Private Health Insurance Branch, Department of Health and Ageing

HUXTABLE, Ms Rosemary, Acting First Assistant Secretary, Acute Care Division, Department of Health and Ageing

CHAIR—I welcome officers from the Department of Health and Ageing. You are reminded of course that the giving of evidence to the committee is protected by parliamentary privilege. However, the giving of false or misleading evidence may constitute a contempt of the Senate. But you will not be required to answer questions on the advice you may have given to government on the formulation of policy or to express a personal opinion on matters of policy. We have before us the department's submission. Do you wish to make an opening statement before we ask questions?

Ms Huxtable—Thank you for providing the opportunity to present the department's submission on the National Health Amendment (Prostheses) Bill. We are pleased to appear before the committee and to respond to the questions of committee members. The bill enables new arrangements for the payment of benefits by private health insurance funds for prostheses used as part of in-hospital procedures. The bill seeks to implement reforms announced by the government in April 2003 and is consistent with the principles announced at that time. The bill and associated administrative arrangements have been developed in close collaboration with stakeholders, including suppliers, insurers, private hospitals, clinicians and consumers. The minister has indicated that there is now a good balance between the range of interests involved and has commended the parties on their willingness to cooperate and work together in the interests of health fund members and patients.

The bill proposes that, in the future, health funds will be required to cover their members for prostheses delivered as part of an MBS-admitted hospital procedure, unless specific exclusions apply. For these prostheses, health funds must pay a minimum benefit, up to the level of the 'no gap' prosthesis, and may choose to provide benefits for all or part of the gap charged for a 'gap permitted' prosthesis. The Minister for Health and Ageing will determine the grouping of prostheses products, the product or products in each group for which no gap is payable, those where a gap may be charged and the maximum amount of any gap.

The Prostheses and Devices Committee will recommend to the minister the listing and benefit levels of new and existing prostheses and devices. This committee will base its recommendations on advice from clinicians and benefit negotiators. A process for new listings will apply, with revised schedules continuing to be released every six months.

The government is introducing these changes to help make private health insurance more efficient and competitive and to assist in delivering value for health fund members. Under these reforms funds must cover all types of prostheses for which there is an associated MBS procedure at least to the no-gap benefit. The assessment process that underpins these reforms will ensure that there is at least one no-gap prothesis for each clinically distinct group of products. For example, bare metal stents and drug-eluting stents will appear in different clinical groups, though they relate to a single MBS procedure. Suitability for purpose is the most important criterion in grouping products. Clinicians and patients will be able to see how

products have been grouped and make judgments about their relative clinical value. In recent years prostheses costs have been growing at around 30 per cent per annum. No-gap benchmarks should encourage greater price competition among like products. This will bring pressure on suppliers and manufacturers to have their products listed at no gap, particularly as new products come onto the schedule. The submissions that the committee has received highlight a broad consensus for these reforms.

Related administrative arrangements are being finalised. One is to ensure that patients are fully informed of prostheses costs. Significant progress has been made and is continuing based on the concept of shared provider responsibility. No single provider is in a position to provide complete advice about the costs of an episode of care but all providers have responsibilities to their patients and to consumers to keep them informed of the full implications of their treatment. The approach proposed in the AMA submission protects patients while recognising the involvement of different industry sectors. All stakeholders recognise that in emergencies patients may not be able to provide informed financial consent. In these circumstances health funds have agreed to bear the full cost if a gap permitted prosthesis is used.

A number of submissions to this committee seek a review of the new arrangements. The government has given a commitment that a review will begin two years after full implementation. As the new arrangements are implemented, the department will continue to consult extensively with stakeholders about the shape and form of the new arrangements and will seek to gain a broad consensus on outstanding matters. In conclusion, the reforms as reflected in this bill have been developed through a broad based consultation process. This in itself has been a valuable by-product, enabling competing groups to find a common ground, a fact that is evident in the submissions you have received. I am happy to table this statement.

CHAIR—Yes, thank you very much, Ms Huxtable. We will have questions.

Senator MOORE—I have a couple of questions about so many areas, so I will ask a couple and then we will see how many others we can fit in. The new bill provides for the advisory group and the expert group. I am interested to know exactly where consumers fit in. In the negotiations until now where exactly do the people who have that other side of the knowledge fit into the whole process?

Ms Huxtable—The consumer organisations have been a very important part of the process, as I think the AMA was mentioning. The consultation as to these new arrangements has been very comprehensive. The Consumer Health Forum has been involved at many levels. It is a multilayered sort of consultation mechanism. The Prostheses and Devices Committee is the top layer and is the body that will make recommendations to the minister. It is a member of the Consumer Health Forum; it is on that body. We also have a policy advisory group, which I chair. It has been an important part of working through with stakeholders the issues that arise from time to time. The Consumer Health Forum has been engaged with that body as well. Hopefully, as we move more to an implementation phase those bodies will continue to have very important roles and will continue to be engaged. Linda can probably add to that.

Ms Addison—As Ms Huxtable said, the levels at which we are working are numerous. On the clinical advisory side, we have the clinical advisory groups. There are consumer health

representatives on each of the clinical advisory groups, so we have them engaged at every level that we are operating on. They are an integral part, as was noted, of the process.

Senator MOORE—Are those people appointed or are they nominated by their association?

Ms Addison—By and large they are nominated by their association. The minister nominated the members of the Prostheses and Devices Committee. That was on the basis of names that organisations had put forward. As for the roles of the people on the Prostheses and Devices Committee, the benefit negotiators and the clinical advisory groups are all the experts, so they are nominees of their organisations. They do not represent their organisations in that context, the difference being as to the Policy Advisory Group, which the department chairs. That is the body that works through all the hard policy questions to provide advice to the minister and the department in that context. The members of that body are there as representatives of their organisations. That includes the member from the Consumer Health Forum.

Ms Huxtable—I do have a little diagrammatic representation—

Senator MOORE—I do like them a lot! I think they are good to look at and you can see—

Ms Huxtable—With the exception of the benefit negotiators, the consumers are involved in all of the other advisory processes.

Senator MOORE—One of the things that has been common in this process is an expectation that the legislation will lead to savings. There is also an understanding that there has not been a particularly effective database for knowledge about this area for a long time. It has been operating but the exact knowledge of the data—the numbers, the costs—may not have been as openly shared as we would hope. On what basis were the savings calculated? I know that savings are always guesstimates but I would like to have some idea about the savings estimate. Secondly, I would like to have some understanding about the process from now on once there is a decision on the legislation. How do we then collect the appropriate data to do the effective monitoring and the effective reviewing about whether it is working or not and how it can improve?

Ms Huxtable—Those two are reasonably separate and I will deal with the data one first. For the first time, we will have a lot more information now around benefits paid, gaps permitted, and no-gap services, and that will be listed in the schedule and will be part of the negotiated process, and no doubt you have heard a lot about that today. Certainly there is an industry expectation—and it mirrors our expectation—that that process will in itself be an important manager of cost, particularly in regard to new listings. When new listings come on they will be comparing and contrasting themselves to no-gap products that are already within the clinical group where they are likely to interact. That is one of the cost impeders, I suppose you could say. As for the more formal data collection, I do not know if you can add anything in the interim in terms of how we will be looking at the data that comes forward.

Ms Addison—One of the things that will happen with this process is that we will have data that we have not had before. For a start we will have the data that the CAGs, the clinical advisory groups, have put together and their assessments of the actual products. Similarly, the benefit negotiators will actually be reaching benefit negotiating positions that will go as

recommendations to the Prostheses and Devices Committee and then on to the minister. So we will be able to see the benefits being settled, and that will be publicly available. That data will become part of the publicly listed determination.

Below and beyond that we are working with health funds at the moment in terms of setting out arrangements for data collection to capture expenditure and how that translates in terms of impacts on consumers. It is fair to say that the data that has come in is far from robust in the hospital casemix protocol and we are working through a process now to try to improve the integrity of that data in anticipation of the new arrangements coming into play. We are talking to the industry and to our stakeholders in that context about what form the data should take and the best mechanism for collecting it. Those discussions are not yet final; they are in train. But we are very conscious of the need to have the data and, while we are very excited about what will go out and be available in the public sphere, there is also the level of doubt that we are working through with stakeholders about how we will obtain that and how it will be maintained and whether it will be publicly available as well.

Senator MOORE—Yes. That last one is fairly important in terms of public access and whether we get that commercial-in-confidence response that we often get when we are talking about private health issues.

Ms Addison—One of the things that will change with these arrangements is what has in the past been to some extent commercial-in-confidence information will not be as the processes move forward. So where those boundaries lie will be expanded, I would hope. Because there is naturally a lot of commercial sensitivity, we use the Policy Advisory Group to ventilate those positions and to try to come to a consensus view about what will be agreed in terms of those different aspects of the process. That is how we will deal with the data collection one as well, I expect.

Senator MOORE—What is the proposed time frame for the devices to become public? Of the 5,000-odd devices—which is an easier word to say—that are now on the list, what will incur a gap payment and what will not? In terms of the knowledge of what is going to happen, that is the critical issue—the fact that there is now not a gap.

Ms Addison—You will know which devices as soon as the minister makes a determination. It will become a legislative instrument under the new legislative instrument provisions, and it will be tabled in the parliament. We would propose to have that available on the department's web site, so anyone could look at it, see the device and see whether the minister had made a determination which was a benefit at a no-gap level or a gap permitted level and what the minimum and the maximum would be. That will occur from basically the time the minister makes the determination and it is tabled in the parliament.

Senator MOORE—And any changes to that will go through the disallowance instrument process.

Ms Addison—Yes. Currently a schedule is released every six months, and the intention is that we will continue to issue a schedule every six months. Each schedule, under the way the act operates, will replace the previous one. So each schedule that comes out every six months will be tabled and will be available.

Senator MOORE—I would like to ask one more question—

CHAIR—Senator Moore, just before you leave that issue about savings, I understood that this is not really about savings; this is about managing the growth in this area and being able to manage the costs that are associated with prostheses. Is that right?

Ms Huxtable—That is correct. That is a very important focus in terms of the future—there is no doubt about that—as is how new listings come on to the prostheses schedule and what internal competition is created. There is also—and this issue was discussed when we were sitting behind here—a link to broader processes around ascertaining the effectiveness and clinical effectiveness of procedures through other processes within the department, the Medical Services Advisory Committee, and linking requirements on funds to procedures being funded as part of MBS procedures. To do that, a new device or prosthesis needs to go through an MSAC process to determine its relative cost effectiveness. So there is a sort of first hurdle with regard to whether or not this is actually going to add value in terms of clinical outcome, and that then flows through into the prostheses schedule.

CHAIR—The analogy that was given to us earlier today is that this is a little like the PBS—that is, if the costs are not managed now, the new and emerging better products will never be able to be afforded in the future. Do you consider that to be a good analogy?

Ms Huxtable—Certainly this provides a great deal more certainty. It provides processes for all the stakeholders to be engaged in. It provides a public forum in which no gaps and gaps permitted can be scrutinised. All of those things are certainly a means of looking at those cost issues in the future.

Senator MOORE—From my point of view, it is an attempt to control expenditure into the future and chasing it through. I will come back to the issue of informed consent because that has been a critical element. But I just want to follow-up on the analogy of the PBS, because I keep thinking that there are similarities. One of the issues with the PBS is that sometimes something goes out publicly about what a benefit it will be and then, seemingly, there is a long delay in having the final approval. Is that kind of process acknowledged or in hand in the planning of this one? An example is that someone gets a super device that comes from the US or somewhere that is going to be of value to a certain number of people. What we have seen in the PBS process is that a particular drug can get a high profile and get lots of media attention, and we hear heart-rending stories about how this child could be aided if this drug was available, but there is a delay. Is it right to say that there is going to be a six-monthly turnaround in terms of the adaptation of the schedule and that the final determination is a ministerial direction?

Ms Addison—That is right.

Ms Huxtable—This fits into these MSAC processes as well. So in the case of a new procedure or a new device for which an MBS item does not exist, it needs to go through a cost-effectiveness assessment before it really gets to this stage. So it is dependent on getting through that first hurdle, I suppose, for it to become something that then must be covered, because it will be part of an MBS procedure. There is discretion for things that are not part of MBS procedures to also be covered, but that is a much more discretionary activity.

Senator MOORE—Then that goes to the advisory group or the other one—the one that was higher than the advisory group.

Ms Huxtable—That is more around what the health funds choose to do.

Senator MOORE—Sure, it is a double level.

Ms Huxtable—With their members.

Ms Addison—I would like to add that if there is an existing MBS procedure and the device comes along and it would fit within that MBS procedure then there is a process by which new products get listed through this process. For example, we have 300 applications for new products to be listed in the February schedule, which is due out shortly. So there is a process going on looking at those, looking at where they fit and whether or not they fit with an MBS procedure or fit within an existing category that might be accessed or not. That process will be finalised before the schedule is then released, and those that have been dealt with will then either appear on the schedule or go back and suppliers will be advised that they did not have the TGA reference, or whatever the case may be. As Ms Huxtable has said, if it is a brand new device that does not have an MBS procedure then it does need to go through the MSAC process. If it would help, I have some flow charts—

Senator MOORE—Yes, please.

Ms Addison—which explain how we review the existing products and how we go about listing the new products.

Senator MOORE—That would be useful.

Ms Addison—We can provide those for you.

Senator HUMPHRIES—I have a quick question. There are 9,000-odd products listed at the moment as prostheses for which a benefit applies. How many products in use in Australia would you estimate are not listed at all at the present time? Do you have any idea?

Ms Addison—I do not have the answer to that. I will have to take that on notice. I can check whether we would have any idea at all—

Senator HUMPHRIES—A guesstimate would do.

Ms Addison—Unfortunately, I do not think we would have that. We just look at the applications we receive and then the data we have is then about the ones that appear then on the existing schedule 5, which will become the new schedule.

Senator HUMPHRIES—Presumably, though, everyone who is making or selling a prosthesis in Australia would at some stage have submitted an application for it to be listed. That information would presumably be obtainable then, wouldn't it?

Ms Addison—Not necessarily. There are arrangements around, for example, TGA processes that they need to go through before they get to a listing on the existing schedule 5. I can have a look at what information we or the TGA might have that is of the order that you are looking for, but I cannot answer that conclusively for you.

Senator HUMPHRIES—Why would the TGA deal with prostheses? Is that the process that they go through? Are they considered by the TGA before they are considered by this process?

Ms Addison—Yes.

Senator HUMPHRIES—So in other words there are some still in the pipeline that have not reached—

Ms Addison—Yes.

Senator HUMPHRIES—It sounds as if there are not many products in use in Australia today, though, that have not already been considered for listing at some point somewhere in the system.

Ms Addison—I really could not answer that. I will have to take that on notice, I am afraid.

Ms Huxtable—Nine thousand is a very big number.

Senator HUMPHRIES—I am just wondering what kind of unmet need there is out there that savings in the system might allow us to look at. But I understand that you cannot answer that question.

Senator BARNETT—I have read your submission. In regard to the consumer safeguard and the AMA's document that they have prepared, what response do you have to that document and your confidence that consumers will be adequately advised?

Ms Huxtable—We have been a part of some of these discussions around the document, and it is being developed very closely between the stakeholders. It balances the various input from stakeholders. We do not necessarily have an opinion about it, I suppose. It has come through those processes and seems to be a very valuable collaborative contribution for all involved.

Senator BARNETT—The AHIA submission indicated the level of increase in expenditure in terms of prostheses benefits over a period of time. Last year it was about 28 per cent. Do you have an analysis of some of those figures in terms of the costs and the price? Do you concur with the AHIA analysis?

Ms Addison—We have data and I can provide you with a table that we have on the data about the increases in benefits and the increases in costs of services associated with prostheses. If you are asking about the data that breaks down the drivers behind those costs, no, I do not have that.

Senator BARNETT—The MIAA, the Medical Industry Association, said that it was about a CPI increase in terms of the cost per prosthesis, in their view, as opposed to the expense in terms of benefits paid. Because of the medical technology, there are obviously more prostheses available and it has increased that way. I wondered if you had a response as to where the increase has been and whether it is in the number of products or in other areas. Do you have a view on that?

Ms Huxtable—There is no doubt that what sits behind the data is fairly complex and there are a number of factors that would be involved. Some would be around the increase in price; some would be around volumes and utilisation. One of the problems is that we have not got the means to dig behind the data in that way.

Senator BARNETT—Will that come in the future?

Ms Huxtable—Through some of the things that we have been talking about today, yes. We are going to have a lot more rigorous data and more capacity to access data than we have had

in the past. But there is no doubt that this is a cost driver and you can see that in the data that we can table.

Senator BARNETT—It makes a lot of sense. Thank you.

Senator DENMAN—Who is going to bear the costs of this new approval process? Will it be the department?

Ms Addison—It will be the industry in terms of the suppliers and the manufacturers. The current arrangement is that they pay a fee for listing their devices on the existing schedule 5 and they will continue to pay a fee for listing on the new schedule. We flagged for the prostheses and devices industry that the listing on the new schedule will be more expensive than in the past to reflect the additional costs that are involved in the role of the Prostheses and Devices Committee, the clinical advisory groups and the benefit negotiators.

Senator DENMAN—This is a question from a personal perspective. In the bill it says that health funds will be required to cover their members for prostheses delivered as part of the Medicare Benefits Schedule, which are the new prostheses arrangements that you have talked about. In a case like my own for instance, where I have had hips and knees replaced, can the private health insurance companies refuse to cover you for that gap because you had an existing condition?

Ms Addison—I cannot answer that question because it will depend on the health fund. Under the new arrangements, if there is a gap provided for in the new schedule, it will be up to the health fund as to whether they cover that gap or not. They may cover some or all of it or they may choose to offer a product which covers none of it.

Senator MOORE—I have questions about the expectations of the process. One of those is: who is responsible for providing the patient with the absolute knowledge that they must have when making a choice between the options given? How does the department advise the various stakeholders about how they share this responsibility and what is the best way of allocating the responsibility to ensure that people know what they are getting into? This is something of which you have great experience because of other payments and so on.

Ms Huxtable—Are you referring to financial issues or to product choice issues?

Senator MOORE—Both, because I think they are linked. My own view is that a patient going to see a doctor about a heart activity may or may not have any technical knowledge about which device would be the best for their purpose. They rely exclusively on advice from the doctor. But what it is going to cost is something that they control, particularly with making an informed choice and the liability, if someone is getting a cost to be processed.

Ms Huxtable—One of the benefits of this arrangement is that it makes some of those decisions. It is based on clearer information that is publicly available and that is a benefit. At the end of the day the clinician and the patient will talk about what their options are, but they will have at their disposal information about the various prostheses that are grouped into clinically relevant and clinically consistent groups. For example, there will be a number of prostheses with regard to a specific condition and there will be a clinical advisory process that has grouped these products into the same clinical effectiveness groups. There will always be one of these products available at a no-gap benefit. There may or may not be others that have

gap permitted benefit, but that provides a basis for the clinician and the patient to have an informed discussion around what the options are.

The informed financial consent form, which is an adjunct to that, clearly enables some of the issues to be drawn out but at the end of the day it will be the clinician who will not have all the information because health funds will vary in the degree in which they may cover gaps. There will be fundamental things the same—that is, if it is a no-gap prostheses and it is an MBS procedure then the fund will be required to provide the benefit in respect of that. If there are gap permitted prostheses which, in discussion between clinician and patients, may be preferred then it may vary from fund to fund as to the degree of the gap which they cover. That is where the funds also have to be part of the informed financial consent form.

Senator MOORE—When we had evidence earlier from the AMA we heard that they had done some surveys with their members about the use of the forms and feedback and they said that the department had already done similar work by sending a survey out to practitioners. Is that right?

Ms Huxtable—There is some other work going on which Ms Addison can refer to with regard to the task force that it is looking specifically at this issue.

Ms Addison—The government has established the Informed Financial Consent Strategy Task Force to look at informed financial consent. As part of the work of that task force there has been some consumer survey work undertaken. We have used not only this process but also the informed financial consent task force process to look at better ways of informing consumers about the costs overall—not just about prostheses but also about the costs of procedures—because there are a number of different areas where costs can become a concern to consumers. I am lucky to have responsibility for both the informed financial consent task force and the prostheses reform so I get to make sure that one side is balancing off the other.

Senator MOORE—You are truly blessed.

Ms Addison—I am; I regard myself as being that. I get those two groups to talk and to work together. I heard the AMA refer to some other consumer health forum representatives being brought in to talk about the consent form in particular. Those members were people who are participating as part of the informed financial consent task force. We have used practice managers as part of that process to trial some of the arrangements, particularly the form, and to talk about the informed financial consent arrangements that would apply specifically to prostheses but more broadly to procedures.

Senator MOORE—Has any of the documentation relating to the issues that came out, survey results and that kind of thing, been made public?

Ms Addison—No, they are not at this stage. The survey work that was done was completed in December and it has not become available yet.

Senator MOORE—Is that December of last year?

Ms Addison—Yes.

Senator MOORE—But the point is that you are using that information and cross-referencing that wider consultation to the implementation of this bill?

Ms Addison—Yes.

CHAIR—I thank you both very much for coming. Ms Huxtable, I congratulate you on behalf of the committee for being recognised with the Public Service Medal for all the fantastic work you have done. Congratulations.

Ms Huxtable—Thank you.

CHAIR—I thank all for their attendance.

Committee adjourned at 3.19 p.m.