



COMMONWEALTH OF AUSTRALIA
PARLIAMENTARY DEBATES

SENATE

Official Committee Hansard

COMMUNITY AFFAIRS LEGISLATION
COMMITTEE

(Consideration of Estimates)

FRIDAY, 14 NOVEMBER 1997

BY AUTHORITY OF THE SENATE
CANBERRA 1997

CONTENTS

FRIDAY, 14 NOVEMBER

Department of Health and Family Services—	
Program 5—Aged and Community Care—Subprogram	
5.1—Community Care and Support for Carers	428
Program 1—	
Subprogram 1.2—Health regulation	442
Subprogram 1.3—Health Research and Information	443
Subprogram 1.2—Health Regulation	444
Subprogram 1.3—Health Research and Information	445
Program 2—Health Care and Access—	
Subprogram 2.1—Medicare Benefits and General Practice	
Development	448
Subprogram 2.2—Pharmaceutical Benefits	462

SENATE**Friday, 14 November 1997****COMMUNITY AFFAIRS LEGISLATION COMMITTEE****Portfolios:** Health and Family Services; Social Security**Members:** Senator Knowles (*Chair*), Senator Lees (*Deputy Chair*), Senators Denman, Eggleston, Forshaw and Synon**Substitute member:** Senator Ross Lightfoot to substitute for Senator Synon from Wednesday, 12 November till Friday, 14 November 1997**The committee met at 9.05 a.m.****DEPARTMENT OF HEALTH AND FAMILY SERVICES**

Proposed additional expenditure, \$23,148,000 (Document A)

Proposed additional expenditure, \$58,135,000 (Document C)

In Attendance

Senator Herron, Minister for Aboriginal and Torres Strait Islander Affairs

Executive—

Mr Andrew Podger, Secretary

Professor Judith Whitworth, Chief Medical Officer

Ms Mary Murnane, Deputy Secretary

Mr Ian Lindenmayer, Deputy Secretary

Program 1—Public Health

Public Health Division

Ms Liz Furler, First Assistant Secretary

Dr Margaret Dean, Medical Adviser

Dr Cathy Mead, Head, National Centre for Disease Control

Ms Jan Bennett, Assistant Secretary, National Public Health Planning Branch

Mr David Marcus, Assistant Secretary, National Centre for Disease Control

Ms Sue Kerr, Assistant Secretary, National Health Promotion and Protection Branch

Mr Roger Hughes, Director, National Drug Strategy, National Health Promotion and Protection Branch,

Ms Katherine Harris, Acting Manager, Business Unit

Ms Laurie Van Veen, Director, Public Health Education Unit, National Centre for Disease

Mr Robin Wells, Director, CJD Project Team

Mr Tom Carroll, Senior Adviser, Research and Marketing

Therapeutic Goods Administration

Mr Terry Slater, National Manager

Ms Ngaire Bryan, Director, Business and Services

Dr Susan Alder, Director, Drug Safety and Evaluation
Dr John Cable, Director, Conformity Assessment
Ms Laurayne Bowler, Acting Director, Chemicals and Non Prescription Drug Branch
Mr Brian Priestly, Scientific Director, Chemicals and Non Prescription Drug Branch
Dr Keith Lokan, Director, Australian Radiation Laboratories
Dr Elaine Walker, Director, TGA Laboratories Branch
Office of the National Health and Medical Research Council
Mr Robert Wells, First Assistant Secretary
Dr Cindy Wong, Assistant Secretary, Health Advisory Branch
Program 2—Health Care and Access
Health Benefits Division
Dr Louise Morauta, First Assistant Secretary
Ms Penny Rogers, Acting Diagnostics and Technology Branch
Ms Gail Batman, Assistant Secretary, Medicare Benefits Branch
Dr David Graham, Assistant Secretary, Pharmaceutical Benefits Branch
Dr Vin McLoughlin, Assistant Secretary, General Practice Review Branch
Mr Col Bailey, Assistant Secretary, Medicare Schedule Review Task Force
Dr John Primrose, Medical Officer, Pharmaceutical Benefits Branch
Mr Alan Keith, Assistant Secretary, General Practice Branch
Professional Services Review
Dr John Holmes, Director
Mr Peter Dunnett, Executive Officer
Health Services Development Division
Dr Harvey Whiteford, Director, Mental Health Branch
Mr Mike Mossop, Assistant Secretary, State Financing Group
Ms Chris Woodgate, Assistant Secretary, Health Insurance Development Group
Health Insurance Commission
Mr John Evered, Managing Director
Ms Jackie Wood, General Manager
Mr Michael Whelan, General Manager, Finance and Planning
Mr Ralph Watzlaff, Acting General Manager, Professional Review
Private Health Insurance Administration Council
Ms Gayle Ginnane, Director
Mr Michel Lock, Director, Program Management and Funding Development
Ms Alison Dell, Director, Health Issues
Program 5—Aged and Community Care
Ms Jane Halton, First Assistant Secretary
Mr David Learmonth, Assistant Secretary, Policy and Evaluation Branch
Mr Andrew Stuart, Assistant Secretary, Residential Program Management Branch
Ms Stephanie Gunn, Assistant Secretary, Accountability and Quality Assurance
Mr Warwick Bruen, Assistant Secretary, Community Care

Ms Margaret Kilpatrick, National Manager, Retirement Customer Segment Team, Centrelink
Program 6—Disability Programs

Mr Warren Cochrane, First Assistant Secretary

Ms Judy Blazow, Assistant Secretary, Strategic Management Branch

Mr Roger Barson, Assistant Secretary, Policy and Planning

Ms Ruth Goren, Assistant Secretary, Office of Disability

Mr Paul McGlew, Acting Assistant Secretary, Office of Hearing Services

Health Services Australia

Mr Peter Fisher

Commonwealth Rehabilitation Service

Mr Alan Law, General Manager

Program 7—Corporate Leadership and Management

Corporate Services Division

Mr Neville Tomkins, First Assistant Secretary

Mr John Carroll, Assistant Secretary, Legal Services

Ms Wynne Hannon, Legal Services

Mr Mark Johnson, Assistant Secretary, Financial Management

Ms Tricia Searson, Assistant Secretary, Public Affairs, Parliamentary and Access

Mr Andrew Wood, Assistant Secretary, Audit and Fraud Control Branch

Portfolio Strategies Group

Dr Robert Wooding, Assistant Secretary, Budget and Performance Strategies

Mr Gerry Linehan, Director, Budget Strategy

Information Services Division

Dr Ian Heath, First Assistant Secretary

Department of Finance—

Irene Foster

John Davies

Louise Clarke

Katharine Mercado

Rebecca Hilton

John Ignatius

Lawrence Bourke

Clair Bingham

Robert Janssens

Adrian Beekmeijer

Stephen Beyers

CHAIR—I declare open this public hearing of the Senate Community Affairs Legislation Committee considering additional estimates. The committee will continue examination of the Health and Family Services portfolio. I welcome the Minister Representing the Minister for Health and Family Services, Senator John Herron, the departmental secretary, Mr Andrew

Podger, and the officers of the Department of Health and Family Services. Minister, do you want to make an opening statement?

Senator Herron—No, thank you.

CHAIR—Programs 3 and 4 and subprograms 1.1 and 1.4 have been completed. The committee will continue the consideration of estimates for subprogram 5.1.

Program 5—Aged and Community Care

Subprogram 5.1—Community Care and Support for Carers

Senator WEST—Would you please give us some indication of what was agreed to yesterday?

Ms Halton—Yesterday there was a meeting, as you no doubt are aware, between the minister and the aged care sector. Industry, consumers and unions were represented. That meeting involved extensive discussions around a range of issues. It was agreed that the existing arrangements that had been put in place by the minister to establish a maximum charge in respect of accommodation of \$12 a day for non-concessional non-assisted residents would remain, that a maximum charge of \$6 for assisted residents and nil for concessional residents would continue and that there was a need to move urgently to inform industry members to inform consumers and the broader community about what those charges are, how they will apply and the payment options people have in respect of those charges.

At the same time, there was agreement that the industry would have a much broader look at the whole question of capital, and they will come back to the minister to discuss that. The minister indicated to them that he was not convinced by their anecdotal arguments put in at that meeting that the charge, as presently established in principles and which will continue, will not be adequate. There was also a discussion in respect of a need for a much broader strategy around ageing, and he said he will discuss that more broadly with his colleagues.

Senator WEST—You said that there would be a program about how the charges are going to apply.

Ms Halton—I said that there was a need to inform consumers, industry and the community more broadly.

Senator WEST—So the information is not yet available?

Ms Halton—The information, I think we discussed last time—

Senator WEST—No, the details of how it is going to apply and the final detailed information to go to the industry, to aged people and to the professions is not yet available?

Ms Halton—There will be a circularisation of all of those groups on Monday. Certainly, as to the detail of what we have been working on to date, you are aware that the minister established by principle those charges. Subject to the confirmation of the meeting yesterday, we are now working as a matter of some urgency to produce a range of information materials. Our expectation is that they will be distributed to people on Monday.

As you are aware, the information hotline has had those details since they were established by the minister. Certainly, in the interim, the peak organisations are aware of yesterday's outcome. They are currently informing their membership, as they indicated to us yesterday they would. Our intention is to provide a much more detailed package of information to people on Monday.

Senator WEST—What peak bodies were involved yesterday?

Ms Halton—The peak bodies included—not necessarily exclusively because I might miss somebody—Aged Care Australia, NANHPH, ANHECA, the Council on the Ageing, the Carers

Association, and the Australian Pensioners and Superannuants Federation. We had representatives from the churches: the Catholics, the Anglicans, the Baptists and the Uniting Church. We had the ACTU represented by the ANF. We had the Independent Retirees, the National Seniors Association and the Alzheimers Association. I think that that is it.

Senator WEST—Did you have the Royal College of Nursing or the New South Wales College of Nursing?

Ms Halton—No, we did not. We had a representative of the ANF.

Senator WEST—Ms Halton, we have had this discussion before about who represents the professional side and who sets the professional integrity and the professional standards of nursing. Who do you think it is?

Senator Herron—Senator West, there were representatives of the Australian Nursing Federation there.

Senator WEST—That is wonderful. Senator Herron, I am glad you are here, because you are a doctor. You are a member of the AMA; you are also a Member, or probably a Fellow, of the Royal Australian College of Surgeons. If there is something that relates to surgery in that profession or area, who would you want to be there representing you—the AMA or the Royal Australian College of Surgeons? I suggest that you would say the Royal Australian College of Surgeons. Maybe you would want both.

As a member of both the colleges of nursing and as someone who has been a member of the health unions, I would like both. But, if you are only going to give me one, I would want the organisation who is the keeper of the professional integrity of the profession; someone who is going to uphold professional standards. You have done it again. I have made this point very clearly before when you have not included the Royal College of Nursing or the New South Wales College of Nursing: why not? You keep telling me that the ANF is representing nurses. The ANF represents the industrial wing of nurses, and they do a very good job in trying to uphold the professional standards, but they do not set them. We have two very distinct groups.

Senator Herron—If you are going to have a meeting about standards of nursing or the standards of care, you would have a totally different group to the group that was there yesterday, which was a combination of the consumers and the providers. If you want a debate about whether there should be standards of nursing care, I would expect that there would be a totally different group there. This was a group meeting yesterday about the cost of the provision of care and the facilities available to the consumer.

Senator WEST—So there was no—

Senator Herron—There was an observer from the ANF.

Ms Halton—A participant.

Senator Herron—There was a participant from the ANF so that they can report back. If you want to have standards of nursing care, of course there should be a much wider body to discuss that, and not just somebody from New South Wales. It would have to be a national peak body.

Senator WEST—That is fine, but there is also an organisation called Geriaction, which is the peak group for those nurses who have post basic qualifications in gerontological nursing.

Senator Herron—I appreciate that.

Senator WEST—Those are the ones who are usually running the major nursing homes and hostels, and who are having a major input with the professional gerontological nurses. It is

the gerontological nurses who have the key involvement with aged care. Again, I think the colleges of nursing have been left out.

CHAIR—Senator West, I think you have made your point. Can we move on please?

Senator WEST—I am most distressed about that. I am happy for you to take this question on notice, given that you will be getting some of the stuff out on Monday. I would like a copy of all material that has been sent to hostels, nursing homes and residents since the latest change last Wednesday and that which will go out on Monday—or whenever it will be—as part of the campaign. That can be an ongoing question that sits on notice.

Ms Halton—We will provide you with that copy as soon as it is printed.

Senator WEST—Thank you. Will that include the payment options?

Ms Halton—Yes, it will include information on payment options.

Senator WEST—There is going to be a broader look at the issue of capital.

Ms Halton—The industry is going to look at that issue, that is correct.

Senator WEST—When you say ‘industry’, what do you mean by that?

Ms Halton—The groups that were represented yesterday indicated that they wished to put to the minister a view in respect of capital requirement in the sector. It was for that group to decide whether they were going to come forward individually or as a collective. So I cannot tell you whether, for example, groups of consumers will band together with some of the providers. Collectively, there was an agreement that they would come back to the minister on that issue. I would anticipate there would be a number of submissions in that regard.

Senator WEST—There was something that the minister was going to take back to his colleagues. What was that?

Ms Halton—He is going to look at the broader notion of a strategy in respect of an ageing Australia.

Senator WEST—At this stage it is not proposed to have consultation again with the industry and groups?

Ms Halton—He will discuss with his colleagues the notion of a much broader strategy. There is absolutely no doubt that if there is an in-principle agreement to such a strategy there would have to be very wide-ranging consultations.

Senator WEST—We do not know what time frame that is?

Ms Halton—No, that is not clear, and he clearly has not had an opportunity to talk with his colleagues yet, so I cannot foreshadow a time frame. He indicated publicly yesterday that he saw there being a synergy with the International Year of Older People, which of course in 1999. Working towards the development of a strategy in that context I think is what he was signalling yesterday in the public arena.

Senator WEST—We will follow that one up the next time around. Can I move to the standards. I mentioned to you on Wednesday some work done by Chris Aisbett on an analysis of the single instrument for classification of residents in nursing homes and hostels. I understand that the department has been sent a copy of at least the executive summary, which is what I have got to work off. Has anyone had a chance to read it and comment about it?

Ms Halton—This has literally only just been received, and just before we started I managed to read the recommendations and the conclusion. To say it has been studied in detail would probably be a misrepresentation of the facts.

Senator WEST—I think you were otherwise occupied yesterday.

Ms Halton—Indeed I was. Can I say to you, however, that I do note from the conclusion that he is suggesting that the number of issues he has raised should be dealt with in the context of the government's proposed review. As I indicated to you on Wednesday, the reason the government has set in place the three-month review of the instrument is to enable us to have a look at the instrument in practice. I do not think there has ever been a suggestion that on a first run out of such an instrument you expect to get it 100 per cent right. The precise reason we agreed to have a three-month review was to look at not only the instrument in practice but people's interpretation of questions and all things to do with the instrument.

As I indicated on Wednesday, the real test of the instrument is how it actually performs in the field and whether it produces the outcome expected by Catherine Rhys-Hearn's work. What we will be able to do at the three-month review is look to see how it actually is being used and what the outcomes are. It is probably a limited point in debating some of the statistical things in here right now, but I think they are rightly picked up in that three-month review, and they will be.

Senator WEST—I do not think you or I have the statistical information or knowledge to sit here and have a detailed discussion—

Ms Halton—If I extract my statistical training from university, I could probably just remember some of it, but I think you are right. It would be my intention to give this to the experts in the context of the review and ask them for advice.

Senator WEST—I do have concerns about the original document because of something on page 6. At the top of that, it says, 'A non-robust aspect of the design is revealed in the inter-rater reliability results in volume 1.' And page 52—there is that one. There is also 'the logic of the discussion'—volume 1, page 51—'cannot be determined.'

Ms Halton—May I comment particularly on the issue of inter-rater reliability. This was an issue discussed in the steering committee at some length. It was acknowledged that in this kind of work inter-rater reliabilities tend to be quite low. The inter-rater reliabilities observed on a number of these items—in fact for a study of this kind—were respectable. They certainly were not statistically right at the 95 per cent level, but you would never expect such a level in a study of this kind.

The statistical advice we received on that issue, which was considered by the steering committee in some detail, was that in this kind of exercise the kinds of inter-rater reliability we observed were reasonable, and we do come back to whether or not the instrument performs as it is expected. I take the point that you are raising. He has raised a number of issues.

Senator WEST—Chris Aisbett from LAETA I think has done some consultancy statistical work for the department—

Ms Halton—I am not familiar with him.

Senator WEST—I have not got his CV with me.

Ms Halton—I am absolutely prepared to consider the points that he raised and raise it with the review committee.

Senator WEST—When I read this it bore out some of the comments that I have been getting from directors of nursing, that they were having problems with it. They were having problems, as I said the other night, with that group of patients—

Ms Halton—The non-ambulant, you mentioned.

Senator WEST—You cannot call them anything other than patients. They are not able to do anything for themselves. When I look at the scale, a lot of them, if they are incontinent, if they are unconscious or semi-conscious, slip from a category B and C back to an A, which is basically a zero rating. They pick up in the nursing one, but the assessors are finding it hard—when all those other ones slip back to A—to pick up enough points to get them back up where they should be in category 1.

Anybody who has done any nursing will tell you that someone who is basically unable to move and has to have everything done for them is heavy nursing care. It requires some specialist work, but it usually does not even require a great deal of that. Physio may be needed just to give them a very brief assessment and order as to the sorts of passive exercises they can do to stop catatonic contractions, but that is about it.

CHAIR—Senator West, could I just encourage you to come back to the actual additional estimates instead of some general discussion?

Senator WEST—I am looking at the annual report and looking at things in relation to the classification and so on. There is that major concern. There is a concern also that the level of funding that is attached to that classification instrument is not adequate and not appropriate. There are some concerns about that from administrators.

Ms Halton—In respect of the level of funding attached, you would appreciate that what we have done is take what was the existing funding and redistribute it across that industry.

Senator WEST—And probably what has happened is that they cannot get these people who are very incapacitated and in heavy, frail aged nursing care back up into category 1. They have a funding drop. These people take a lot of resources in terms of VN or RN time.

Ms Halton—The instrument is designed—I think we have discussed this before—to measure relative care need. There are no doubt some issues to do with the implementation of a new instrument: people's understanding of how it works, issues around documentation and a series of other things. There are also issues that we will look at in that three-month review. It is probably difficult to have a theoretical discussion. What we will do is pick up all of the kinds of feedback you are giving and look at statistical robustness of the instrument in that three-month review to make sure that the instrument does exactly what we want it to do and that there are no unintended consequences.

Senator WEST—When were people supposed to start using the new forms in relation to assessment for residents, patients, clients—whatever you want to call them?

Ms Halton—Are you talking about assessment prior to entry or assessment on their need?

Senator WEST—All assessments.

Ms Halton—Are you talking about assessment by an ACAT or are you talking about—

Senator WEST—No, in the institution.

Ms Halton—It takes weeks to reassess somebody across the new instrument. Our expectation was that new residents who entered after 1 October or any resident who was due for review from 1 October would commence the period of reassessment, recognising that there is a period of some weeks where a resident is assessed when they first enter. All facilities would therefore have begun to use the new form probably most likely by the end of October.

Senator WEST—I have a DoN who, on 30 September, did a reassessment of a patient who had been there 12 months. She did it on the old form because it was being done prior to 1

October. The form came back: 'Do it on the new form.' So she had to turn around and redo it on the new form. She had a couple of admissions.

Ms Halton—This was a form on the 30th?

Senator WEST—She filled it out on the 30th.

Ms Halton—When was the resident due for reclassification?

Senator WEST—I do not know, but the 12 months was about up. There had been a change of DoNs in the institution as well, so she was not totally sure of what precise date it would have been done.

Ms Halton—That would probably be the issue.

Senator WEST—She had a couple of admissions in the last week of September. She did not do those assessments for a couple of weeks. She left them to settle down and to give the staff time to get to know her so she could do an objective assessment. Because she had had the previous old form returned to her with a request to put it on a new form, she put the two admissions who had come in prior to 1 October, but whom she was assessing after 1 October, on new forms. She promptly got those sent back to her with a request that she do them on the old forms. To say that I have a fairly annoyed director of nursing and that she is not exactly singing the praises of the department—

Ms Halton—I apologise if she feels that she has been confused as part of this process. All nursing homes were provided with very clear advice in the manual, in the information sheets and in the training, recognising that we have trained many thousands of people right around the country. The advice they were given explicitly, in many places, was that any resident who was to be reassessed up until the end of September was to be assessed in respect of the old instruments, both nursing home and hostel, and any resident admitted after 1 October or due for a reappraisal on or after 1 October was to be assessed on the new instrument. That advice has been consistently given. In fact, that advice has been consistently given since about May, because we were originally intending to do this from 1 July. I am sorry that this particular person feels that they have not had clarity of information, but I can assure you that that information has been very widely available.

Senator WEST—Once 1 October rolled around, why was there the need to have some on the old form and some on the new form?

Ms Halton—It is probably unreasonable to expect every director of nursing right around the country to go around and reassess every single resident in that home. The move to the new instrument—

Senator WEST—I am not asking for that. I am asking why, when 1 October rolled around, if someone was to be assessed or reassessed, was there not an interim period when you were able to cope with either form? I presume the homes all had the new forms prior to 1 October. Why this absolute necessity to have these ones that were admitted to homes and hostels on 24 and 25 September assessed on the old form?

Ms Halton—Legislation, Senator. The law. The law basically says that the new instrument commences from 1 October.

Senator WEST—I always said it was a silly piece of law and I think you have confirmed that for me. People running large, busy nursing homes and hostels do not have the time to be slipping between, 'Do I assess this one on the old form or do I assess this one on the new form?' There has obviously been a period of time there, several weeks, where you have had

administrators and directors of nursing homes having to think, ‘Oh dear, what was the precise date that this was due?’

CHAIR—Senator West, what is your question? Can we move on, please.

Senator WEST—I am trying to make the point that problems have been created that need not necessarily have been created for people in that industry because they are having to do those assessments. I have a specific question on the classification instrument, question 19—the one about medication. It would have to be in hostels more than nursing homes because this is on the self-administration. Most hostels that I have come across are using the Webster pack, which they are having filled at the expense of the hostel. According to this document, that is the minimal way to be going. I have an administrator who went to a training session, who had been prior to that classifying the use of a dosette as a B. They use a dosette, and it is filled in the same way the Websters are. She was told at the training session that they were to be classified as a C.

Ms Halton—That is correct.

Senator WEST—A document has now been sent back to her saying that, where there is a dosette or a Webster pack used, it must be classified as a B.

Ms Halton—There have been extensive negotiations around question 19, particularly in respect of medications. If there is one question that there has been substantial debate around it would be question 19 in respect of medications. Clarification was issued in respect of question 19. I cannot tell you exactly when. It was before the commencement of the instrument.

Senator WEST—She got this only in the last fortnight. I saw her in the last ‘up’ week, so it had come to her either on the Monday of last week or on the Friday of the previous week.

Ms Halton—The negotiations with the industry peaks and, dare I say, the ANF in respect of that question were occurring prior to the introduction of that instrument. There is no doubt that I want to have a look at that particular question in the three-month review, because there are divided opinions about that issue and about B and C. I think and hope that everyone is clear about that question. It may be that that is a particular issue for clarification in the information we send people next week. If what you are telling me is that you believe that, at least in your experience, one director of nursing is still unclear in respect of that question, I will make sure we provide people with clarity in the package we send out next week.

Senator WEST—She is very clear, because there was a piece of paper that appeared to come from the department saying that it was a B classification. And, when you look at C, the word ‘measure’ is in there. It was being argued in this documentation that, because the actual institution was not doing the measuring, it had to be a B. I would argue, and presumably you are agreeing with me, that because they have a professional person—either an accredited doctor or a pharmacist—fill out the dosette or the Webster pack somebody has actually measured it. The difference between a B and a C in medicine is substantial. That is having a major impact on what category some of the people are going into it.

Ms Halton—Yes, we are aware of that, Senator.

Senator WEST—Are you going to wait the three months to rectify that—

Ms Halton—As I said, we have taken a decision in respect of how that issue is to be classified, and people have been advised. There is no doubt that there are still two camps, effectively, on that question.

Senator WEST—It sounds as if there are two camps within the department.

Ms Halton—No, I think there is only one camp in the department, because the advice that was given was quite clear. Most certainly it is a question I want the three-month review to look at, based on the experience of the industry and, for example, the experience of the nursing staff responsible in that area.

Senator WEST—If I can find that piece of paper—and somewhere in this I have it—I will give you a copy, because it was quite clear to her that it had come from the department. To say that she was less than pleased was, as you can imagine, a pretty mild statement. Okay, so that is going to be sorted out. Another problem that some of the hostels were having—and they are obviously still going to have it—is to do with the fact that one of the options for the payment of the bond is to claim from the estate. I presume that hostels are going to continue to have that option which they did not have before?

Ms Halton—In hostels we always had an arrangement, historically, not just under the new legislation, that people had up to six months to pay, mandated—and, by agreement between the resident and the provider, longer. There was always the option to negotiate a longer payment arrangement, if that was your family's preference. There are a number of providers who have said to me that they have collected the obligation from the estate in a number of cases. That option remains for people in hostels. You will be aware that the new legislation says very clearly that people have a choice between a bond and a periodic payment and that we have a six-month option, again mandated under the legislation. Again people do have a capacity to negotiate a longer option or to pay from the estate, if that is their preference.

Senator WEST—This was a place that had never utilised the estate option, and I do not think anybody was aware that it was an option. They are quite concerned that, for hostels in particular, if the patient—you call them residents—gets to a category 4 and cannot stay there and gets moved on, they have no means of following up what eventually happens to this patient when the patient dies. This is particularly worrying if they get moved away from where they have been. That can often happen in country areas: they keep them in the hostel and then move them to Sydney or God knows where. There may be an estate to be claimed off, but they do not know who they should contact or where they should be claiming or how.

Ms Halton—That option is by negotiation between the provider and the resident. Clearly there would have to be an arrangement that would ensure that, if there is an obligation to the provider, the provider can realise that. If there is a debt, it does need to be paid. Without intruding into every single circumstance and series of affairs, the legislation is quite clear that the option a person has is an accommodation bond or a periodic payment and that you have, by legislation, six months grace. After that it is by negotiation between the provider and the resident.

Senator WEST—I am just alerting you to a concern that has been expressed to me about that. I would like to ask about waiting lists. Have you had any indication from people about what is happening with waiting lists for nursing homes and hostels in the last couple of months?

Ms Halton—There have been some anecdotes but, in terms of formal statistics, no, I do not have any data.

Senator WEST—When do you expect to have some formal statistics?

Ms Halton—We get data indirectly through the ACATs, and that comes through the state government systems. We are usually running behind—sometimes up to years behind—but we are chasing information in that respect at the moment, as you probably well understand.

Senator WEST—I was going to ask you a whole stack about that information.

Ms Halton—Yes, but I do not have it, unfortunately.

Senator WEST—I will have to ask my state colleague. I think it is probably more than anecdotal. There is no way you can tell by the amounts that you are paying out whether there is a drop off in actual numbers in some places?

Ms Halton—Statistically, there is no indication of that yet in terms of payments.

Senator WEST—How often do you make the payments?

Ms Halton—Monthly.

Senator WEST—In advance or in arrears?

Ms Halton—In advance, and then we reconcile.

Senator WEST—I have been told—some of it is anecdotal but some of it is actually first-hand from the administrators—that they have one or two empty beds and they have never had them before. They know of other places that have three or four empty beds. I have also been told by ACATs that they now have long waiting lists for the community options and the aged care package. But you would not have any figures on that—

Ms Halton—No, I am sorry, I don't.

Senator WEST—That is the information the ACATs are giving me. They are also giving me the information that the level of dependency of people seeking the CACPs and community options is of a much higher level of dependency. You have not got the figures?

Ms Halton—Again, because we are a bit down the chain in terms of information and statistics, I do not have any data.

Senator WEST—Okay. How are CACPs paid? Are they paid as a lump amount of money to an organisation to give packages?

Ms Halton—We allocate places. There are very strong parallels, because this is their origin, with the residential care program in that there are individual places and a provider is perhaps allocated 30, 40 or in some cases more. We fund those places at a particular level—

Senator WEST—Does the level vary according to dependency of the person?

Ms Halton—No. We provide them with, if you like, a budget which comprises number of places by level of subsidy. They then balance the needs of the residents across that pool. For example, there are some providers, and I am thinking of the Sisters of Mercy when I say this, who would tend to care for more package holders than the number of places we have allocated them, just because it is how they tend to use those funds.

Senator WEST—It is also because they have got, I cannot say cheap labour, but they have a group of people who have a vocation to provide a service without making a charge.

Ms Halton—I understand that. Most providers would have on their books the number of people that they have the number of package places for. Certainly there has been a view in the last few years, remembering that they came from the hostel program, that people of increasing dependency were trialling nursing home care packages, that people of high levels of dependency indeed can be cared for in the community and wish to be cared for in the community.

Senator WEST—The group that I am being told about are those that the professionals consider are not ideal to be cared for in the community and are opting to try and do that. They have got grave concerns that there is going to be an increase in the numbers of fractured necks

of femurs and malnutrition. I do know of one case where someone was ripped off because they tried to stay home longer and they tried to pay a carer, and it all went horribly wrong. I think the police might be involved, with a bit of fraud or theft or something there. If you have not got the figures, that is a bit of a worry.

I have also had from a couple of sources a story that elderly people with private health insurance are actually utilising private hospitals for the 35 days that they can get classified as acute or whatever the classification is before they have to be reassessed. Then it is like a merry-go-round: being in for 35 days, the doctors will not give them a certificate, so they go home for a week, 10 days or a fortnight and then they get readmitted. I have had advice from one private hospital and an anecdotal story from another that they are actually seeing an increase in that. Are you aware of that?

Ms Halton—No, I have had absolutely no reports in that respect.

Senator WEST—It is probably not going to be your area that is going to see it, is it?

Ms Halton—Maybe not, though we do tend to be told things about older people's experience of, for example, hospitals, and I certainly have not heard that story.

Senator WEST—I have only had two, and one was from the actual administrator of a not terribly small private hospital, one that does acute stuff, so it was not a parking area. They had noticed an increase in this in recent months.

Ms Halton—The only thing I would say to you is that I think we are all aware that there were certainly stories in Sydney over the winter of older people being admitted in much greater numbers to hospitals, and that was simply as a consequence of the flu.

Senator WEST—No, they are of the opinion that it was not flu related. It is still continuing now. I am quite happy if you take it on notice, but the DOHRS program—what is that one?

Ms Halton—I have never heard of it. I do not know.

Senator WEST—I haven't either.

Ms Halton—Do you know what the acronym stands for?

Senator WEST—No, I do not even know that.

Ms Halton—Can you tell me where it comes from?

Senator WEST—It may be a state one. I will have to track that one down. I was told about the DOHRS program in the formula in the relationship with the minimum data set figures. I am glad someone else was looking blank. I thought, 'This sounds an interesting question to ask for aged care.'

Ms Halton—My community care colleague down the table is shaking his head. I have never heard of it. We will make inquiries as well if you wish.

Senator WEST—If you have not heard of it, no. I will try and get more information. The national action plan for dementia counselling pilot was going to finish at the end of June this year, wasn't it?

Ms Halton—Correct.

Senator WEST—Now it is continued on?

Ms Halton—That is right. The government made a budget allocation to enable counselling services to continue. I think at the estimates before last we discussed that issue. We are having discussions at the moment with the Alzheimer's associations about refocusing, I suppose, tightening up and learning from our experience of the counselling services over the couple

of years of the NAPDC to ensure that we get the best outcome having regard to what was the experience of the NAPDC.

Senator WEST—I have also had it alleged to me now that, whilst the budget for that was kept, the overall budget for some of these aged care programs was not; there was a shift within the budget so that they did not get any increase in their funding.

Ms Halton—I suppose I am at a bit of a loss, Senator.

Senator WEST—It might actually be the Commonwealth's negotiations with the state. Would that have some—

Ms Halton—The NAPDC, as you will recall, was a five-year program. We had a number of initiatives that were time limited. There were a couple of initiatives which, I think it was agreed universally, had real merit and should continue. The counselling activity, in fact, was one of those initiatives. So the government made an ongoing allocation to enable information and counselling to be provided. Without quite understanding, I suppose, what is driving the question: in essence, what we have done is had very fruitful discussions with the Alzheimer's associations about how we target counselling, and that grant is continuing.

Senator WEST—This is where some of these programs have been with ACAT teams and other aged care groups. There has been no change to the overall funding—in fact, it has probably suffered a drop, and the drop has been the amount of money that has gone to that dementia.

Ms Halton—That was a separate allocation from the allocation in respect of counselling. There was also an allocation in respect of providing specialised assessment for people with dementia—and, again, I think at the estimates before last we did discuss examples of a couple of those cases.

Senator WEST—Yes.

Ms Halton—I think we talked about the fact that the government had made an allocation. I think we talked particularly about rural assessment teams and their need to have specialised dementia resources. That allocation was made in the budget; indeed, resources were distributed by the states, as you would know they always are, for ACAT teams to enable provision of specialised dementia assessment by some of those teams. You will recall, I think, that we did talk about the fact that those resources were not provided to every team; they were sent differentially, depending where the need was. Indeed, that has continued.

Senator WEST—On the issue of certification, my recollection is that standards will increase over time.

Ms Halton—In terms of the certification score?

Senator WEST—Yes, that the pass mark will be raised or, what is expected, will be increased.

Ms Halton—I think again we have discussed this in the past. In essence, the expectation is that the certification score in the first instance represents the minimum hurdle—if I can describe it as that—for services to charge accommodation bonds, if you are talking about hostel care residence or, now, the accommodation charge for nursing home type residence. And, yes, there is an expectation over the medium to longer term that that hurdle, that bar, will be lifted. I think we discussed last time that there needs to be an active debate with the industry and, indeed, with consumers as to where that bar should be lifted and over what period.

Senator WEST—That is what I am being asked. I have hostels and nursing homes who have high 70s early 80s who are asking—

Ms Halton—Do I need to get higher?

Senator WEST—Over what time frame do they need to get higher, and what do they need to get higher in, and what is the situation.

Ms Halton—Yes. The process which has been agreed is that the certification instrument, which was taken out to use to assess all of the facilities, is currently being reviewed and will be refined. In fact, I think it will be a shorter document, based on that review. The expectation is that the bar will not be lifted either significantly or at all—and that decision has not yet been taken by the minister—probably for the three-year period leading up to the accreditation date in three years time.

The industry have rightly asked for clarification about what the score will be and over what period. The minister has said that, yes, he will give them some clarity, but he wants the instrument to be refined first, and he wants advice from the industry and from consumers about what is reasonable. What we have said though is that, probably for this three-year period, it is not our intention to reinspect facilities in the three-year period, until they come forward for accreditation.

If they come forward for accreditation towards the end of the three-year period, their existing certification score stands until they come forward. That means, for example, that a nursing home or a hostel that scored 75 is absolutely comfortable for this three-year period. A home that perhaps scored 57 or 58—

Senator WEST—I have not come across any of those.

Ms Halton—There are a few. Those homes, I think, would be well advised to be looking very seriously at remedial work. But I cannot tell you yet whether the score will be 60 or 65 by the end of that period. It is improbable that the score will be 85 in a three-year period because that is not achievable.

Senator WEST—You would not have too many of them open.

Ms Halton—No, that is not achievable. But I am hoping that, in fact, the work group who are looking at that whole issue of certification will be meeting in the next two weeks. I anticipate that they will then give the minister some advice and the minister will take a decision.

Senator WEST—Does the certification instrument itself take cognisance of the differing building codes between the different states?

Ms Halton—It takes cognisance. The inspectors who actually did the work were conscience of and informed of—because they came from those states—the different state based rules. What the instrument did was basically look at issues around fire safety, issues around building standards, things around resident amenity, et cetera.

One of the differences that you do see from the outcome in respect of certification is, for example, differential rules. If I can give you an example: in Victoria, fire standards, bluntly, are not as good as elsewhere in the country. So you tend to have Victorian homes doing worse on fire than they do in other parts of the country.

Senator WEST—Yes, it was actually fire. I was told by one institution that they had got something like 87 but they had lost a number of points because they did not have a sprinkler system. And they were aware of another institution just being built, having passed all the

regulations, that also did not have a sprinkler system; it had everything else that was required. They were saying their knowledge was that, in New South Wales, sprinkler systems were not required. Yet they were being docked marks on the certification because they did not have a sprinkler system.

Ms Halton—In essence, the instrument enables us to differentiate between somewhere that is at the pinnacle, if you like, in respect of safety—the most safe—and facilities that are less safe. The reality is that a facility that has a sprinkler system has more measures in place to provide safety in the event of a fire than a facility that does not. It is a fair point that some states do not require sprinkler systems. The absence of a sprinkler system is not a critical hazard, a thing that would automatically fail you on the certification instrument. But, yes, if you do not have a—

Senator WEST—But these ones are at the top and they are getting a bit peeved because they have complied with the building codes of their state and have probably done a bit more as well and they see themselves being docked. They regard it as a sleight on them that they are not at the top in respect of the codes in what they are required to have. It is not as if they are just trying to scrape in with the minimum legal requirements.

Ms Halton—But, in essence, the instrument is not designed to say, ‘Do you pass the state requirement?’ The instrument is designed to give a broad perspective of safety, and fire sprinkler systems provide a better level of safety. Yes, it is over and above the requirement in some states; it is not in others, but in some states it is. That does mean that some of those facilities would lose marks. But, as you have said, in that particular case that facility has done terribly well.

Senator WEST—Sprinkler systems probably should be compulsory in all of them anyway. If you have a bunch of people who cannot move, you have to evacuate 20 bedridden patients in the middle of the night with only three staff, the fire brigade is a bit slow in getting there and you do not have neighbours you can call on, you are not facing a very nice prospect. What negotiations and consultations are taking place with the states to try to get a national standard, because presumably that is what this is leading to and this is what is needed?

Ms Halton—It is interesting that you raise that question. We had that conversation with a number of providers and with a couple of states recently. We are currently working with the Australian Building Codes Board, the ABCB, to look at, firstly, a national approach in respect of buildings which perform the function of a residential aged care facility. There are ongoing discussions with states on a range of issues to do with aged care. We have commenced some preliminary discussions on that particular issue. I think you would appreciate that the jurisdictions involved are not just Commonwealth and state; they are also local government.

Senator WEST—It is a minefield.

Ms Halton—It is a minefield. Certainly our interest at the first run at this is to look at the building standards. Indeed, the building code people have already commenced a national review to try to streamline that element. We will have ongoing discussions as to whether we can, for example, deal with issues around fire, although I signal that that might be quite protracted.

Senator WEST—I would have thought one state, after a particular fire and a coroner’s report last week or the week before, might have been quite happy to go to sprinklers in a hurry. In relation to the improvement in standards and the getting rid of five-bed wards and things, there is a feeling out there that there is a push that everybody should be in a single room en suite. That is an interpretation that is being picked up. Whether it is a false

interpretation, I would not want to say; but it is an interpretation that has been picked up by some of your comments, Ms Halton.

The question put to me is what sized rooms would you need for a single room en suite to actually have a bed plus the lifter and staff to actually manoeuvre this. Single rooms would require higher staff ratios. Would there be something in the instrument that would compensate them for that? What are the implications for landlocked institutions—it is nursing homes that you are talking about more than hostels—where they are covering only a small given space of land? Are they going to be forced to go up, with the consequential problems of lifts, stairwells and increased fire hazards? It is a concern that some in the industry have certainly expressed to me.

Ms Halton—There have been extensive discussions about what is expected in the future. Certainly I think there are consumer expectations that four-bed and more wards are not appropriate in terms of providing ongoing residential care for older people. Certainly the department has quite consistently said that we believe consumer and community expectations are changing and that many people will expect single bedrooms. But we have also said quite consistently that we know from experience that some people, when they enter residential care, actually do quite like the company. Our expectation is that providers will need to balance all of those considerations when they consider the configuration of a facility they might be looking to either expand or modify.

Senator WEST—Given the high level of dependence that is now being cared for in nursing homes, and that is from your own documentation and college evidence, if you have people with dialysis, hyper-alimentation and some of those procedures to be carried out, and those people were in an acute hospital, some of those would be in a high dependency ward which would be mixed—mixed sex and multiple beds. I am not suggesting that in nursing homes, but I am suggesting to you that there might well be a case for a four-bed or even a five-bed ward if it had sufficient space and if the institution had a significant number of very high dependency people.

Ms Halton—We are not prescribing what in fact is the right answer. We are simply making the point that there has been a change in community expectations. I recently visited—in fact, in many senses it parallels the kind of model you have just raised—a very small landlocked facility in Melbourne. It is a facility which has recently been redeveloped. That facility has at the front of it a four-bed ward. It also has a series of two-bed wards and then a series of single en suites. They consciously redeveloped that site knowing that they were going to have a mix of residents, some of whom would like company, some of whom were going to be admitted with a spouse, some of whom would be very heavily dependent. For ease, both of nursing and also to give those people some company, perhaps a four-bed ward was appropriate.

What we are saying to providers quite clearly is they need to think about this issue. They need to think about not only their needs in respect of providing good and excellent quality care but also the preferences of their residents, and consciously think about, for example, married couples, et cetera. In that redeveloped facility in Melbourne, interestingly, the four-bed ward at the front in fact is the most popular for a variety of reasons. It is close to the front door and people can see people coming in. In fact, the bedfast residents in that facility queue up to get a bed in that four-bed ward because there is more traffic.

There are a variety of things that go to the decision about how facilities are configured. You have raised a couple that are very relevant. We are not saying that every facility has to be a single bed en suite, but it does depend on the variety of considerations, including the

consumers' expectations. We are advocating that providers think quite consciously about how they meet all of those needs.

Senator WEST—What work is being done? Is the department doing some work with the industry about this, or is it just being left up to the industry?

Ms Halton—The industry are largely taking responsibility for this. Certainly to the extent that they have come and raised with us issues apropos design, for example, we are talking to them. But, yes, largely the industry are taking responsibility for thinking about those design issues.

Senator WEST—I will leave it there, Madam Chair. I will see whether I can find that document that came from the department on B and C.

Ms Halton—Yes, please.

CHAIR—There being no further questions on program 5, I thank the officers from program 5.

[10.04 a.m.]

Program 1

Subprogram 1.2—Health regulation

Senator HARRADINE—On the last occasion we met I asked whether the department would again request the results of clinical trial CTN 95-205 completed on 6 January 1997, as mentioned by Professor Fraser in his letter of 22 May. Also, as Professor Fraser sponsored this trial, why did he inform the department he was not aware of the fact one woman in the trial expelled her foetus at a McDonald's restaurant, when this was made public at the Family Planning Association's biological sciences meeting in May? Also, could the department also request the results of the trial of misoprostol in second trimester termination of pregnancy conducted at the King Edward Memorial Hospital for Women in Western Australia? Has Professor Fraser responded to your requests and, if not, why not?

Dr Alder—We have written twice to Professor Fraser, and he has not responded to either letter to date.

Senator HARRADINE—Since your organisation approved the CTN, what action are you taking about that?

Dr Alder—Our last letter to Professor Fraser was at the end of October. We have not received a letter to date. We will be following it up again.

Senator HARRADINE—When did you write to him and in what terms?

Dr Alder—Our letter to him was on 21 October, and we provided a copy of the questions that had been asked and asked whether he would provide us with information to provide to the committee.

Senator HARRADINE—Do you have a copy of the letter that you sent to him?

Dr Alder—I do not have a copy of the letter in front of me, but I am quite happy to provide it to you.

Senator HARRADINE—Thank you. Has there been any contact with Professor Fraser in respect of this matter other than that letter? Has the TGA or anyone within the department contacted him about this rather disconcerting matter?

Dr Alder—Our only contact with Professor Fraser has been the letters that we have sent to him.

Senator HARRADINE—So there has been no telephone conversations with Professor Fraser relating to this issue in any way?

Dr Alder—No, not that I am aware of.

Senator HARRADINE—Wouldn't it be of some interest and concern to the TGA that a woman who was given the drug misoprostol—because of the fact that it takes some time to work—then expelled her foetus at a McDonald's restaurant? Mr Podger, isn't that a matter of interest to the health department?

Mr Podger—I will look further into that aspect of it. I am concerned that we have not got a reply from Professor Fraser.

Senator HARRADINE—Can the TGA confirm that RU486 is not currently in use in the provision of abortion services anywhere in Australia?

Dr Alder—To our knowledge that is the case. We have had no requests for the use of RU486 in any way in recent times. The last request that we had, which goes back many months, was for the use of a patient with a brain tumour.

Senator HARRADINE—No. I deliberately asked the question and you have said you have had no requests. I am asking you: can you confirm that RU486 is not currently in use in the provision of abortion services anywhere in Australia?

Dr Alder—The only thing I can confirm is that we have had no requests for either the importation of the product or the use of the product as an exempt item under the act.

Senator HARRADINE—No-one in the department has heard that it may well be used in some areas in the provision of abortion services in Australia?

Dr Alder—No, I have not heard any evidence or any information that it is being used in Australia.

Senator HARRADINE—I will ask my other questions on this subprogram later.

CHAIR—That is fine. I ask the officers of the TGA to remain while we deal with subprogram 1.3.

[10.12 a.m.]

Subprogram 1.3—Health Research and Information

Senator WEST—Some stuff has appeared on the Internet saying that the Australian Rural Health Research Institute at Charles Sturt University in association with the Faculty of Health Studies, CSU, the New South Wales Greater Murray Health Service and a select group of invited health professionals met with the senior members of the NHMRC to identify and discuss a case for rural health research to be given particular attention over the next triennium. Are you aware of that?

Mr Wells—Yes, I am aware of that meeting. I think it was a couple of months ago. Some of the officers from my area attended and talked about the research processes used by the NHMRC for providing incentives or for selection of grants.

Senator WEST—This has come off the ARHRI's web site on the Internet. They were expressing the concerns that the expertise of rural research is not recognised by the NHMRC and that applications for grants from rural areas are often turned down because the infrastructure is considered very limited. They are critical that there are gaps in asthma research in Australia and that this is a reflection of the process of the selection by the NHMRC, which does not give sufficient attention to rural asthma research. Have you got any comments about those?

Mr Wells—The selection processes for the NHMRC are predominantly peer reviewed assessments. Obviously, that favours researchers who already have a track record and who have the infrastructure around them to conduct their research. The issue of rural research is one of concern. The NHMRC now has a strategic research and development review committee. One of the aspects it is considering is how the NHMRC can bring into research and, if you like, nurture research where the track record in infrastructure is already there but where clearly there would be benefit from developing that. That is a fairly long-term process. But that is happening, and meetings like the one you have referred to are part of the process of raising awareness and working through the issues as to how we might improve the performance in that area. I cannot comment specifically on asthma. I could get figures out if you wished on what asthma research we are funding in rural areas. I would suspect it would be little.

Senator WEST—It is very prevalent out there. I suspect the causative agents are probably different to the city because we do not have the smog there but we have lots of pollens and those sorts of antagonists. It also says that there was a third national rural health research workshop in September. Are you aware of that?

Mr Wells—Yes, I am. I forget where that was. Was it at Wagga? I did not attend it, but I am aware of it.

Senator WEST—It might have been the Wagga conference that was on, but I did not link the two.

Mr Wells—At least one of my officers was present at that as well.

Senator WEST—So you do not have any information that you can give me on that workshop?

Mr Wells—Not with me. I could get a report for you if you wish, Senator.

Senator WEST—I would appreciate that. The minister has come back. I shall leave it there and follow this up with great gusto at the next one.

[10.17 a.m.]

Subprogram 1.2—Health Regulation

Senator HARRADINE—Is the department aware of the breach of the TGA act through the illegal importation of a cervical dilator by a Queensland abortionist?

Mr Slater—We are aware of a number of breaches of the TGA act with regard to certain devices.

Senator HARRADINE—Is the department aware that the Royal Women's Hospital in Melbourne and the Victorian retailer Surgicare Pty Ltd are also under investigation?

Dr Cable—We are aware of the situation and it is under investigation at this time.

Senator HARRADINE—Could you inform me whether or not any charges have been laid for breaches of the act?

Mr Slater—The TGA has a role to investigate and provide material to the DPP. It is a decision of the DPP as to whether any charges are laid.

Senator HARRADINE—I understand that, but I am asking you whether you are aware of any charges having been laid.

Mr Slater—We are not aware of any charges being made in the Melbourne case that you referred to. We are aware of charges being made in relation to cases in Queensland.

Senator HARRADINE—Of course. I think everybody is aware of that. There was a report in the *Australian* of 21 October. You are aware of that report no doubt.

Dr Cable—Yes.

Senator HARRADINE—In that report the therapeutic goods surveillance officer said that only one doctor had been granted approval to use the dilator for experimental purposes under ‘stringent’ conditions. Who is that doctor? What is the approval for? When was it given? What are the experimental purposes?

Dr Cable—We can take that on notice and provide you with that detail. I do not have it with me just at the moment.

Senator HARRADINE—Who made the decision?

Dr Cable—We will have to provide that information to you.

Senator HARRADINE—When was it made?

Dr Cable—Again I do not have that with me here.

Senator HARRADINE—Surely you would have expected somebody to ask the question since it is a matter of public knowledge and was on page 3 of the *Australian*? Not everybody reads the *Australian*, no doubt.

Senator Herron—Is there no officer here that can answer that question?

Dr Cable—No.

Senator HARRADINE—What procedures are in place to monitor illegal importation of medical equipment?

Mr Slater—The TGA has a number of surveillance staff, and we have a role to surveil the illegal use of therapeutic goods.

Senator HARRADINE—The doctor charged in Queensland, according to this report, is a Dr Bayliss. Is there any other doctor in Queensland to be charged? Is there any other doctor utilising this particular illegal importation?

Dr Cable—The only case where the investigation has proceeded to court at this point is the one that you have mentioned.

CHAIR—Thank you. Senator Forshaw, for your information, we have just gone between subprograms 1.2 and 1.3. Do you have any questions?

[10.23 a.m.]

Subprogram 1.3—Health Research and Information

Senator FORSHAW—My questions on 1.2 were put on notice. I have some questions on 1.3 on the trials on tall girls and short children with the drug diethylstilboestrol. The minister issued a press release on 9 October claiming that the department had conducted a review into the so-called ‘tall girls’ experiments. Who precisely conducted the review?

Mr Wells—Basically the work was done within the office of the NHMRC. Some consultations were made with experts in particular areas who are not within the department. They are practitioners or scientists from outside the department. But the work was the work of the department.

Senator FORSHAW—Are you able to be any more specific than just saying that it was within the NHMRC?

Mr Wells—It was an officer within the office of the NHMRC—a medically qualified departmental officer with a research background.

Senator FORSHAW—Which relevant medical experts were consulted?

Mr Wells—There was some consultation with experts in epidemiology and with an expert in the field of cancer, particularly cancer epidemiology.

Senator FORSHAW—Can you name them? The minister's press release said that the review was conducted in consultation with 'relevant medical experts'. You have referred to that, but are you able to specifically indicate who those medical experts were? Can you give their names?

Mr Wells—I would prefer to consult with them first, Senator, and take that on notice.

Senator FORSHAW—I am happy for you to take it on notice. I do not know whether I agree with or can accept the caveat that you are putting on it at the moment. The difficulty is that when a minister says, 'Relevant medical experts have been consulted outside the department,' it leaves it hanging. I would have thought that more often than not there is not a problem with such persons' names being actually mentioned. We had discussions the other day about the trials on Infanrix in other countries and the experts were identified.

Mr Podger—I agree that more often than not we would provide those names, so we will take it on notice.

Senator FORSHAW—Thank you. Has the report of the review been provided to the women who participated in the trial?

Mr Wells—No. A report has been provided to the minister.

Senator FORSHAW—Is there any reason why it has not been provided to the women who were involved?

Mr Wells—The report is the minister's report and it has not been released.

Senator FORSHAW—Is there any consideration being given to the report being released in due course and made publicly available or, if not publicly available, at least available to the people involved in the experiments?

Mr Wells—I would need to take that on notice and confer with the minister.

Senator Herron—Senator Forshaw, when trials are conducted it is normal for an assessment to be made and then for the results to be published so they are available generally. There is usually a peer group assessment of that report to see whether it is scientifically valid before it is published and assessed. I presume that would have been set up with that in mind. Then, at the end of that, it is normal procedure to contact the people who have been in the trial giving them an overall report on the result. I would think that that is what would be occurring.

Senator FORSHAW—But how extensive would that contact and that overall indication of the results of the trial be? It is a bit hard to ask these questions without knowing what is in the report.

Senator Herron—I have been involved in similar trials, and it is fairly standard procedure that a letter would go out to the participants at the end of the trial. Once it has been scientifically assessed as valid, a publication is developed and generally a letter goes out to the participants thanking them for their contribution to the trial and giving the results of the trial in general terms. That goes out after the publication because it has to be assessed by international authorities. A copy of the publication is available to those who wish to receive

it. It is usually in a scientific journal. I would assume that that is what would occur. But we will check with the minister to see that that procedure has been followed.

Senator FORSHAW—Thank you. And if the decision is that the report of the review—the review was requested by the minister—is not to be made available—

Senator Herron—It would not be at this stage.

Senator FORSHAW—If it is not to be made available in the future I would like to know the reasons why.

Senator Herron—Sure.

Senator FORSHAW—You probably need to take this one on notice too. Could the committee be provided with a copy of the report?

Mr Wells—The research report?

Senator FORSHAW—No. As I understand it, the minister requested a review of the trials, which was conducted, as you said, by an officer within the NHMRC and by consultation with outside experts. That is now with the minister. I am asking whether that also could be made available to the committee.

Mr Wells—I will take that on notice.

Senator FORSHAW—The minister's press release also states that the ethical issues raised have been referred to the NHMRC. I think Senator Harradine, in an earlier program, asked some similar questions in regard to something else. This goes to the question of the existence or otherwise of the ethics committee. Firstly, who is considering the ethical issues raised in these trials?

Mr Wells—The reference was considered by the NHMRC executive—I forget the date—at a recent meeting. The matter was referred to Professor Chalmers as the chair of the ethics committee. It was relatively recently—within the last month or so.

Senator FORSHAW—I think we had some evidence the other day, in answer to questions from Senator Harradine, that the ethics committee effectively does not exist. It had not met for 10 months or something. Isn't that the case?

Mr Wells—Other than Professor Chalmers, the members have not been appointed.

Senator FORSHAW—A committee of one?

Senator Herron—I checked after Senator Harradine's—

Senator FORSHAW—Even Gough had a committee of two.

Senator Herron—There is a committee of two, apparently.

Senator FORSHAW—When are the other members going to be appointed?

Mr Podger—I think, Senator, we answered that as best we could on Wednesday.

Senator FORSHAW—I am sorry, I think I was away at that time. If you have answered it, could you answer it again for me?

Mr Podger—I do not know when those appointments will be made. I hope they will be made shortly.

Senator FORSHAW—Does the department provide a list of the possible appointees? What is the department's role in the establishment of the membership of this committee?

Mr Wells—There is a process. The act specifies how the ethics committee is to be constituted. There is a process of seeking nominations from various organisations. That process

is undertaken by the department, and the results from that process are then forwarded to the minister as the advice, under the act, on the appointment.

Senator FORSHAW—I apologise if I am repeating the question that was asked the other day, but I had intended to raise this in this particular program. When did the department give its advice and its list, or whatever, to the minister? When was that process completed?

Mr Wells—I do not have the exact date, but it was earlier in the year—the March, April period. I did not bring my papers with me.

Senator FORSHAW—Could you advise the committee when the department presented the advice and the list of possible appointees to the minister?

Mr Wells—Yes.

Senator FORSHAW—Thank you. It is fair to say, is it not, that there is nothing more the department has to do—you are just waiting for the minister to get around to actually appointing these people?

Mr Wells—It is with the minister.

Mr Podger—The matter is with the minister. It is true, Senator, that the process between when the department provides its advice and the final decision takes some time because there has to be consultations that the minister personally undertakes, including with his colleagues.

Senator FORSHAW—In this case it looks like a minimum of nine months and maybe longer. What is your definition of ‘some time’?

Mr Podger—I do not think it is appropriate for me to give a comment of that sort, Senator.

Senator FORSHAW—You did make the statement that it does take some time. I am not trying to—

Mr Podger—You would be asking me to give a judgment on the matter, and I do not think it would be appropriate for me to do so.

Senator FORSHAW—We are not trying to sneak you.

Senator Herron—How long is a piece of string, Senator Forshaw?

CHAIR—I rule the question out of order, Senator Forshaw.

Senator FORSHAW—That is what I understood the answer to be, but I do not believe that that is a satisfactory answer. I think it is quite reasonable for us to raise the concerns here. The minister has not yet finalised that decision, and it puts us in the position of not being able to even ask questions about the operations of the committee because it is not operating. Why is it not operating? Because it does not have any members other than the chairman.

CHAIR—The point has been made, Senator Forshaw. You might care to move on now.

Senator FORSHAW—That is all I have on subprogram 1.3.

CHAIR—That concludes subprogram 1.3. We will move on to program 2.

[10.36 a.m.]

Program 2—Health Care and Access

Subprogram 2.1—Medicare Benefits and General Practice Development

Senator FORSHAW—I am advised that divisions of general practice have recently been notified of funding changes. Is that correct?

Dr Morauta—Yes.

Senator FORSHAW—Can you explain what those changes are and the reasons for them?

Mr Keith—Basically the changes are a move from providing funding on a project application base to providing block funding on a program base to divisions. The previous arrangement was that divisions were invited to put submissions in for particular projects. At any particular time the department would be handling over 1,700 projects. The projects could start on any one day of the year and conclude on any one day of the year.

A number of divisions and people we consult within general practice found this arrangement unsatisfactory because of the uncertainty it provided. When the program first started there was quite a deal of capacity within the program. Divisions felt that if they put in for an annual project there was a deal of certainty that that project might go on in perpetuity. The difficulty was that, as divisions became more established, they put in more applications for projects. This led to a position where there was no certainty about where funding was coming from for divisions.

It was agreed, therefore, in consultation with general practitioners and divisions to move to program based funding. This would mean there would be certainty in funding, because the entire appropriation for divisions would be distributed across divisions on an agreed formula with general practice. That would provide equity and certainty. Divisions would be given more flexibility in how they applied those funds.

At the moment, funding can be used only on the particular project for which the money is given. A number of divisions from time to time had written in and said, 'While we are running this particular project, we would like to use the money for something else.' So the new funding arrangements are to provide more flexibility to divisions to respond better to local needs.

Senator FORSHAW—Are you able to provide a list of the divisions and the funding changes for each one?

Mr Keith—Certainly.

Senator FORSHAW—Would you do that?

Mr Keith—I will happily do that. One of the undertakings we gave to divisions was that we would be quite transparent in ensuring that each division knew what each other division got under the formula.

Senator FORSHAW—So you will take that question on notice. Has a freeze been placed on all future funding?

Mr Keith—No.

Senator FORSHAW—You said a moment ago that the divisions had indicated to you their views about these funding changes and that they had made requests in the past for certain changes. What has been the response from the divisions and interested parties to these changes since they were implemented?

Mr Keith—Divisions were advised of the changes formally on 1 November, and they were asked to respond by 1 December whether they wished to move to these new arrangements. At this stage we have had no adverse criticism of it. One or two of the divisions have indicated they would have difficulty in trading down to the new arrangement and have sought advice on how flexible the arrangements will be.

Senator FORSHAW—So there are still some responses to come in.

Mr Keith—Yes.

Senator FORSHAW—Would you mind providing to the committee indications and, if possible, copies of their responses after the cut-off date of 1 December?

Dr Morauta—We can provide copies of their written responses.

Senator FORSHAW—Thank you. Then we will be able to have an indication of what their attitude has been. I want to now move on to another issue under subprogram 2.1 relating to Medicare benefits. Can you advise where the new Medibank Private offices will be located? Evidence has been given to this committee previously, both in estimates and more recently in an inquiry into the legislation, that Medibank Private offices will be separated from the Medicare offices, and I think approximately 70 specific Medibank Private offices will be opened over the course of the next 12 months. Can you give us an update on where they are going to be and how long it is going to take?

Mr Whelan—The commission of Medibank Private will cease to share branch offices from 30 June 1998, and that has necessitated Medibank Private developing its own distribution strategy, which involves, in part, branch offices. The exact number and final location of those branches has not been decided at this point in time, although the roll-out of those branches has commenced. Two Medibank Private only branches have opened in New South Wales—one at Hurstville and one at Penrith—and I understand a further branch will open in Bankstown in the next week. Plans for further branches are being developed at the moment but have not been finalised.

Senator FORSHAW—A number of Medicare offices have already closed as a result of the other decisions. Have all of those Medicare offices that were due for closure now closed? A lot of them were to go before the end of October, weren't they?

Ms Wood—Seventeen of the 43 offices have closed to date.

Senator FORSHAW—Could you provide me with a list of the 17? I have some of this information from the previous estimates, but they were projected at that time. Could you also give me the proposed dates for the closure of the other 26?

Ms Wood—They have not varied their proposed dates from the earlier information that was given.

Senator FORSHAW—If you could give me a summary, that would be good. With the 17 that have been closed, what has happened with the Medibank Private services that were previously available in those offices?

Ms Wood—When we came up with the criteria for the closure of these offices, the criteria was minimal disruption to the public, within very close distance to another branch office and staff redeployment. So, like all our programs, the Medibank Private program servicing from the branch just moved to the closest branch to the one that closed.

Senator FORSHAW—Can I take it from what you have said that the new Medibank Private offices will be opened progressively? I think that is obvious. Over what period of time are you talking about here? The official date, as you said, was 1 July next year.

Mr Whelan—We expect that the two functions will cease sharing a branch office network from 30 June 1998. We expect that Medibank Private will have rolled out a substantial part of its branch office network by that time. I would add that the branch network is just one mechanism of servicing the customers of Medibank Private, and a range of agency arrangements, telephone support arrangements and direct servicing arrangements have also been put in place for that function.

Senator FORSHAW—If you do not happen to get all of the new offices opened by 1 July next year—which, from what I can see, would be a pretty tall order but maybe you are going to do it—will there be an opportunity for the Medicare offices to continue providing Medibank Private facilities in particular areas where there is no new Medibank Private office open at that stage?

Ms Wood—At this point, no. However, Medibank Private is looking at ensuring that their customers are not disadvantaged by the split.

Senator FORSHAW—That is what is prompting my question. I would have thought that— notwithstanding all the new-beaut ways of lodging claims that Senator Herron and I had a discussion about last time, such as telephones, fax machines and so forth—this is a shopfront service that has been in existence for quite some time and people are quite used to that, particularly certain groups of clients. To just have their Medibank Private service closed in their area without one being opened, albeit in a wider region, would have some impact. Notwithstanding how many letters Medibank Private sends to them, and I get them all the time because I am a member—

Ms Wood—At this point in our planning, everything is running on time and we do not see the problem arising. If we get early notice that there may be some delays, we will obviously deal with the issue as we see a problem arising. At this point, we are quite confident.

Senator FORSHAW—How many of the new Medibank Private offices will be located in rural and regional centres?

Mr Whelan—I cannot give you that detail at the moment. The numbers and final locations of the branch offices of Medibank Private have not been determined at this stage. I would imagine, though, that the branch office and distribution mechanism for Medibank Private would align with the distribution of its membership.

Senator FORSHAW—Why has it not been done? Would it not have been sensible and efficient to have worked out which regions and towns you were going to locate these offices in prior to proceeding to push the legislation through the parliament and also close these other Medicare offices? Why was it not all put together beforehand?

Mr Whelan—There was a lot of planning undertaken in that regard. As you would imagine, Medibank Private operates in competition with a range of other private health insurance funds. My observation, with regard to finalising the actual decision to locate in particular locations, is that the location of its branches is something that goes to its commercial position in the marketplace. So, while a lot of planning has been undertaken and that planning indicates that Medibank Private will be able to support its membership in the future, there is still tuning and finalising of those exact locations. I do not expect that the fund will be in a position to make announcements of those that are at a particular point in time as to what will be the exact number and the exact location of those branches.

Senator FORSHAW—This is a fairly significant change in that you have around 250 or 270 Medicare offices that are being reduced by 43, and Medibank Private and all of those facilities are being closed down in the remaining Medicare offices and 70 new ones are being opened up. That is a pretty big drop. It looks like it is easier to make a decision as to where you close the offices and also a decision to stop the service in all of the Medicare offices but not, at the same time, to have worked out where you are going to put the new ones. That comes afterwards.

Mr Whelan—I guess there are two issues at play here: the issue of the government to close Medicare offices for the purposes of redirecting resources for the distribution of Medicare and the decision of the government to separate Medibank Private from Medicare. They are not necessarily the same decision.

Senator FORSHAW—But for the Medibank Private members, which is the biggest fund—there are a lot of members—it has the same effect. There are 43 Medicare offices to be closed. Originally some of them were going to be closed in regional areas, but the government changed its position on that. In addition, the service is being removed from all the remaining offices, so it has the same effect at the end of the day. Do you agree?

Mr Whelan—At the end of the day the separation of Medibank Private from the Health Insurance Commission is going to have an effect on Medibank Private customers. But Medibank Private is looking to put in place a distribution mechanism to support its membership in both regional and metropolitan Australia.

Senator FORSHAW—I would ask you to take it on notice if you cannot tell me today and tell us where it is intended to locate these new Medibank Private offices; that is, the whole 70 of them. I am particularly interested in the rural and regional areas, where the problems of distance are greater.

Mr Whelan—It may not be possible to provide that information to you. It goes to the commercial nature of Medibank Private. It is an extremely commercially sensitive piece of information.

Ms Wood—We are in negotiations.

Mr Podger—The whole issue about the split will be that Medibank Private will be a full commercial arrangement. We, the government, as shareholder in that, will be very keen to see its financial performance. We would be very keen for it to keep up its membership and so on. But it will not be a matter then for detailed issues of exactly the way they manage their offices and distribution.

Senator FORSHAW—I have asked the question and I am conscious of time, so I want to keep moving on. What is the total cost of the opening up of the new offices? What is the estimated cost of these 70 new offices?

Mr Whelan—I am not making any observation about whether there are 70 offices or whatever number of offices that Medibank Private might open. The cost of the distribution network for Medibank Private is again a matter that is commercially sensitive.

Senator FORSHAW—We were told in the other hearing that it was around \$80,000 per office for fit-out and relocation. Take that one on notice too and come back to me. Finally on this one, will people who are members of Medibank Private be able to lodge claims in pharmacies or doctors' premises in the same way it is intended to be able to lodge Medicare claims? Is that facility going to be available?

Mr Whelan—The private health insurance industry in general is looking at the introduction of electronic commerce. I would imagine Medibank Private customers will be able to have access to claims lodgment facilities in pharmacies and other places, but it is unlikely they will be using the same facility Medicare clients use.

Senator FORSHAW—I was not suggesting they were, because there is a separation going on here. But one of the arguments that is put is that there are going to be these alternative ways which are fairly common now anyway. Therefore, I wanted to know whether Medibank Private was getting that set up as well.

Mr Whelan—Yes, it is.

Senator FORSHAW—I had some questions on chronic fatigue syndrome.

CHAIR—Senator Gibbs has put a number of questions on notice on chronic fatigue syndrome. You may care to have a look at them and see if they are similar.

Senator FORSHAW—I think I can put mine on notice. They relate to program 2.1. My recollection is that Senator West also had some questions on that issue but in the context of 2.2, pharmaceuticals.

Senator EGGLESTON—I would like to ask some questions about funding for the WA Centre for Remote and Rural Medicine. I read an article in the *West Australian* recently where the WACRRM was concerned that its level of funding might be decreased. My questions are in terms of the federal component. What I am particularly interested in is the rural incentive program, RIP. My first question is: are levels of funding for the rural incentive program to be maintained or is there a proposal to change them?

Dr Morauta—The general answer to that question is that there are two reviews going on at the moment about general practice. The minister has said that he is comfortable with these reviews coming forward with changes to existing programs—suggesting ways of improving programs and doing them better. It is not a savings exercise but an exercise in seeing whether there are better ways to do things. It would be fair to say that in any of those general practice programs which are part of the general practice strategy it is possible that changes will occur, but at the moment it is not being seen in the context of a savings exercise. It is more like changing—

Senator EGGLESTON—What you are saying in effect is that you are not proposing to cut the funding to those programs but perhaps to change the allocations within them?

Dr Morauta—Yes, that is the sort of scenario which is on the table with the reviews.

Senator EGGLESTON—I believe one of the factors in the rural incentive program in the allocation of funding is something called the remoteness index. Is that the case?

Mr Keith—Yes, that is right.

Senator EGGLESTON—Are there changes proposed to the remoteness index?

Mr Keith—The index that has been used in the past is quite crude, in a sense. That has resulted in a disproportionate distribution of the money across the states. Western Australia does rather well under the current program. We are looking at that distribution. You mentioned WACRAM. We are having discussions with WACRAM about funding options for the future.

Senator EGGLESTON—WACRAM is quite concerned about the revision of the remoteness index, in that, while Western Australia is in effect a city state and a lot of Western Australia is remote and rural, they feel that WACRAM may be disadvantaged in the rejigging of this index and that Western Australia could lose substantial funding provided under the rural incentive program. Can you give me an assurance that that will not be the case?

Mr Keith—I do not believe that will be the case.

Senator EGGLESTON—How will it not be the case if the index is rejigged but the amount of money is not changed? If the pot does not grow bigger, surely Western Australia will find itself at a disadvantage in comparison with, say, Queensland and New South Wales?

Mr Keith—In saying we would rejig the pot, I used the wrong words. We are looking at the formula at the moment and, in discussions with the people who are doing the rural incentive package, certainly a guarantee has been that there will be no changes this year to

the funding in the allocation. That is pending the outcome of the review. I would imagine that we would have difficulty agreeing on a new formula in places like Western Australia and the Northern Territory, given our commitments to this program.

Senator EGGLESTON—WACRAM has an excellent record of having significantly increased the number of doctors in rural Western Australia from something like 250 to over 400. It has provided locum services for doctors in rural and remote WA. It has provided excellent continuing medical education programs and has encouraged high school students in country areas to enter medical school and, on graduation, return to country areas. I would ask that these achievements be borne in mind. In the promotion of the interests of rural medicine WACRAM has become something of a world standard centre. I would like to put on record my concern that WACRAM is concerned that they may, once this remoteness index is rearranged, suffer a considerable funding reduction. If that undermines and lessens the effectiveness of WACRAM's programs, it would be a very great pity.

Mr Keith—We share your confidence in the achievements of WACRAM to date. Part of WACRAM's funding also comes from the state government, and we are having discussions with the state government also, to ensure that there is not substitution of our money for their money. I am quite confident that we will reach an agreement with WACRAM to maintain the high levels of service they currently provide.

Senator EGGLESTON—It seems, though, that most of the funding comes from the federal government, as I understand it, for the WACRAM budget. Is that not the case?

Dr Morauta—Can we take the question on notice? We thought it might have been the other way around. But let us take the question on notice. We will provide you with that information.

Senator EGGLESTON—I think that they get quite a substantial amount of money under the rural incentive program.

Mr Keith—They do. But the state also provides them with money for different other purposes, including infrastructure. There are some discussions with the Health Department of Western Australia about ensuring that they maintain that level of funding.

Senator EGGLESTON—But are there not other factors at work within the Western Australian health budget which might affect WACRAM's funding?

Mr Keith—I would hope not.

Senator EGGLESTON—Could we ask that details of the funding provided to WACRAM and other similar medical organisations around Australia concerned with the promotion of rural health initiatives be provided on notice.

Mr Keith—We are happy to do that.

Senator HARRADINE—Could I go to the question that I was commencing previously. It really is leading up to the Health Insurance Commission and Medicare, as well as requiring some responses from, I suppose, the departmental officials that provide the information. I referred on Tuesday to how Dr David Grundmann, Medical Director of Planned Parenthood Australia, described the methods he used on the ABC 7.30 *Report*. He referred to the D&X method, dilation and breach extraction method, as follows:

Essentially it is a breach delivery where the foetus is delivered feet first and then, when the head of the foetus is brought down into the top of the cervical canal, it is decompressed with a puncturing instrument so that it fits then through the cervical opening.

That is his own description of what he does. At the last estimates committee I followed up a number of matters that I had asked previously, and one of these was about whether the foetus

feels pain. After having written to various people, you gave your response to me on notice No. 127, which must have only recently come in, I suppose in September, because I asked the question on 19 August. Your response is:

The conclusion of the abstracts was that 'these data suggest that the foetus may take hormonal stress response to invasive procedures'. They raise the possibility that the human foetus feels pain in utero and may benefit from anaesthesia or analgesia for invasive procedures.

Could I just ask why the department would suggest that. Doesn't the department know that Dr Grundmann does not use a general anaesthetic?

Ms Batman—I did not know that. I do not know whether other people in the department knew that. The article that the Royal Australian College of Obstetricians and Gynaecologists provided us with was not particularly in relation to the procedure that you were asking about. We have asked again. The article in question was really about interuterine needling. But I am just not aware of the procedures that David Grundmann does and whether or not anaesthetic is used.

Senator HARRADINE—I am quoting from a paper that was written by him. It talks about the advantages of the D&X method, that it can be performed under local or twilight anaesthesia and there is no need for narcotic analgesics.

Ms Batman—The issue from the point of view of the Medicare benefit schedule is that we make sure that anaesthetic units are available in connection with procedures which may require anaesthesia. We do not have any capacity to insist on it. The appropriate medical practice in that regard is a question for state authorities most usually, and I understand that the Queensland Medical Board and the Queensland health department are in fact investigating the doctor in question and his practices, and that is generally the appropriate forum for those inquiries.

Senator HARRADINE—I have got another question on the point that you just made, but are you aware that expert testimony provided to the US Senate Judiciary Committee hearings by the American Society of Anaesthesiologists says this:

Very little anaesthesia crosses the placenta when general anaesthesia is administered to the mother, and many pregnant women are safely anaesthetised every day without ill effects to the foetus.

I am asking really why the department should provide information such that, on receiving it, a simple senator might say, 'Oh well, general anaesthetic would work,' but in fact it does not on the foetus.

Ms Batman—We did have that advice, that anaesthesia did cross the placenta. I was not aware of the statement that you read out, and perhaps we should take it on notice—

Senator HARRADINE—No, I did not say that the expert evidence was that anaesthesia crosses the placenta. What I said, quoting the expert testimony by the American Society of Anaesthesiology—

Ms Batman—Yes, sorry, I did understand that. I understood that that was what you read out. However, that is not what I had heard in the past. I am not a medical practitioner and I have no basis on which to discuss it, but I can offer to take it on notice and get some research done on it. But it is contrary to what I have been told by medical practitioners, medical advisers and people from the obstetricians and gynaecologists association. I have no expertise in this matter, and I really think I will have to take it on notice.

Senator HARRADINE—I note that you say, 'The Medicare benefits schedule makes provision for a Medicare rebate for an anaesthesia associated with termination of pregnancy.'

Is it the department's understanding that patients undergoing late mid-trimester terminations of pregnancy would have a general anaesthetic and, accordingly, the foetus would feel no pain?

Ms Batman—The advice that I had been given was that that would be the usual procedure—that, on the basis that these are usually day-only cases, under those circumstances, a general anaesthetic is preferable because people can go home at the end of it whereas with an epidural they may not be able to walk and may need to be admitted overnight.

Senator HARRADINE—I am talking about the question of whether the foetus feels no pain. You have here a statement which says, 'It is the department's understanding that patients undergoing late mid-trimester terminations of pregnancy would have a general anaesthetic and, accordingly, the foetus would feel no pain.' What I am putting to you is that I have not seen anything from the expert testimony of anaesthetists to suggest that—in fact, it is quite the contrary.

CHAIR—Senator Harradine, with all due respect—and I am not trying to stymie your questions—Ms Batman has really said that she does not have the expertise to answer the question.

Senator HARRADINE—I understand that, but she has obviously provided information. I wonder whether somebody in the department might take that one up. It is a very important question.

Mr Podger—Senator, we sought some expert medical advice. You have raised a question. We will go and check that medical advice. I think Professor Whitworth, Chief Medical Officer, has advised me that she is not aware of the details you are talking about. Therefore, we cannot give you an answer now, but the department will do so.

Senator HARRADINE—Okay. But this is a very important question: whether you are paying Medicare for procedures done which are causing severe pain to the foetus. Don't you think that the public are entitled to know whether or not they are paying for procedures which are inflicting pain on an innocent being?

Mr Podger—The issue is that we pay medical benefits for medically appropriate procedures. We do not police those procedures. Those procedures are a matter for state governments and for colleges and so on.

Senator HARRADINE—I am not talking about whether you police them or not. I know that you do not. But isn't this a matter for the interests of the public: that you would pay Medicare for a procedure which inflicts pain on an innocent being?

Prof. Whitworth—Perhaps I could assist in relation to the question of pain perception. The reflex withdrawal and increased hormonal secretions that have been referred to may occur as subcortical reflex responses in the absence of pain perception. The critical question here is when the neural connections are formed to make pain perception possible. Although that is not absolutely clear in humans, there is very substantial neural plasticity.

The expert advice is that it is probably around 26 weeks that those neural connections are formed to allow pain to be perceived and that those connections, in line with the extreme plasticity, will further develop up to and possibly after birth. So we would be very safe in saying that it should not be possible for a foetus to feel pain prior to 24 weeks and probably up to 26 weeks. My advice has been that significant amounts of anaesthesia would cross the placenta. But I personally have not taken expert advice from the College of Anaesthetists, and we would be very happy to do so.

Senator Herron—Could you tell me where that report came from?

Prof. Whitworth—Which report is that?

Senator Herron—That, with pain perception, the connections do not occur before 26 weeks.

Prof. Whitworth—That was based on the panel set up by the Royal College of Obstetricians and Gynaecologists in London. I have also personally consulted with foetal physiologists, developmental biologists, neurologists and so on.

Senator Herron—But could you give me the reference of the article?

Prof. Whitworth—Yes, I will provide that to you.

Senator Herron—Could you put it on the record?

Prof. Whitworth—Yes, I will take it on notice.

Senator Herron—You have not got it with you?

Prof. Whitworth—I have not got it with me.

Senator Herron—Because there is considerable evidence—and I have read the reports—that the pain perception occurs at spinal level in any case. The analogy or reference that I can give you is that that is why the current practice is to give analgesics prior to general anaesthesia. The pain relief, after the procedure, is increased because suppression at spinal level occurs by taking analgesics. For example, with a surgical incision, it is now recognised that analgesics should be given prior to a surgical procedure so that the wound pain, after the procedure, is diminished. That is at spinal level. I would be interested to read that report where apparently that understanding is contradicted.

Prof. Whitworth—It is correct, in my understanding, that it is facilitatory at the spinal level. But pain perception requires cortical connections: for example, withdrawal responses and so on that are seen in quadriplegics.

Senator Herron—Yes, but there is current research saying that that is in dispute. I would be interested in receiving that research.

Prof. Whitworth—We will certainly provide it.

CHAIR—This is somewhat different; we have the questions—

Senator Herron—I crave your indulgence. I will not have the opportunity to pursue it in any other forum.

Senator WEST—You should be up here asking questions.

Senator Herron—I miss being up there, but not very much.

Senator WEST—We will get you up here very shortly.

Senator HARRADINE—Professor Whitworth, have you not made yourself aware of the evidence that was given to the Congress committee in respect of this matter?

Prof. Whitworth—No.

Senator HARRADINE—Why not?

Prof. Whitworth—I had not considered it appropriate.

Senator HARRADINE—Just to question what you have said, could you comment on the testimony of the Professor of Neurosurgery at Case Western University in Cleveland? He said: There are published scientific studies that demonstrate that by the 20th week, many of the neuronal pathways that sense pain have already started to develop. By the 24th week, the connections of the cortex and the thalamus are well under way . . . There is no way to argue with impunity that pain reception is not possible.

Michael J. Murray, who is an anaesthesiologist at the Mayo Clinic in Rochester, agreed. In fact, he said that physicians doing foetal surgery inject narcotic fentanyl and muscle relaxants into the umbilical cord to provide pain relief, even though the mother is already anaesthetised, 'because what they get from the mom is not enough'.

Prof. Whitworth—I am very aware that this is a contentious issue and I am also aware that, as with most things in medical science, it really is not absolutely clear. Nonetheless, on the advice I have been given in relation to developments of the connections appropriate for pain perception, certainly the consensus view is that it is around 26 weeks and probably not prior to 24 weeks. I am aware that there are other bodies of opinion.

Senator HARRADINE—What is your position in the department?

Prof. Whitworth—Chief Medical Officer.

Senator HARRADINE—It surprises me that you have not availed yourself of the testimony that was given at the Congress committee. I raise this matter in the context of the D&X method, which is the preferred use. In fact, it is used by Dr Grundmann. In the supply of medical benefits to Dr Grundmann, you should know that it is his statement that he does not use in any event any general anaesthetics.

Ms Batman—We did obtain material on the American bill and the statement by the AMA. But we did not have the transcripts of all the hearings.

Senator HARRADINE—I asked you before about the provision of indicators on the Medicare form as to the purpose for which the procedure was performed, the type of procedure that was performed and why this could not be done. If you were sure that a procedure was performed for the purpose of sex selection, would you pay Medicare?

Ms Batman—It may well be that the Health Insurance Commission needs to answer that. The items that go on the schedule are based on trying to represent appropriate medical practice. There is a question—at the sort of theoretical level, if you like—about what is appropriate medical practice and what items should be on the schedule that reflect that and the fees that go with it. At the detailed level of practice, on the ground, it is not a question that relates directly to Medicare. The Health Insurance Commission assesses claims to make sure that they are in line with the items and looks at, in general, appropriate clinical practice. But the specific matters that you are raising are really a matter for state medical boards. If, for example, a doctor was performing open heart surgery without using anaesthetic, presumably the Medicare benefits may be payable up until a point when that person was found guilty of inappropriate practice.

Senator HARRADINE—I asked about sex selection.

Ms Batman—The questions are, I guess, across a number of jurisdictions. The item exists for when it is used in clinically appropriate circumstances. The question of whether that is a clinically appropriate circumstance has never arisen at the Medicare benefits level.

Senator HARRADINE—Has not arisen?

Ms Batman—No, not in any discussions around that. It has not come up.

Senator HARRADINE—Are you not aware that Dr Grundmann has no problem with the issue of sex selection abortions?

Ms Batman—Again, I think maybe the Health Insurance Commission might answer. If there were a complaint or some evidence that that was the case, then the Health Insurance Commission could refer that matter to the professional services review scheme, where it would

be reviewed by a panel of peers as to whether that was appropriate clinical practice. If their decision was that it was inappropriate, then the benefits would have to be repaid.

Senator HARRADINE—Are sex selection abortions illegal?

Senator Herron—It is not really appropriate to ask the officer for an opinion. In this circumstance actions of an illegal nature would be pursued by the responsible state instrumentality and similarly the registration board by the state.

Senator HARRADINE—I understand that, Minister, but what I am getting at is the need for some information for people. The last time I asked for information—and they have given us the information—as to what is legal and what is not legal. In respect of that, I have noted what the situation is with the law in Queensland. I have also noted Dr Grundmann's practices and what is happening there. What I am really getting at is the question of payments by the taxpayer through Medicare for the types of procedures which cause pain to the foetus, the types of procedures which are for the purposes of sex selection and the types of procedures which, on the face of it, are illegal under the Queensland jurisdiction. That is why I am asking the questions.

Senator Herron—Medicare benefits go to the patient. The medical practitioner, on the other hand, could be sanctioned under Medicare only if he or she were convicted of an indictable offence. I think that that process would have to ensue before the Medicare benefits are withheld from the practitioner. I think that is the process now. I will ask the officers whether that is correct.

Mr Watzlaff—Yes. In the event that we were to receive a complaint in relation to a matter like that, we would of course investigate it. But, if the matter concerned issues that went to state law or the fitness of an individual to practise, we would be obliged to refer that matter to the relevant medical board for them to take up the issue. Whilst we look at inappropriate practice and we look at excessive servicing and things of that kind, if there is any suggestion that there is a breach of the criminal law or if there is a question that goes to fitness of practice, those matters are properly matters for the state authority to administer and we would so refer those matters.

Senator HARRADINE—Earlier this week we went through the child-care legislation. There are huge penalties for ordinary parents if they do not, for example, give information. I have asked about a person who is in effect a criminal—and I say that quite deliberately, as the High Court has said it—who is conducting procedures which cause pain to innocent parties and who has no problem with sex selection abortions, and you are asking us to pay—I am here representing the taxpayer—money for those procedures. That is what you are asking. The department is not taking any action. They are not even investigating. They are not even prepared to ask questions on the Medicare form as to the purpose of the abortion or, even if they do not want to ask that, they are not asking as to the procedures to be followed—whether those procedures were undertaken, whether they are the D&X method or not.

Mr Podger—First of all, on the issue of the forms, I recall you raised that issue before and it was raised with the minister and the minister determined he was not going to change the form.

Senator HARRADINE—I was going to ask you questions about that.

Mr Podger—On the issue of the person concerned, you have heard what the procedure undertaken by the Health Insurance Commission is. My understanding is the person is under investigation. That is the process we are following, as per normal process.

Senator HARRADINE—Are you aware that that medical practitioner is seeking to expand his business into the state of Victoria? Are you aware of that?

Mr Watzlaff—No, I was not aware of that.

Senator HARRADINE—Is anybody in the department aware of that?

Mr Podger—I am not aware of that, but I am aware that the gentleman concerned is under investigation.

CHAIR—Mr Podger cannot add anything further to that, Senator Harradine. He has given a comment on the doctor.

Senator Herron—Senator Harradine, before you get onto your next question, could you clarify things for my purposes. You mentioned the High Court in a previous statement. I wonder if you would clarify for me what you were referring to.

Senator HARRADINE—You know I do not make those statements wildly, particularly when it relates to individuals.

Senator Herron—That is why I am asking you to clarify it for me.

Senator HARRADINE—It is Lawrence Edwin Georgeson and David Grundmann on 25 September 1996.

Senator Herron—Yes, I am familiar with that now.

Senator HARRADINE—I refer to the need for the taxpayer to know what they are paying for. Surely the taxpayer is entitled to know whether they are paying for procedures that are likely to be causing pain to innocent parties. I wanted to know the purpose for which the procedure was undertaken and at what stage of pregnancy the procedure was performed. The response to me indicated that there are questions of a patient's right to privacy and the limited Commonwealth role in the health system. It really came down to the question that it could breach a patient's right to privacy. I was not asking for the supply of the forms with the patient's name on them. I was simply asking why there could not be included on the form the stage of pregnancy at which the abortion was undertaken.

Ms Batman—It is a matter of government policy.

Senator HARRADINE—Can I have a copy of the minute that you wrote to the minister about on this matter?

Mr Podger—We will take that on notice. You will understand that it is not usual practice to provide copies of the actual advice.

CHAIR—Officers are asked not to reveal advice given to the minister, Senator.

Senator HARRADINE—I will ask them what their view about the matter is then.

CHAIR—They are also not able to give their personal view on any subject.

Senator HARRADINE—I will ask a factual question. How would the provision for a statement on a form as to the stage of pregnancy reached when the procedures were undertaken breach a patient's right to privacy as a matter of fact? Don't you ask similar questions in certain other procedures?

Ms Batman—No, I cannot recall any. Basically, the payment of a Medicare benefit claim relates to a bill by a medical practitioner and a reference to an item or a description of a procedure. The only questions relate to whether the procedure may have been performed in relation to some sort of compensation arrangement. There are no other facilities where the patient is asked any other details.

Senator HARRADINE—In this particular instance, if the patient were asked or if the doctor were required to include on the certificate the stage of pregnancy at which the abortion took place, how is that going to breach a patient's privacy?

Ms Batman—I feel that we are back in the area of government policy again.

Senator HARRADINE—No, I am asking you a direct practical question.

CHAIR—Ms Batman has already said that there is no provision on the form to provide that information.

Mr Podger—The issue of how much information ought to be collected by the Health Insurance Commission on the details of the procedures rather than which procedure is quite a sensitive issue.

Senator HARRADINE—I will just read what your department said:

As information on the stage of pregnancy in which an abortion occurred is not necessary to establish entitlement to a Medicare benefit, introducing a requirement to include this information could be seen as a breach of a patient's right to privacy.

I concede the first. I am asking a factual question as to how the inclusion of a portion on the Medicare form for the purposes of what I have said is going to breach that person's right to privacy.

Mr Podger—One of the privacy principles is that you do not collect information other than what you need for the purposes of the decision making.

Senator HARRADINE—Oh, is that what it is? It is not going to affect the individual person concerned. It is not going to mean that the person concerned is not going to be paid and the information clearly is not going to be divulged to anybody.

Mr Podger—I cannot see that there would be a basis on which we could automatically decide to pay or not to pay on the basis of that one piece of information.

Senator HARRADINE—I am speaking on behalf of the taxpayers of Australia who I believe are entitled to know more about this subject.

Mr Podger—One of the concerns that a lot of people have on the privacy side is how much information is collected, and an assurance that it is collected only for the purposes for which the administration needs that information. If it is for broader purposes, that raises questions with the Privacy Commissioner that we would have to be able to work through. We would have to explain why there was a general research requirement or general public knowledge requirement that was sufficient to warrant us putting that question as a matter of course, and I think we would have some difficulty in doing so.

Senator HARRADINE—So the department is prepared to continue paying Medicare benefits to a doctor who, as I described him and as the High Court has described him, has no problem with sex selection abortions?

Mr Podger—The doctor is under investigation. Depending on what comes out of that, he may well not be paid in the future.

Senator HARRADINE—You are passing the buck. I am saying to you that the public is entitled to know on the question of pain—at least on the question of pain—at what stage of the pregnancy this pain occurs.

Mr Podger—I am not a medical practitioner either, so I am very reluctant to get into a debate about the details. It seems to me that asking the one question will not give an answer to whether or not the benefits should be paid. There will be a number of other pieces of

information required. Once we get those other pieces of information, it would still require us to go back to medical boards and so on to determine whether it really is appropriate and whether the money ought to be paid. It is a very elaborate process, and I am not quite sure whether we would end up with a lot of information that the Privacy Commissioner would say is not actually being used for the purposes of the Health Insurance Commission and the Department of Health and Family Services and therefore should not be asked.

Senator HARRADINE—Is Dr Grundmann the only doctor who is performing abortions post-20 weeks in Australia?

Mr Watzlaff—I really could not answer that.

CHAIR—Is it correct to say that the information is not gathered so you are not in a position to answer?

Mr Watzlaff—The information is not gathered, so we could not ascertain that from our records.

Senator HARRADINE—But, generally speaking, surely somebody within the department is across the speeches and literature that are made on this particular matter? Nobody knows? Nobody cares?

CHAIR—I think that is an unfair inference, Senator Harradine. None of the officers knows. Are there any further questions?

[11.48 a.m.]

Subprogram 2.2—Pharmaceutical Benefits

Senator WEST—I have put a whole stack of questions on notice on subprogram 2.1. Can I move to the announcement on 12 November about the Pharmacy Intranet that the minister launched with the Pharmacy Guild and other groups in Melbourne that day. The media release states:

One hundred community pharmacies in various parts of the country will go on-line in a network trial with volunteer consumers to demonstrate the benefits **Pharmacy Intranet** offers to the community, to health professionals and to government.

It goes on to say:

There is also the exciting potential for future links to doctors and other health professionals, and to providers of financial and consumer services.

What are the details of this Intranet?

Dr Graham—At this point, the Intranet is a pilot, and it is going to be trialled in about 100 pharmacies. It is testing out real-time adjudication primarily. In other words, when a pharmacist makes a claim on a prescription to the Health Insurance Commission, that is done in actual time. At the moment, when a pharmacist makes a claim it is about two or three months afterwards, and that means the data is very historic. In this way, the entitlements of a patient can be checked at that point—

Senator WEST—Does it link back to the HIC?

Dr Graham—All the data in the pilot will be held with the Health Insurance Commission.

Senator WEST—Who will be able to access that data?

Dr Graham—In the pilot, it is anticipated that it will be only, primarily, one way. It will be just like a claim made by a pharmacist at the moment, but the pilot will be testing out real-time, actual time adjudication. The longer term potential of a system like that, if we take, for instance, the Pharmanet system that operates in British Columbia or certain systems that

operate elsewhere in the world, can lead to medication history of a patient being compiled and, therefore, it is a much more accurate from the point of view of patient quality in checking out whether a new medication is consistent with what the person is taking or has had.

Senator WEST—I am interested where it talks about future links to doctors and other health professionals and providers of financial and consumer services. What are those ones?

Dr Graham—If there is a network of computers, it does allow EFTPOS and other things to occur in a pharmacy. So it may be that it could link into the banking system, for instance, because there is a platform of communication. It also allows the pharmacist to carry out business transactions with manufacturers and wholesalers to obtain supplies of goods.

Senator WEST—What are the security implications for this?

Dr Graham—There is a consultative committee that will be looking at those sorts of aspects. I think it has to be accepted that many of those business transactions are occurring on an everyday basis now between pharmacy and wholesalers and elsewhere. So that is nothing new. Certainly the idea of a health network between health professionals is something that is coming. I think it is coming in every country around the world. You are quite right in terms of issues around privacy, protection of the data and how the data is used. That has to be well defined and acceptable to all the stakeholders. That is what that consultative process is doing at the moment, and the purpose of the pilot.

Senator WEST—Who is involved in the consultative process?

Dr Graham—I might not remember all of them.

Senator WEST—Perhaps you can take it on notice.

Dr Graham—It includes consumer groups, health professional groups including the pharmacy and medical professions, state government, the Privacy Commissioner and the Commonwealth government.

Senator WEST—When you talk about health professionals, who do you consider is the peak body for the nursing profession?

Dr Graham—We do not have the nursing profession on that consultative group. We do have, in terms of health professionals, the PSA, the Pharmacy Guild representing pharmacy, the AMA and the RACGP.

Senator WEST—In general, not just for this specific thing, if nursing needs to be involved who in the past have you contacted as the peak body?

Dr Graham—It is difficult with nursing because there is a number of groups. There is the Royal College of Nursing. That is the peak professional body. I am trying to remember who we have represented on APAC, the Australian Pharmaceutical Advisory Council, which is another consultative body that deals with the whole of the national drug policy framework. There are two nursing organisations represented on that but off the cuff I cannot remember which ones they are. I can let you know.

Senator WEST—Thank you. Are you aware of concerns that the AMA has expressed about this Intranet?

Dr Graham—Yes, they have raised concerns around some of these privacy issues and that is exactly what the consultative group is there for—to explore these issues.

Senator WEST—Perhaps you can take it on notice and provide us with details of what the program has been, what consultations have taken place, who has been involved, what will continue to take place in the future and what directions you are thinking of heading with it.

Dr Graham—Yes.

Senator HARRADINE—I think this is a question for 2.2—if not I will put it on notice. Has the department considered ways of supporting the further development of the ovarian monitor, which was designed in Australia to assist women in both achieving and avoiding pregnancy by determining the fertile and infertile phases of their cycles. Could the department seek advice into whether the monitor would be eligible to receive any research and development grants? Could the department advise whether the monitor could be listed on the PBS and on Medicare?

Mr Podger—There has been some work done on that but it was under the public health division and they are not here. Can I take that on notice? I am aware that there has been some work done on it.

Senator HARRADINE—Thank you. Whilst I am here, I certainly did not mean to reflect on the department in my previous comment. I apologise if that was thought. You are a very hardworking lot and you do provide a high standard of information.

Mr Podger—I appreciate that, Senator, because my staff are all very concerned for patients generally.

Senator FORSHAW—I would like to turn to the therapeutic group. Can you give us an update on the progress in implementing the policy of moving to the therapeutic group premiums arrangements?

Dr Graham—The policy is starting on 1 February. We are still finalising pricing arrangements with two or three companies. On the whole, most companies have decided how they want to price their products in relation to therapeutic group premiums. So those matters are still being finalised. We have set up an advisory group for the information program which will be starting in early December and which is to inform health professionals and the community about therapeutic group premiums. That advisory group includes a number of stakeholder groups on it to provide input into how the program might be most effective.

Senator FORSHAW—So 1 February is the commencement date and the advisory group will be appointed—

Dr Graham—It has met twice and it is meeting for the third time in the near future.

Senator FORSHAW—Are there any other specific timetable arrangements between now and 1 February in terms of announcements and so on?

Dr Graham—The program is that from December onwards a major information program will commence. We have funding for a program to continue over into the next financial year. We have \$2 million for this financial year for the information program and \$1.2 million for the next financial year. At the same time there is another amount of money that the Pharmacy Guild will be using to inform its members and also the community about therapeutic group premiums. Those programs and activities are coordinating. We are also looking at funding some of the peak bodies to carry out parts of that information program as well.

Senator FORSHAW—How many companies have submitted prices so far?

Dr Graham—We have negotiated with probably—I think this is accurate—19 out of 20 companies.

Senator FORSHAW—Have you reached agreement with all 19 out of 20?

Dr Graham—Yes. One company has not indicated that it wants to change its prices so we assume that they may want to leave their prices where they are at the moment.

Senator FORSHAW—This may be consistent with what you have just said, but I thought you said earlier that there are a couple of companies that you still have to finalise negotiations with.

Dr Graham—There is that one company, and there may be a couple of other tail-end negotiations still occurring.

Senator FORSHAW—With a couple of the other ones that are in the 19?

Dr Graham—Yes.

Senator FORSHAW—My next question was how many have not submitted prices so far, but can I take it from that that it is one or none?

Dr Graham—Either they have submitted a change in price or they have indicated that they are staying at the same price.

Senator FORSHAW—What are the dollar gaps going to be for the drugs affected by the changes to therapeutic groups?

Dr Graham—We are confident that our initial estimation of about \$2 is still solid.

Senator FORSHAW—But that was an average, wasn't it? I am interested to know what the range is in dollar terms.

Dr Graham—From memory, the highest is about the \$4 to \$5 mark. That is balanced off with ones below the \$2 mark.

Senator WEST—Can you take that on notice so we can have it accurately, please?

Dr Graham—We are asking the companies if we can release their price information. We are as keen as you to start to announce those prices.

Senator FORSHAW—That goes back to my earlier question that I asked you about timetables between now and February. You do not actually have specific dates set as to when those details will be released; you going to be releasing them when they are finalised. Is that the position?

Dr Graham—We are keen to be able to release those at the start of the information campaign. We have approached the companies for permission to release that information, because they regard pricing information before the new PBS schedule comes out on 1 February as commercial-in-confidence. Some companies have agreed and other companies we are asking again if we can release that information.

Senator FORSHAW—What is the method for releasing that information? We obviously have doctors who need to be advised and also pharmacies and particularly patients. Presumably the patients are going to find out through their GPs or their specialists, aren't they?

Dr Graham—There will be an information campaign that is directed also to patients. There are only certain patient groups that may be affected by the therapeutic group premiums. This is how it is proposed: we will be indicating to those patients who suffer from hypertension, for instance, that there may be changes to the pricing of their products and that they therefore should consult their doctor, pharmacist or contact an information line.

Senator FORSHAW—Before they get more hypertensive. Is that direct from the department to those individuals?

Dr Graham—There will be information put out on the radio and also in the press.

Senator FORSHAW—A general public campaign.

Dr Graham—Yes, and there will be pamphlets and other material available in pharmacies, and we are looking at other strategies too.

Senator WEST—When does this start?

Dr Graham—Early December.

Senator WEST—When do the drug changes take place?

Dr Graham—They start on 1 February.

Senator WEST—So you are basically using the silly season and the holiday season to try to get a public message across to people when they are concentrating on Christmas and then holidays?

Dr Graham—We have gone through the consultation process and we are confident that we will be able to get that information across to people.

Senator FORSHAW—You have been asked by Senator West to provide the details of those dollar gaps. What is the reference drug in each group?

Dr Graham—Unfortunately, until we can get the agreement of the industry to release that information, that is dependent on the prices of the products. So we are unable at this stage. But we are hoping to release that information very soon.

Dr Morauta—I want to add something to what Dr Graham said about the premiums. It is also possible in some groups that there will be more than one drug on the base price. Therefore, the average premium should not be regarded as applying to all drugs or even just to more than one in each group.

Dr Graham—I might give one indication because in one group—this is the ACE inhibitors, and this is not identifying companies—there are nine drugs, four of which will be at the base price.

Senator FORSHAW—Will you be able to provide us with the reference drugs in each group?

Dr Graham—I will provide that, yes.

Senator FORSHAW—This committee is not going to meet again for estimates until next year some time. If a lot of this is finalised by February, it would be helpful if we are able to be provided with it rather than have to wait until the next hearing or whenever to get the data.

Senator WEST—How many drugs did you say were in the ACE inhibitors group?

Dr Graham—Nine drug substances. When I say a drug substance, there are more brands and products than that.

Senator WEST—Yes, because some of them are generic.

Senator FORSHAW—We have a list which was attached to the media release put out by Parliamentary Secretary Trish Worth on 10 October. Is that the complete list? If you have a look at this list, maybe you can tell us whether it is a complete list.

Senator WEST—Why were beta-blockers taken off?

Dr Graham—The intention at the start of the policy was that we needed to consult with various groups. The clinical advice with the beta-blockers meant that the subgroups within the beta-blocker group, to make them clinically appropriate, were very small. Also, at the same time, the beta-blocker group as a whole is decreasing in size because it is an older group, and some of the products are dropping off the PBS. Also, a number of those have alternative

brands. In that respect, therapeutic group premiums and alternative brands operate very similarly. So there really was not the need to continue with the beta-blocker group.

Senator WEST—How can you have an alternative brand to a drug grouping?

Dr Graham—It is an alternative brand to the drugs within the grouping. The drug substance can have more than one supplier for that drug substance, and generic brands of course are proven to be equivalent when they are marketed in this country.

Senator WEST—That is dependent on whether the patient has a reaction to some of the buffers that are used in some of those drugs or to some of the coatings on the capsules that are used. That has to be taken into consideration.

Dr Graham—That is extremely rare. That was one of the potential problems raised when brand substitution came in a few years ago.

Senator WEST—I remember being belted around the ears by it.

Dr Graham—In practice it is very rare. There is another interesting thing to note with brand premiums, which on average are about \$1.80. About 70 per cent of people are still choosing to pay that brand premium when they have a choice to go to an alternative product.

Senator FORSHAW—That always intrigues me. What are the factors causing that? Is it simply that people do not know and are not really informed, notwithstanding the campaigns to get pharmacies and doctors to advise patients about the alternatives or generic brands, or is it market resistance? Is it that people still feel confident of the brand name even if they have not heard of it?

Dr Graham—There is certainly brand loyalty. One of the sciences that has come out of brand substitution is that the market has tested how high a premium can be before they lose brand loyalty. There is also concern that consumers may not be informed about their alternatives or their options. As part of this information program on therapeutic group premiums—which, as I said, are very similar to brand premiums—we will be trying to inform people about their choices.

Senator FORSHAW—There is another factor to all of this. If people have been using a particular brand of antidepressant for some time, it may well be that, whilst switching to another brand—to a cheaper product—may have absolutely no change in the treatment, because they feel they have found a brand that is working for them, that in itself becomes a positive aspect. To change that brand may cause them some concern or alarm if they have been given different brands of antidepressants over the years and they have finally found one that they think works. I would have thought that would be a matter of concern to patients and doctors, at least in that area of medicine.

Dr Graham—That is the difference between the brand premiums and the therapeutic premiums. With brand premiums, where people are making a choice of taking a more expensive product when they have an exactly equivalent alternative to choose from, it is not appropriate to ask the taxpayer to pay for the more expensive brand. That is a choice by the consumer. In the case of therapeutic group premiums, the drugs are similar, except where there is a demonstrated clinical need. That is where the exception mechanism comes into play. So it does accommodate that factor.

Senator WEST—Who is doing the choosing?

Dr Graham—Between?

Senator WEST—You are talking about brand names. Who is doing the choosing? I hope the prescriber is doing the choosing on the basis of the best clinical drug they wish to prescribe for their patient's condition, taking into account their patient's idiosyncratic reactions to various chemicals, compounds and other things.

Dr Graham—The prescriber can do that. Therapeutic group premiums introduce a price signal, so the prescriber is considering cost and appropriate treatment. They are not incompatible considerations.

Senator WEST—Of the drugs that are on the list, I would like you to tell me what the normal dose rate is. How many of them are normally prescribed once a day, twice a day, three times a day or more frequently? Does that have some relationship with cost? Compliance is a major component of successful medication treatment and successful treatment of people by medication. If you have somebody who has to take only one tablet a day, you are more likely to have better compliance than you would with someone who has to take a BD or TDS.

I would have thought that, even if the daily drug had cost more, the fact that you were going to get better compliance would lead you to think that that was the better drug. I am sure Senator Herron would agree that, in endeavouring to get compliance and the best outcome for the patient, a daily drug may well be the better one to be prescribing.

Dr Graham—That is certainly taken into account in the groupings of the drugs. We have sought advice from various groups, including the PBAC. That is how the drugs are being grouped together; on the basis of that sort of consideration.

Senator WEST—I know that, with ACE inhibitors, Prinivil and Zestril are daily medications, Capoten is given three times a day and Renitec is given twice a day. I do not see that there is a grouping together there.

Dr Graham—These drugs have entered the PBS largely on the basis that they are proving their sameness to the comparator drug within the scheme. The company has shown to the satisfaction of the PBAC—and this is the clinical evidence they provide—that the drug is equally effective and cost effective on a cost minimisation basis. They put up arguments on exactly the point you are raising: whether or not taking a drug three times a day produces better compliance and therefore produces a better health outcome than taking a drug once or twice a day. That is taken into account when the drugs are listed.

Senator WEST—Have the groupings of the drugs been finalised? Are there only going to be the five groups in the therapeutic grouping program?

Dr Graham—Yes.

Senator WEST—How were they decided? I am quite happy for you to take that on notice because I am conscious of time. What wider consultation took place with the health professionals, particularly with ACE inhibitors, beta-blockers and calcium channel blockers? What consultation took place with physicians, cardiologists and those people?

Dr Graham—Do you want me to take that on notice now?

Senator WEST—Yes, I am quite happy for that to go on notice. I do not know whether Senator Forshaw has asked about what method will be used to determine the reference price and how some of the benchmarks will be conducted. Will there be any room for exemptions from the therapeutic groupings?

Dr Graham—Yes, there will be. Do you mean drugs or patients?

Senator WEST—Patients and drugs.

Dr Graham—The groupings have been decided on the clinical input, so they are clinically appropriate. In terms of idiosyncratic needs of individual patients, there is an exemption mechanism that is being developed, and that will be around the authority system. The reasons for an exemption still have to be finalised, but it would be like a normal authority restriction under the pharmaceutical benefits scheme.

Senator FORSHAW—This is the system where doctors can apply for an exemption for the patient. Is that correct?

Dr Graham—Yes.

Senator FORSHAW—According to the press release by the parliamentary secretary, the details of that special authority process will be available by the end of the year. Can you be more specific?

Dr Graham—Yes. We will be asking the advice of the PBAC, which advises on all authority restrictions, at its meeting in early December—I think it is 4 and 5 December. If people have submitted to us suggestions about how that authority might work, we will be placing that before the PBAC.

Senator FORSHAW—I have to reiterate the point that Senator West made, and that is that this is really cutting the timing fine if the process is not going to be resolved until the end of this year. The new system comes in from 1 February. That does not leave a lot of time for medical practitioners to sort out who they are applying for exemptions for and talking to those patients, particularly given it is at holiday time. Can consideration be given to delaying the start date from 1 February? You will probably have to take that on notice. It is more a question for the government to consider, I suppose. What is the method for doctors to apply for an exemption? Do they have to write in or do it over the phone? What is the system?

Dr Graham—It is anticipated that they will need to put in a written request to exempt that patient, and that will be handled by the HIC.

Senator FORSHAW—All the more reason for having a look at the start-up date, I would have thought. What about elderly patients? Are there any special exemptions for elderly patients who have been used to a brand name for some time and may be confused and worried about these changes?

Dr Graham—We can take that type of suggestion to the PBAC. Brand premiums are still a choice for the patient. If they choose to take the higher priced brand, they do not have an exemption or exception from the brand premium.

Senator WEST—What advice can you give to doctors who might have somebody walk into their clinic today with hypertension and needs to commence treatment? What advice can you give them as to what they should be prescribing?

Dr Graham—We will be starting the program primarily towards the doctors, because I agree with you that they need to have this information as early as possible so they can start to realise what their treatment choices are. It is still completely their choice, but this is just introducing another price signal that they will need to take into account.

Senator WEST—Given that one of the side effects of the anti-hypertensives for a number of males is impotence, and given the huge increase that we are seeing in male sex clinics offering to cure impotence even in patients with hypertension and diabetes, I wonder how many more people we are going to see fronting up with Medicare claims on the male sex clinics for cure of their impotence when it could have been cured more cheaply by changing their anti-hypertensive. They cannot afford to change their anti-hypertensive because they are

on a very low income, but they can afford to go to a male sex clinic and be bulk-billed and treated that way.

Dr Graham—Is that a question?

Senator WEST—Yes. I am wondering if anybody has considered it. There is a significant medical question there.

Dr Whitworth—That would be true if they were changing from one class of drugs to another, but it should not be a particular problem within the specific class of drugs. I think it would have been more relevant in relation to the beta-blockers, but I think with the ACE inhibitors and calcium channel blockers it is unlikely to be a big problem.

Senator WEST—But it still can be an idiosyncratic reaction by an individual to any drug, particularly in those groups and particularly for the treatment of that disease.

Senator FORSHAW—I have asked you to have a look at that list. Is that the complete list?

Dr Graham—That is the full list. There are a couple of new drugs coming into the scheme which were applications to the PBAC since the list was developed. I cannot announce them now, but there will be a couple of new entries.

Senator FORSHAW—Perhaps you could provide us with that information when you are able to, and I might get my list back. Could we formally have that tabled?

Senator WEST—When you are working on the list, could you also give an indication of when those particular drugs came on to the market and link the relative newness of the drug—and therefore the more efficacious it is—with the price as well?

Dr Graham—I am not sure if newness and efficaciousness is a correlation.

Senator WEST—I am not sure whether newness and price is a correlation, but I would like to find out and that is one way that I can see of doing it.

Senator FORSHAW—Can you provide a list detailing any drugs which cannot be taken in conjunction with the drugs that appear on this list?

Dr Graham—We can do that. There are certainly drug interactions with just about any drug. We are talking about drug classes—

Senator WEST—No, I am talking about individual drugs, because there are different interactions between some drugs and there are also different side effects with some of those drugs; not the class of the drug but the individual drugs. I have had cardiologists say to me that a drug like Isoptin is the cheapest but can cause constipation and also a slow heart rate. If you get a slow heart rate you can also get sudden death. That is one of the calcium channel blockers. There are no recognised side effects with some of the others within that particular category. What do I say to my cardiologist?

Dr Graham—That that was considered and verapamil was excluded from the group.

Senator WEST—Sorry?

Dr Graham—Verapamil, which is the drug—you are talking about a brand name—is not included in the calcium channel blocker group.

Senator WEST—He tells me he thinks it is a calcium channel blocker. So not all calcium channel blockers are going to be on that list?

Dr Graham—That is what we said from the start; that it relied on clinical advice as to what was appropriate to group within those groups. This is the outcome of that process. Verapamil, as an example, for some of the reasons you have stated, was not included.

Senator WEST—So you only have half of the calcium channel blockers in?

Dr Graham—There are three calcium channel blockers in the therapeutic group. That is subject to therapeutic group premiums.

Dr Morauta—I would like to go back to Senator Forshaw's question and clarify what you are asking for, because it sounded on the large side. It sounded to me like it was the interaction of any of the drugs on this list with any other drugs.

Senator WEST—On that list.

Senator FORSHAW—That is right.

Dr Morauta—On the list?

Senator FORSHAW—No, what I was after was a list of drugs which cannot be taken in conjunction with any of these drugs that are on the list. In other words, are there ones that, one would assume, should get an automatic exemption? The issue is: if a patient is having to take a particular drug for another purpose, would they be required to go to a different drug on this list which would cause an interaction? What I am after is a list of drugs that specifically cannot be taken in conjunction with any of the drugs that appear on the list of therapeutic group premium drugs.

Dr Morauta—So you are not looking for the class effect; you are looking for drugs that specifically cannot be taken with one formulation but can with another in that class?

Senator FORSHAW—Yes.

Senator WEST—It would not be quite in *MIMS* but it would certainly be in some of the—

Dr Morauta—We can do that. I was just getting the question clear.

Senator FORSHAW—I would like to deal with a couple of issues to do with consultation. I know we are getting very close to time here. What consultations have the government or the department had with the College of Psychiatry, with cardiologists, with medical authorities with regard to their use of drugs for ulcers, gastroenterologists—the groups within the medical profession and the colleges that would have a specific role in respect of the uses for which these drugs are prescribed?

Dr Graham—I took that question on notice earlier from Senator West.

Senator FORSHAW—Did you? I am sorry. If you are going to provide that, that is fine. In that announcement from Mrs Worth on 10 October, four drugs were excluded from the TGP arrangements. Do those exclusions affect the savings that were expected from this measure?

Dr Graham—They would have some effect. Our anticipation would be of the order of \$10 million over the four years.

Senator FORSHAW—How much?

Dr Graham—Ten.

Senator FORSHAW—Ten million dollars over four years?

Dr Graham—Yes.

Senator FORSHAW—My last question, other than the couple of questions I want to put on notice, is: which companies have approached the minister or the department expressing concern about the effects of this policy on the pharmaceutical industry in Australia? Can you provide details of that? Also, have any of those companies raised concerns about loss of jobs or loss of investment as a result of these changes? If you can tell me now, fine, otherwise you can take it on notice.

Dr Graham—It would be easier to take it on notice.

Senator WEST—I will put on notice a number of questions in relation to the question that Senator Forshaw asked last time about the Australasian Pharmaceutical Manufacturers Association and the report that was done by Gross and Fortescue. I do not think we have received back from you your considered point of view.

I have some more questions on drugs. With regard to terbinafine and onychomycosis, to say that dermatologists are not happy is putting it fairly mildly, is it not?

Dr Graham—We have had letters from dermatologists. I think of the order of about 12 or so dermatologists have written to us, expressing concern about the delisting of terbinafine.

Senator WEST—What do you think of the arguments that the College of Dermatologists and professors of dermatology have made about the relative efficacies between terbinafine and griseofulvin?

Dr Graham—It is a difficult issue because the debate has not really been around the effectiveness of terbinafine. It is acknowledged as a more effective drug than griseofulvin. The PBAC, coming from the PBAC point of view, has a dual responsibility to consider not only effectiveness but also cost effectiveness. The difficulty with terbinafine is that it has been extremely difficult to control under the pharmaceutical benefits scheme.

Senator WEST—What about with the use of authorisations and mycological diagnosis?

Dr Graham—That has been tried. From when it was first listed, this drug was very closely monitored. Over a period of time we have had concerns expressed to the government from the PBAC and also the drug utilisation subcommittee. It started off as an authority drug and it had to be dermatophyte proven. The response from the company to that was to supply all GPs—or many GPs—with a kit. There were a number of expressions of concern about that kit producing false positives.

When we tried to further tighten the authority, we were threatened with legal action from the company, so it has been a very aggressive company in the marketplace with terbinafine. It has been an experience where the growth has probably gone to about five times what was estimated when it was first put on—and that is through the cost-effective route. We feel that is largely because it is an extremely difficult drug to control through the authority system.

Senator WEST—There are gradations of the authority system. There are drugs that can be given out only by people with certain qualifications and specialty qualifications, plus the mycological identification. I asked you last time, particularly in relation to people with diabetes or HIV or who are immunologically compromised, whether you would consider looking at some way that that group could access this drug. Has anything been done about that?

Dr Graham—To answer the first part of your question, in terms of the authority restriction, the PBAC did consider whether they could restrict it to severe onychomycosis. That was very difficult to apply in the marketplace. That is very much a subjective decision.

Secondly, the government has always had problems in restricting drugs, particularly drugs like terbinafine, to just a subgroup of medical practitioners. The AMA, for instance, is very much opposed to that sort of differentiation. There is nothing to stop either a medical group—the dermatologists, for instance—or the company putting in a submission to the PBAC to consider terbinafine for a more restricted usage in terms of a patient group. That would require it to go through the normal route of evaluation of its effectiveness and cost effectiveness. But, at this point in time, neither of those parties have done that. But that is a process that could occur.

Senator WEST—They have certainly written to you. Have you had any consultations with the college and with some of the professors of dermatology?

Dr Graham—I have not personally. There has been correspondence going backwards and forwards—

Senator WEST—Have they been offered that alternative?

Dr Graham—It has been indicated that that is an alternative. I am not sure to which specialists specifically that has been indicated, but certainly groups that have contacted the department have been aware of that facility and, as I said, there are no barriers to a company or a professional group—

Senator WEST—I am not particularly interested in what the company might have wanted to do. I was thinking more in terms of the medical side of it, so that it is actually medically driven and driven by professional expertise and professional decisions that have been made by the professions on medical grounds.

Dr Graham—Quite often with the evidence based process that is used, they do need access to the drug company data to prove their point. It certainly could be an opinion by a specialist that this drug would be suitable for a diabetic, for instance, and there might be some literature reports around that. But they might need to join forces with a company to get the degree of information that might show that that is cost effective.

Senator WEST—Dr Graham, I would have thought, from the correspondence that you have had—because it has been copied to me—that you would have started having consultations with some of these groups. The points the colleges and the specialists are making are fairly powerful.

Dr Graham—I think the difficulty of controlling terbinafine has been well known for a long while.

Senator WEST—Yes, and they recognise that.

Dr Graham—That has been something that is quite public. As I said, we have not set up any barriers to people making submissions to the PBAC to consider that case, and I think that has been apparent to the dermatologists. I did not attend the last Senate estimates, but we had received no letters from specialists when I attended at the estimates before that.

Senator WEST—That was June. By August the story was different.

Dr Graham—Yes, we started to receive letters. Those letters followed something of a pattern, so I suspect they had received the message that the government had not received indications of concern. In the process it has been made very apparent to the profession that there is an opportunity to put up a case, but it has to be an evidence based case.

Senator WEST—I am gravely concerned. I am concerned about the overuse, yes, I recognise that. But I am concerned about specific groups of patients: those with diabetes; those who are immunologically compromised, such as your HIVs; even your people who are on chemotherapy and things like that. The last thing that those people need is a possible route for them to get a superimposed bacterial or fungal infection. They are very susceptible to it, as most people here would know. I am concerned that it seems to be taking such a long time to actually get some resolution to what I consider to be a critical problem in this area. I will ask again: will you please make it very clear to those involved that they do have this route to travel down and that in fact there should have been discussions taking place also with people like Diabetes Australia, because they represent the sufferers of diabetes? I will renew my plea and I will ask questions about it next time. I am also looking for some questions I

had on benchmarking in relation to the diabetic test strips, and I will put those on notice when I find them. That is all of my questions. Thank you.

Mr Podger—Madam Chair, in program 7 we actually have some errors in our annual report on some staffing numbers. I would like to table the amended figures for the committee.

CHAIR—Fine. I advise you that written questions have been placed on notice by Senator Forshaw on programs 1, 2, 3, 6 and 7, by Senator Gibbs on program 2 and by Senator West on program 2. Thank you, Minister, Mr Podger and all the officers for your attendance. I thank Hansard, the secretariat and senators. The meeting is closed.

Committee adjourned at 12.38 p.m.