HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Concession card availability and eligibility for concessions

CANBERRA

Tuesday, 3 September 1996

OFFICIAL HANSARD REPORT

CANBERRA

HOUSE OF REPRESENTATIVES STANDING COMMITTEE
ON FAMILY AND COMMUNITY AFFAIRS

Members:

Mr Slipper (Chairman)
Mr Quick (Deputy Chairman)

Mr Ross Cameron	Mr Kerr
Ms Ellis	Ms Macklin
Mrs Elson	Mr Allan Morris
Mr Forrest	Dr Nelson
Mrs Grace	Mrs Vale
Mrs De-Anne Kelly	Mrs West

Matters referred for inquiry into and report on:

The current array of concessions available to low income Australians, with specific reference to :

the adequacy and efficiency of administration of the current system with a number of concession cards issued by different agencies, including the use of concession cards to provide concessions by Commonwealth, State and Local Government agencies;

the adequacy and desirability of current means testing for eligibility for concessions; and

the desirability of greater consistency in the concessions available to concession card holders in different regions and suggestions on standard core concessions.

WITNESSES

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Concession card availability and eligibility for concessions

CANBERRA

Tuesday, 3 September 1996

Present

Mr Slipper (Chairman)

Mr Ross Cameron	Mr Quick
Ms Ellis	Ms Vale
Mrs Elson	Mrs West
Mr Forrest	

The committee met at 9.04 a.m.

Mr Slipper took the chair.

CHAIRMAN—I am pleased to open this first day of public hearings of our inquiry into concession card availability and eligibility for concessions, as referred by the Minister for Social Security, Senator Jocelyn Newman, in June this year. Under our committee system, committees can investigate reports of departments handed down during the period of our existence, and we can also investigate matters referred to us by responsible ministers. The committee is looking at several matters, including the range of concession cards currently available; the level of access to these concessions; the complexity of the administration of the current system both for recipients and for those delivering services; as well as how state and local governments are using the cards with the delivery of their own concession services.

This inquiry is being conducted against the background that the government has a commitment to reducing administrative complexity of the current arrangements, in order to improve and simplify the administrative process. The committee will address express concerns that some people may be using a concession card which they are no longer entitled to or which was not issued to them. The terms of reference for the inquiry also require the committee to examine the current means tests for concession eligibility and the degree of consistency applied in different regions of Australia.

To date, we have been very pleased with the response to our advertisements. We have received a total of 36 submissions from a range of organisations and individuals with an interest in the inquiry. I would like to take this opportunity publicly to thank all of those who have made a contribution and whose cooperation has greatly assisted our efforts to come to grips with the complex issues being considered by this inquiry.

The committee, in commencing its round of public hearings in Canberra, will take evidence from major Commonwealth departments and agencies and a peak consumer organisation and industry group based here in the Australian Capital Territory. It does not mean that we take the view that evidence from Canberra is more worthy than that from other places, and we will have a hearing program which will continue later in the year in Adelaide, Melbourne and Sydney, with the remaining capital cities to be covered next year.

This schedule will enable a consideration of issues raised by witnesses around Australia and a more specific focus on gaps in evidence identified to date. For this reason, the evidence to be given today will provide the basis for the initial exploration of the key issues and will assist in preparation for the further hearing program. However, before we proceed, I would seek leave of the committee to authorise publication of submissions Nos 19 to 36 in connection with the inquiry of this committee. There being no objection, it is so ordered.

PHILLIPS, Mr Michael, Director, Concessions and Allowances Section, Special Payments Branch, Department of Social Security, Athllon Drive, Tuggeranong, Australian Capital Territory

WINZAR, Ms Peta, Assistant Secretary, Special Payments Branch, Department of Social Security, Athllon Drive, Tuggeranong, Australian Capital Territory

CHAIRMAN—I now call witnesses from the Department of Social Security to be sworn in. Welcome. As you would understand, at all public inquiries of parliamentary committees, everything you say is being listened to and being taken down and will be produced as evidence. The committee has already authorised the publication of your submission in volumes of submissions in connection with the inquiry, and your submission has also been circulated to all of our members who are attending the inquiry this morning. I dare say that all of us have read your submission very closely. Would you wish to make an opening statement before we commence our questioning? You may want to tie the submission together or summarise it.

Ms Winzar—Thank you; we will. As outlined in our submission, the original purpose of the concession card regime was to give pensioner cardholders and their dependants access to free pharmaceuticals under the Pharmaceutical Benefits Scheme, and associated free hospital treatment. That has since been overtaken somewhat by the introduction of Medicare and subsequent changes to the Pharmaceutical Benefits Scheme which have seen the introduction of concessional rates of pharmaceuticals for pensioners holding cards. Associated with that, a co-payment was introduced a few years ago. State and territory governments use the cards as a de facto way of accessing their own concessions or those provided by local government or, in some cases, private providers. Collectively, these concessions are sometimes known as fringe benefits.

We outline in our submission a short history of concession cards. The first one was introduced for pensioners in 1951, which was some time ago. Since then, there have been a range of changes to eligibility conditions for cards and the type of income support payments which give rise to one card or another. One of the most significant changes that has been made in recent years has been the extension of pensioner concession cards to part-rate pensioners, and that was introduced in about 1993 in response to a lot of pressure from customers on part-rate pensions, who felt that they were doing it tough, if you like.

That change was subject to extensive negotiation between the Commonwealth and the states and territories about the impact on the states and territories of extending the concession card to the broader group of part-rate pensioners. As part of the agreement between the states and the territories, the Commonwealth agreed to make a specific purpose payment to partially compensate the states for the provision of core concessions to that wider group.

One of the other signal changes was the introduction in 1982 of a card for low income people who are not in receipt of social security payments, under what is known as

the disadvantaged persons scheme. The income test for that particular payment is structured so that it allows people who have incomes just above the cut-out point for Jobsearch Allowance to qualify for a card. There are obvious benefits there to the government in terms of reducing disincentives to take up work, because people get worried about the lack of access to concessional medicines, et cetera.

Another signal change which has happened in recent times was the introduction of the seniors health card in 1994. That was, again, targeted at low income non-pensioner retirees, and it only gives them access to Commonwealth health benefits. Most of the states and territories do not recognise that card for the provision of any additional concessions. The income cut-out point for that is such that the person would otherwise qualify for a pension but, for some reason, they do not. Usually, asset holdings bar them from the pension.

We had some difficulty in preparing this submission in trying to identify for the committee the annual cost of concession provision across the country from all levels of government. Our best estimate is about $4 billion, so it is quite a large contribution. The basis for that estimate is some work which was done in 1992-93 with a Commonwealth-state working group. The group estimated at that time that there was almost $3 billion in concessions going to pensioners alone.

In terms of the individual cardholder, the value of a concession card can vary quite a lot, depending on their health and on whether they are a home owner or whether they own a motor car, et cetera. Our estimates are that the average value of a concession to any particular pensioner, under the pensioner concession card arrangements, is probably $1,100 to $1,200 per year.

The Department of Social Security at the moment issues four cards: the pensioner concession card, which I have spoken about; the Health Care Card, which includes Health Care Cards to income support recipients and also Health Care Cards under the disadvantaged persons scheme; a Health Benefit Card, which is at the moment issued to sickness allowees for the period covered by their medical certificate; and the seniors health card. It was announced in the budget that, from July next year, the health benefits card to Sickness Allowance recipients will be abolished and those customers will instead be issued with a Health Care Card, which will give them just about the same range of Commonwealth health benefits and, in most states, access to the same range of state benefits as well.

In terms of the range of benefits available to individual cardholders, I have mentioned that the Commonwealth benefits are pretty much standard across the range of cards, and they are certainly uniform across all parts of Australia. The range of benefits available to people from state or territory governments varies quite considerably, depending upon which state you happen to be in. But all states provide the core concessions for pensioner concession cardholders—lower fares on public transport; lower

property and water rates; some discount on energy bills and motor vehicle registration charges. Although that is reasonably uniform, the way those concessions are delivered again varies from state to state. Sometimes it is a rebate on a bill; sometimes it is a proportional rebate or a waiver of all or part of the fees. There is quite some difference there.

The legislative framework for issuing concession cards reflects the original purpose of those cards and, as a consequence, the authorising legislation is in the health acts, except for the Commonwealth seniors card, which is in the Social Security Act. There are some other Commonwealth acts which extend concessions to people such as the Hearing Services Act and the Postal and Telecommunications Commission (Transitional Provisions) Act. State and territory governments, of course, have their own enabling legislation which is more or less in synchronisation with the Commonwealth legislation.

Our submission did discuss briefly some aspects of the efficiency of the current system of card administration. Social Security itself has estimated that we issue around about 11 million cards a year to social security recipients and low-income earners. We believe there are four key issues to be addressed in assessing the efficiency of the system. The first one of those for us would be whether the process of assessing entitlement and issuing cards is efficient; whether the control of fraud in the concessions area is effective; whether it is efficient to spread administration for concessions across three Commonwealth portfolios, those key ones being Health, Social Security and the Department of Veterans' Affairs. The final issue for us is whether, from a state and local government perspective, it is efficient or effective to allow the Commonwealth to identify those low-income earners who should be accessing concessional assistance.

We also had some difficulty in trying to estimate for the committee the administrative cost to DSS of administering concession cards. We have provided some information about the cost of issuing them in terms of printing, postage et cetera. But the staff workload in assessing entitlement is a bit more difficult for us to quantify. One of the reasons for that is that the cards for most people derive from the assessment of their initial income support entitlement. Once we have assessed them for a pension, if it is granted the card entitlement flows automatically. There are some additional workloads associated for us with renewal of cards, replacement of duplicate cards if somebody loses their card, and so forth.

Our cost of issuing cards we estimate at around about $3 million a year. But that, as I have indicated, is just a fraction of the cost of processing.

There are some groups of income support recipients who do not receive a concession card automatically by virtue of their income support status. The largest group of those is Austudy recipients. Those customers at the moment are required to provide income details and asset details to the Department of Employment, Education, Training and Youth Affairs for their Austudy entitlement and then they have to provide very similar

information to the Department of Social Security if they wish to get a low-income concession card.

Other groups that are in a similar situation include those on CDEP communities—the work for the dole schemes—who also must apply separately for a Health Care Card because CDEP payments are not regarded under the health legislation as an income support payment per se.

We make the point in our submission that efficient card administration systems must balance frequency of card issue and the costs of that against the prospect of somebody who is not entitled to a card any longer still having possession of a card and using it. Each income support payment has a different frequency of card issue. Pensioner concession cards and seniors health cards, for example, are issued every 12 months. That, in part, is based on the fact that pensioners' financial circumstances do not change particularly frequently so we have some reasonable guarantee that—apart from death, which would be the major risk factor there—most people will continue to have their entitlement for 12 months.

Jobsearch allowees and special beneficiaries, for example, receive their Health Care Cards for a 12-week period and every 12 weeks they receive another card if they have a continuing income support entitlement. Some other periods of card issue are for Drought Relief Payment recipients and people receiving cards under the disadvantaged persons scheme, and they receive their cards for a six-month period and then are required to renew.

We gave some thought to the prospect of reducing the number of cards to simplify administration, both for customers and for concession providers. As I have already stated, during the budget it was announced that the Commonwealth Health Benefit Card will be abolished from July next year. That will reduce the number of social security cards to three but, of course, there are still a couple of others from the Department of Veterans' Affairs that you will hear about later.

We believe there are some prospects for reducing the number of cards that are issued to people, but they perhaps require quite a radical rethinking of the basis on which we assess card entitlement at the moment. We do know that there are some cases where the social security system issues duplicate cards to people for reasons other than that the person has lost them. One of the events that gives rise to that is when somebody moves from one payment to another.

At the moment, for example, if somebody moved from Jobsearch Allowance to mature age allowance, when they got to their mature age allowance grant point, they would be issued with another card. Our system has some mechanisms in place to try to prevent that by looking at the expiry date of the original card and saying, 'Well, we won't issue the new card until the old one has expired.' But that is a less than perfect system at

the moment. We have some major computer enhancements under way which should be in place perhaps late next year, which will put all of our systems on a common platform and that will mean that that problem will no longer arise.

In terms of effective control of fraud in the concession card area, there are a couple of key fraud control aspects that I would like to draw your attention to. The first, of course, is that because the cards on the whole derive from somebody's income support assessment, the fraud control mechanisms that are in place for income support assessments also apply to cards. Things like establishing somebody's identity by requiring different documentation from the customer, or verifying their income through data matching or through looking at somebody's bank account, et cetera, provides the up-front basis for fraud control in that sense.

Even for those cards which do not necessarily hang off an income support payment, such as the disadvantaged person's scheme low income health card and the Commonwealth seniors card, customers are still required to provide proof of identity and proof of income before they can access the cards.

Once the cards have been issued to the person, there are a couple of other key fraud control mechanisms that are run by this department. The first one of those is that the department transmits daily data to the Health Insurance Commission to enable it to verify entitlement to pharmaceutical benefit concessions. The sort of information we pass to them includes the start date of somebody's entitlement, whether it has been cancelled, and any changes to the number of dependent children or dependent partners that that person has.

The department also runs a Client Confirmation Service for state and territory governments and local governments which wish to use it. It is based on a computer tape exchange, which enables those organisations providing concessions to verify that, for example, Peta Winzar is still a current pensioner of the Department of Social Security and is entitled to a rates concession.

Over the last few years, the number of organisations wishing to use that service has certainly increased and in some states, for example, local government authorities have been asked to verify four times a year that somebody is still entitled to a rates concession, so they would match quarterly with our records. It is, of course, a voluntary arrangement and we ask clients to give their approval for us to match that data with the other authorities.

We have an estimate that less than 0.01 per cent of clients refuse to have their information matched. You can understand that it would be reasonably attractive to most customers to do so, because it saves them having to get a letter from DSS saying, 'Yes, this person is a current customer' and then take it physically into the electricity authority or the local council.

CHAIRMAN—Ms Winzar, I am just wondering how much longer your opening statement will take. We appear to be up to about page eight of a 25-page submission.

Ms Winzar—Probably about five minutes. Most of the rest of it we have covered already in brief, but I will speed it up for you. In terms of fraud control, we do believe there are some things which the department can do to improve fraud control. I guess the Rolls Royce model would be to go to an on-line customer confirmation arrangement which would allow very speedy updates of client data instead of quarterly tape matching, for example, to local authorities and state governments. We believe that we can do some presentational changes to the cards to highlight expiry dates, or colour-code them, for example, to alert concession providers to the fact that the person is or is not entitled.

There are some areas, and no doubt you will explore these further in your discussions with states later on, such as transport concessions which is an area which is very hard to police in terms of fraud. It is also a very large area of expenditure for state governments in terms of concessional provision.

In terms of other aspects of the efficiency of the arrangements at the moment, we believe that the arrangements would be improved if Commonwealth legislation for concession entitlements was consolidated not in the health legislation but in the Department of Veterans' Affairs portfolio and our portfolio legislation from which it most closely derives.

In terms of the adequacy of the current means testing arrangements, I have given you a brief description of the seniors card and the Commonwealth Health Care Card system for low income earners and where those income cut-out points are pitched. We believe that those two cards could benefit from some review. The Health Care Card income test is based on measuring somebody's income over a four-week period before they claim. If granted, they keep their entitlement for the subsequent six months. We ask clients to tell us if their income goes up by 25 per cent, but it is very difficult to ascertain whether or not in fact that has happened.

That particular form of income testing does not exist anywhere else in the social security system. Most other income tests measure income over a much longer period to give you a better idea of the longer trends in income and to avoid people manipulating their income by, for example, reducing overtime during the four-week period that they wish to have their income measured. We believe that needs further investigation. We would also suggest that perhaps the Commonwealth seniors card is not as well targeted to low income retirees as it could be. For example, the cut-out point is around about $30,000 for a married couple who have sufficient assets not to qualify for pension. I guess there is a question there about whether or not that is appropriate.

In terms of uniformity of concessions across Australia, I have touched on some of the differences in concession provision. There are some immediate alternatives to make

concessions more uniform across Australia, and one of the obvious ones would be to cash out concessions and add that money on to somebody's income support payment. The difficulty with that is that it takes an average approach and consequently can overcompensate some people—for example, those that are in good health, those that do not have a home, or those who do not have a car—and it can undercompensate some other groups who have particularly high needs of assistance in some areas.

We have some suggestions that the greatest demand for concessional assistance, the greatest benefit received, is from those who are long-term income support recipients. So, rather than providing concessions to those in their first 12 months on income support payments, assistance might be better targeted by pitching it at those who are long-term recipients.

CHAIRMAN—I think the five minutes is up now. We are on a fairly finite time schedule. I understand that it is the practice of the committee to get certain departments back after we have taken evidence in other parts of the country if we need clarification or some further information.

It seems to me that in the early 1950s the government of the day decided that it would be a good idea to bring in some assistance to pensioners initially, and from then this scheme has grown like topsy. I was somewhat attracted to your suggestion to cash out the benefits if one could calculate what it cost the Commonwealth on average for each person and then if benefits could be increased. Of course you would still have the Pharmaceutical Benefits Scheme and the ordinary Safety Net there which would assist those people. The other alternative, it seems to me, is maybe having only one card because, as you point out, most of the benefits under the range of cards from a Commonwealth perspective are essentially the same. There are variations, but the core benefits are the same. Do you have any comment to add on those two matters?

Ms Winzar—Taking the first issue of the benefits of cashing out, it would be simpler; it would not provide the main security that the card arrangements do at the moment which is to allow people to cope with 'lumpy' expenditure, if you like. Some of the work that was done by social security a couple of years ago by a group called Ageing Agendas, which were looking at retirement incomes generally, asked pensioners whether or not they would be willing to have a cash payment instead of their concession card of perhaps even two or three times the card's value. The overwhelming response was no, that the main value for people of the card was a reduced electricity bill or a reduced rates bill which otherwise would be very hard for them to manage. So I guess, although there are some definite attractions to cashing out, there are also some attractions to delivering a concession at point of need to the person who needs it. I guess a cashed out mechanism is a very blunt instrument for helping people.

In terms of the single card, from the Commonwealth perspective I believe that would be quite useful because of the similarities of concessions, and I believe we could

perhaps work to make those Commonwealth concessions more similar. The states would, I guess, be likely to insist on some identifier on the card to indicate the person's underlying income support payments so that they could target their concessions. For example, in some states you can only get a transport concession if you are unemployed, and it is designed, obviously, to help people who are out there looking for work. But if we could do that then, yes, that is feasible.

Mr QUICK—If the responsibility for aged care rests with the states, are we going to be in a bigger mess than we are at the moment?

Ms Winzar—I do not know that I am in a position to comment on that. Do you mean in terms of inequality of concessions across states?

Mr QUICK—That is right, across states. Who would monitor the fact that there is equity right across the country? The concession card holders?

Ms Winzar—The Department of Social Security has a role at the moment in monitoring the uniform provision of concessions across the states. Basically, it is up to the states themselves to move to uniformity where they can. But I guess the other comment I would make about uniformity is that there are some obvious differences between, for example, the needs of a pensioner in Victoria in terms of electricity or heating concessions and somebody living in the Northern Territory. It is hard to work out the extent to which concessions in one state or another balance each other out.

Mr QUICK—Conversely, you could say that the people on pensions in the Northern Territory might need solar heating, which is a lot more expensive, than people who live in Melbourne.

Ms Winzar—Yes.

CHAIRMAN—It seems to me also that there are a number of departments with their fingers in the pie on these things. What savings to the Commonwealth would result from a change which would see one department being solely responsible?

Ms Winzar—That is not something I could really tell you off the top of my head. I guess we could have a think about that with our colleagues from the Department of Veterans' Affairs and see if we could provide the committee with some further information on it.

Mr QUICK—Would you have a suggestion as to who might be the best body? Should it be the Health Insurance Commission, because most of them are related to some form of benefit to do with health or disability?

Ms Winzar—Most of the benefits provided by the Commonwealth, I guess the

overwhelming number, would be Pharmaceutical Benefits Scheme concessions. The difficulty with passing responsibility to the Health Insurance Commission solely would be that the expertise in terms of income assessments lies with the Department of Veterans' Affairs and the Department of Social Security.

CHAIRMAN—What sort of relationship does your department have with other Commonwealth departments whose clients are issued with concession cards? We are talking about perhaps having one department responsible. But with the number of departments currently involved is there good coordination across departmental lines?

Ms Winzar—We communicate pretty frequently with the Health Insurance Commission and the Department of Veterans' Affairs on concession matters. Broadly speaking, I think the coordination is fairly good. There are some obvious difficulties in that, although there are a lot of players with fingers in the pie, there is at present no one driver at the Commonwealth level.

CHAIRMAN—We have had some evidence before the committee that the concessions provided by local councils have decreased over the last few years, particularly since the extension of eligibility for the Pensioner Health Benefit Card in 1993. At the time, the Commonwealth agreed to compensate the states and territories for extending concessions to the wider group now eligible for those concessions. Can you tell us what action has been taken to monitor state and territory governments' compliance with that agreement, and does that agreement also extend to concessions provided by local councils?

Ms Winzar—I guess there are a couple of observations I would make there. We do ask each year that the states advise us that they are, in fact, providing concessions to that wider group, as in that 1993 agreement between the states and the Commonwealth. In terms of monitoring the precise amount or proportional rebate that is provided to concession card holders we do not have that role. We ask the states to monitor their own provision, and that of local government. There is one point, though. Apart from the core level of concession on rates, some local councils have additional concessions which they offer to maximum rate pensioners, for example. That is over and above the base level of agreement between the states and the Commonwealth. If they chose to do that, or if they chose to withdraw it, that is entirely a matter for them.

Mr QUICK—Following on from the Chairman's question, should there be an Australian citizen entitlement? We are dealing with people who are classed as either Queensland citizens or Tasmanians. Shouldn't there be a national entitlement that is transferable across the states, for all these concessions? It would make things a lot simpler: X number of rail entitlements, X number of cuts in local rates, and whatever it might be. There would be less uncertainty and fewer hassles.

Ms Winzar—Certainly that would be a great improvement for customers. I guess that with rates, for example, one would seek to have a proportional rebate applied—say,

20 per cent off the rates bill—rather than a flat rate amount, because otherwise you would disadvantage, say, somebody in Sydney who paid an extremely high rate bill versus somebody in your own state.

CHAIRMAN—Some local councils in Queensland recently declined to give any pensioner rate remission on the basis that it places a burden on other ratepayers. If the Commonwealth is supposed to compensate local councils are these councils misguided?

Ms Winzar—I think that is an issue that they would have to take up with their state governments in terms of recompense for the rate rebates that they provide. It is certainly not one I have heard before.

CHAIRMAN—Are there any other questions?

Mrs WEST—You mentioned that there were 11 million cards issued a year. Do you have an age and stage breakdown of who gets those cards?

Ms Winzar—No, unfortunately we do not. We can give the committee some information about what type of income support recipient gets what type of card, but that is about the extent of it. The management information that we hold on card recipients is pretty minimal. We could derive some of that information from looking at the income support populations themselves and saying what proportion of Jobsearch allowees are under 30 or between 30 and 40, for example—if that would be of use to you?

Mrs WEST—Yes, it would be.

Mr ROSS CAMERON—I have a couple of questions. You estimate that it costs $3 million to run the card scheme and that there are about $4 billion worth of benefits out there. Have you got a global figure on what it costs governments—federal, state and local—to run and administer the entire concession process?

Ms Winzar—No, we do not. The $3 million that I referred to earlier is Social Security's cost of printing and mailing cards only. It does not include any of the income or entitlement assessment costs at all.

Mr ROSS CAMERON—Could you calculate that figure and get back to us?

Ms Winzar—Not easily, but we will try.

Mr ROSS CAMERON—If you do not know, for example, the breakdown of the 11 million cards and we do not know how much it costs us to administer the schemes, how do you make decisions about what is an efficient way to manage the resources?

Ms Winzar—Perhaps I can attack that from a couple of different angles. Because

most of the card entitlement derives from the income support entitlement, the additional administrative costs are pretty low. So decisions about assessment would be principally focused on the income support regime rather than on the concession card entitlement. That is the first issue.

In relation to the Commonwealth seniors card and the low income Health Care Card for disadvantaged persons, there are some additional costs on that, but given that the value of those cards is considerably less than for pensioner concession cards to the customer, there is, I acknowledge, less scrutiny of how much it actually costs us to run that scheme. For example, the average benefit to a Commonwealth seniors cardholder might be of the order of perhaps $600 or $700 a year. Health Care Cards would be perhaps about the same.

Mr ROSS CAMERON—If, as you say, a number of the cards flow as a sort of automatic result of classification in a particular low income band, what is the department's experience about the problem of giving people a powerful disincentive to ever move out of that income band? Do we actually run the risk of locking people in psychologically to a lower level of income because of a fear of losing a range of concessions which will flow automatically from moving out of that income band?

Ms Winzar—That is an allegation that is made frequently in relation to pensioner concession cards particularly—that older people do try and rearrange their financial affairs to qualify for a pension. They might only qualify for $1 of pension a week, but they access the card, which is seen as highly valuable to them.

We have not been able to demonstrate or disprove that. We felt that when we introduced the Commonwealth seniors card, for example, we might ease the pressure on people who are trying to qualify for just a very small amount of pension. But there did not seem to be any significant level of movement in rates of pension; there did not seem to be any drop-off in the number of people who are holding a very small amount of pension just so they could get a pensioner concession card. It is an allegation that is made. I do not know, in short.

Mrs VALE—I am particularly interested in people in families with disabilities. Submissions to this inquiry from ACROD and the Multiple Sclerosis Society of Western Australia refer to reduced earning capacity and extra costs incurred by people with disabilities. It has been proposed that income be discounted by disability related costs for the purposes of any income testing for eligibility for concession cards for this particular group. It has been proposed that people with disabilities and families with disabled children receive concession cards irrespective of family income. Would you have any comments to make in that regard?

Ms Winzar—Perhaps one comment I would make about that is that it would be very difficult to have that sort of disregard for disability related costs from income

assessments for cards alone and not apply it to the principal income support payments as well. It would certainly complicate administration quite considerably.

Mrs VALE—So that would be the main deterrent for considering a concession card for people in that situation?

Ms Winzar—The other proposal, I guess, would be to look at automatic issue of a concession card to people who do have a disability of some sort. Off the top of my head, I am not sure how that would interact with the existing Safety Net arrangements under the Pharmaceutical Benefits Scheme which are also there to protect people who have high medical costs. Obviously, that is not the only cost incurred by people with disabilities but that would be one factor to take into account, that there is a Safety Net arrangement there.

Mr FORREST—I am interested in the question about seniors and retirees. I note from table 1 that the Commonwealth Seniors Health Card is available to 11,000 recipients at a cost of $33,000.

Ms Winzar—Perhaps the other way around—a cost of $11,000 to 33,000 recipients.

Mr FORREST—Sorry, I misread that. I am confronted quite often by self-funded retirees who are just on the margins, they are not manipulating anything, they just happen to be there. I am interested in the question but I need to know what the potential costs might be. I am just wondering whether you are able to comment. You have got some handle on numbers and the costs that occur with those. Are you able to help the committee by offering any advice?

Ms Winzar—In terms of a proposal to give a seniors card to all people of retirement age, irrespective of income?

Mr FORREST—Perhaps modifying the income level or the test that controls it.

Ms Winzar—I do not have any information I could give you off the cuff, but again it is something we could take on board and have a look at for you. It would not be a trivial cost, I think you will find.

Mr Phillips—Some indication might be that if the existing seniors card were extended to all people who do not currently qualify for it, the cost would be $100 million plus.

Mr FORREST—I suppose I would be interested in some sort of sliding scale as an adjustment of the means test. I know that some states offer a seniors card and some do not. The availability of access is somewhat limited, but these are people who are worried about their pharmaceutical costs and their health costs. So it is almost an open cheque,

anyway. We have got some figures on what it costs for the others; it seems to be about $400 for each $11 million. If there is some sort of sliding scale of adjusting the means test, to get some feel of what the cost might be, I think there is an equity issue in there that I am quite keen on.

Ms Winzar—The other interesting aspect of the Commonwealth seniors card population is that not everybody who is entitled has taken it up. Our estimate is that there are about 70,000 to 80,000 people who would qualify for a seniors card but there are only about 33,000 current recipients. We have promoted the card through things like Social Security's *Age Pension News*. When we reject somebody's claim for pension, we automatically assess them for a seniors card.

Despite our best efforts, we have been very slowly pushing the numbers of people up. So it seems to me that while you are probably right, that there are some retirees, particularly with high medical costs, who would like access to a seniors card, there are many others who do not take up their existing opportunity for entitlement. I am not sure why.

Ms ELLIS—Going on a little further from that previous line of questioning, I noticed a documentary on the news a few months ago which indicated that there may be a small industry of advisers growing out there in the public, making a bit of money by advising our older people how they can in fact arrange their circumstances so that they can get that sought- after card. Are you aware of any change to the take-up of those sorts of offers with that so-called industry running out there?

Ms Winzar—I am not aware of any increased interest by customers to access those services, but I did in fact see a press clipping yesterday which outlined pensioner concession card rules and seniors card entitlement and then suggested people should go and see an investment adviser. So I know there are a lot of people plugging for the business, yes.

Mr ROSS CAMERON—Do you have an estimate? You talked in your submission about the question of fraud and how we can establish the administrative arrangements to get the best result in that regard. Have you got an estimate on what fraud is costing the Commonwealth in the area of concessions?

Ms Winzar—The cost to the Commonwealth would be fairly low because of the daily exchange of data between the Health Insurance Commission and the Department of Social Security at least. There is always some potential. For example, if we mail a card to somebody who dies and their relatives continue to use it—their spouse or, perhaps, their children—it is very difficult to detect immediately unless that person is accessing pharmaceutical benefits.

In terms of the cost of that, I think that would be very difficult. One of our

problems is that we do not have enough information on who uses concessions and when, either at state or Commonwealth level.

Mr ROSS CAMERON—You talked about on-line verification as a Rolls Royce model. What are the obstacles to on-line verification and what would it cost us to go down that track?

Ms Winzar—In terms of the systems redevelopment work that the Department of Social Security would need, I would hazard a very vague guess here and say it would be of the order of $1 million to produce that sort of system. The most expensive part is not the transmission of data because telephone lines, et cetera, are fairly cheap to put in, but at the other end it would require our concession providers to have compatible equipment to access Social Security's information. We obviously have some privacy requirements that we would have to put in place to make sure that that information was only used for the purpose of accessing entitlement to concessions and not for any other purpose.

Mr QUICK—How can you monitor that? We are about to change. Some Medicare offices in rural and remote areas are about to disappear off the face of the earth and the local chemist might have a 16-year-old girl there who is part-time and does not know anything about the privacy legislation. If Mrs X comes in and she is HIV positive then it is all round the town. What sort of things can you do to monitor something like that?

Ms Winzar—One of the things that we can do is, for example, if somebody comes in to claim a rates concession, they have their rates notice with their name and address on it. We can match that name and address and the information that we might give the council would simply be yes, the person is a current pensioner or no, they are not. We would not give any greater access than that. Likewise, in terms of access to concessional pharmaceuticals, at the moment the person has a card which has their Social Security Reference number on the card. If the chemist could type in the reference number, the response that they might get from an on-line confirmation service would be yes, the person is qualified or no, they are not. That would be the limit of information provided.

CHAIRMAN—The department's submission refers to the abolition of the Health Benefit Card and its replacement with the Health Care Card from 1 July 1997 and the card will, of course, show the cardholder's payment type to enable concession providers to determine eligibility for particular concessions. It has been submitted to the committee that many concession cards deteriorate over time making it difficult to accurately distinguish entitlement details. I imagine you have probably anticipated this problem but have you done so and will you ensure that the individual payment type details on the combined Health Care Card will remain legible?

Ms Winzar—We are having a look at our production technology for Health Care Cards at the moment. I do not know if the committee has seen a Health Care Card but it is basically a light piece of cardboard. It is not particularly durable and if it gets dragged

in and out of a wallet too many times, yes, the print does deteriorate. We are looking, at the moment, at other options such as finely laminated cards which would have a better retention. There is a bit of a balance for us, of course. If they are only current for a 12-week period, we do not want to spend a lot of money on making a highly durable card which is only going to be used for three months.

CHAIRMAN—The pharmacy guild has admitted to the inquiry that the entitlement number on replacement concession cards is often invalid and that consequently pharmaceutical scripts are not reimbursed by the Health Insurance Commission and pharmacists lose income. Is there any evidence available as to the extent of replacement cards being issued with invalid numbers? How could this happen, and why does it happen? It seems grossly unjust that the pharmacist who relies on the information on a card put out by a government department might fill the script and then be out of pocket. It just seems to be a matter of gross inequity.

Ms Winzar—It is not a complaint that has been drawn to our attention so far, but we will certainly have a look at it.

CHAIRMAN—Could you come back to us on that?

Ms Winzar—Yes.

Mr QUICK—If 45,983 HBC people are going to disappear on to the HCC, and you are going to have the same card but with different information, why can't you put the CSHCs onto the pensioner concession card and have something similar? You could have two cards. You are going from four to three; why not go from three to two?

CHAIRMAN—Or one?

Mr QUICK—At least we could make a move to two because you have two different sorts: a pensioner concession card and a Health Care Card. The seniors are basically the pensioners, and you have got two types of people. At least that would be a quantum leap for bureaucracy, surely.

Ms Winzar—I am not sure that it would actually assist either customers or concession providers though because customers would be likely to say,'I have a pensioner concession card, why can't I access the full range of PCC benefits?'

Mr QUICK—But DVA have got DVA cards; you have a red card and a yellow card.

Ms Winzar—Yes.

Mr QUICK—So why can't you colour-code the PCC with just a red strip or a

yellow strip? I would be interested in how much it costs you to put out the 32,982 CSHC cards. What is the—

Ms Winzar—It costs us about $11,000 a year.

Mr QUICK—And what was the cost of the HBC card? Was it exactly the same cost?

Ms Winzar—Yes. It was about $29,000 a year for those because we issued them to a rolling population. Whereas, the seniors card population is pretty much stable for the whole year. It is one card per person.

Mr QUICK—So has any thought been given to changing them, to have the pensioner concession card with two types of colour coding? You are basically producing the same card with the same information about age, and so on. Why not have a red stripe or a yellow stripe?

Ms Winzar—We can certainly do that. We have given some thought also to having a single card for social security with the person's payment type on it. Once we start to do that, we would need to be able to assure the state governments that they would still be able to identify people who were entitled to different types of concession.

If we have one pensioner concession card that is a different colour for seniors cardholders—that is, non- pensioners and pensioners—effectively, we have two cards. That is the way the customers would perceive it. But in terms of our production costs—

Mr QUICK—But basically, the status of the pensioner concession cardholders is not going to change, really, is it? They are not going to be suddenly in work where their income is going to suddenly jump up and down. So basically, why have you not given that almost 2,750,000 people a Medicare permanent type card? They are going to be on the same stratum from 60 on until they disappear.

Ms Winzar—I guess that that is the issue for us. We do not really want too many cards out there that have been issued to people who have disappeared.

Mr QUICK—They pass away. Every couple of years our Medicare cards get regurgitated and we have to get updated ones with all the stuff on the black strip. For those pensioner concession cardholders, have you thought about having a permanent type card?

Ms Winzar—We have thought about issuing a smart card for pensioners, very similar to the Medicare card which would hold all the details of the customer on the little magnetic strip on the back. Again, it is incremental use of technology. It is what it would cost us to do that, as opposed to the benefits that would accrue directly to the

Commonwealth or to the states.

Mr QUICK—So what is the cost?

Ms Winzar—I am not sure.

Mr QUICK—How much would they cost?

Ms Winzar—I am not sure what the exact cost is. We are looking at our capacity to put that information on a smart card, and the capacity of concession providers to install smart card technologies to read the information at the other end.

Mr QUICK—I would like to follow that up because I am really interested. Is there a working party through you guys, DVA and the Commonwealth health department to say, 'Look, let's get together collectively and figure out how we can put on the one card DVA information, DSS information and information from the Commonwealth health department—as long as it is still around—so that we can share the cost and maximise the benefit'?

Surely, rather than you going ahead and carrying the burden, we need an inter-agency approach and a bit of logic to say, 'Okay, there are two and three quarter million people that you are dealing with. How many are DVAs? How many other Commonwealth people are there? Let's talk to local government and state government and see if we can put in a massive order with whoever does the American Express cards or some of the smart cards that are currently out there.' Some banks are a lot smaller than you guys and dealing with a lot fewer people yet they have already got cards out being trialled. Where are you in the great scheme of things, as a separate agency or as part of a working party, in developing these?

Ms Winzar—We have not got a Commonwealth working party in operation at the moment, but the standing committee of income security administrators, which is one of the subcommittees that serves community services and welfare ministers, is looking at a whole range of issues in relation to concession cards at the moment. It has been on their work program for most of 1996 and they are picking up some of the issues that will be addressed by this committee, including uniformity, fraud control and a whole range of things. That is the forum in which a lot of the discussion is happening at the moment.

In terms of the issue of smart card use, the Department of Social Security has done some work in exploring opportunities for it to use smart cards, but not in relation to concessions. One of the differences between us and somebody like American Express, for example, is that the businesses which use American Express have an interest in a profit and so they can certainly justify expending money on swipe card technology at their end. Whether or not concession providers would be willing to expend that money is an open question.

Mr QUICK—I would suggest to you that you are on about profit. You have got a group of people within your organisation that is dedicated to retrieving debt that has been acquired illegally. Someone must have done a cost-benefit analysis to say, 'If we had a smart card and we've got, I don't know, 38,000 people spread around Australia or however many it is—'

I read in the paper the other day that budget estimations as to what both Labor and Liberal governments are going to save bear no relationship to what they actually do save.

CHAIRMAN—Perhaps you could look into the matter and come back to the committee with a further submission on that.

Mr QUICK—I would be interested to know exactly where you are in the pipeline as to establishing these things.

CHAIRMAN—You pointed out in your submission that most of the Commonwealth core benefits are the same and you have got various add-ons for various cards. But were you to reduce all of the cards out there at the moment down to one card, what would be the saving to the Commonwealth? Do you have any comment on the possibility of then allowing the states to look after concessions to pensioners or other eligible persons in accordance with their own values, within their own geographic localities?

Ms Winzar—In relation to the savings, I suspect they would not be particularly great. There would be some minor savings in not having to use a couple of different types of card stock to print the concession cards on. But the major cost for most of our concession cards would be the postage aspect, rather than the production of the card itself. In terms of the income assessment for seniors cards or for low income Health Care Cards, there would effectively be no change to the income assessment, so that would be a cost that would still remain.

In terms of the merits of the Commonwealth having one card and letting the states do their own gatekeeping, it certainly has some attractions. I suspect the states would push at least for some identifier on the card to enable them to do a shortcut on that and to say, 'Well, yes, somebody is in Jobsearch Allowance or they are on sole parents pension.' If the states had to make their own assessment of whether or not somebody was entitled to a concession, I would imagine that they would do that by getting a letter from Social Security to say that the person was a customer and what sort of payment they were on so that in fact the burden would just be transferred back to the department. There would be no saving. All of the states would have to do their own income testing arrangements and that would be quite costly for them.

Mrs ELSON—Is there any cross-checking on someone who becomes unemployed, gets issued with a Health Care Card and then finds a job? There are a number of cases

that have been brought to my attention where those health cards are still used six months later while the holders are employed and above that income. Is there any cross-checking later on when they are utilising these pharmaceutical and dental benefits to send an account back to them for the products they got while they had the card? The cards never get recalled and they use them until the effective date runs out and I just wonder why, when someone does find a job, the department has not asked for that card back. That is where the fraud seems to happen the most.

Ms Winzar—There are a couple of issues that you have raised there. We do ask the customer not to use the card when we tell them that their income support payments have been cancelled. We have the data matching with the Health Insurance Commission and the on-line confirmation of service which allows some concession providers, including the Health Insurance Commission, to protect their expenditure on pharmaceutical benefits. In terms of sending the person the bill, that is an interesting proposal and I think that is certainly one that is worth—

Mrs ELSON—There seems to be an abuse out there that needs to be cross-checked because they are blatantly doing it and gloating about it, and I just figure there must be some system where you monitor whether they are using that service—if, say, you lined it up with when they started their job and what they were getting as far as utilising free services is concerned.

Ms Winzar—The only other comment I would make is that if somebody were using a card six months after it had expired then it really is up to the concession provider.

Mrs ELSON—Not after they are expired. The users become unemployed and they know they are going into another job. They register for unemployment benefits to get the Health Care Card and then use that until the expiry date is up. They are doing it out there very blatantly, and that is where I figure the system is being abused. We are supplying free medication: they do it deliberately to go and get their dentures and a few other things and then hand the card in when the expiry date is up.

Ms Winzar—I do not know if the committee is actually talking to the Health Insurance Commission or, for example, to Australia Hearing Services, but that might be something that you might like to raise with them, as to whether they would be interested in billing the customer, because it is their expenditure that has actually been involved rather than ours.

Mrs ELSON—That will stop the fraud then because it is all around the place that people can do this and work the system, whereas if someone sent an account for abuse then it is going to stop.

Mr ROSS CAMERON—My concern is the question of the quality of the data we have upon which to make decisions in this area. The Deputy Chairman was raising the

question of a cost-benefit analysis of a particular decision. I look at this and I see from your data that we know we have a $4 billion scheme out there. It is a major social equity initiative of the government. We do not know what it costs to administer; we do not have an estimate of the cost of fraud; we do not have a breakdown of who the 11 million Australians are using the scheme. We acknowledge there is no agency providing real policy leadership on it. How do you, as a public sector manager, generate the data upon which to make decisions?

Ms Winzar—We generate data on concession card holders mainly through the existing income support arrangements because the vast majority of cards actually derive from people who are entitled to income support. So in that way, as we undertook to do before, we can get some idea of the distribution of the age of people who are holding concession cards, for example.

We cannot derive any information on the fraud side because we do not actually provide concessions ourselves. In terms of the states, particularly, which provide the vast bulk of the concessional assistance, the record keeping that they have varies quite considerably. Some states have recently moved to upgrade their information, particularly on transport concessions, in terms of who is accessing concessions and what sorts of trips they are taking. But that is by no means common across the states.

In terms of informing policy change within the Department of Social Security, because we hold very little information about low-income Health Care Card recipients under the disadvantaged persons scheme, we would have to do special data runs to examine that population of cardholders. We do not pay a lot of attention to it because, in the larger scheme of things, the concession card contribution is relatively small. By way of example, in terms of fraud control, we are much more interested in somebody who is collecting $150 or $200 a week on an income support payment than somebody who may be accessing $2.50 worth of concessional pharmaceuticals every month. It is a question of balance and it is a question of where we get the best returns in investing our money.

CHAIRMAN—Except that the cost of those pharmaceuticals would not be $2.50. A lot of these pharmaceuticals are very expensive.

Ms Winzar—That is right. And again, I think that is something that would be worth while taking up with the Health Insurance Commission. I do know that, in terms of the Pharmaceutical Benefits Scheme, about 80 per cent of the costs of that relate to concessional pharmaceuticals from our clients.

Mr ROSS CAMERON—One example there is that I have a customs officer who comes to see me. He says that they installed some X-ray equipment to detect narcotics at airports' points of entry and exit. He said that, to their astonishment, they did not detect huge amounts of narcotics, but they found something—in his estimate—in excess of $30 million a year worth of legal pharmaceuticals going out of Australia to be sold around the

world, presumably bought at cost under the Pharmaceutical Benefits Scheme. The pharmaceuticals are then sold in the Middle East, around Asia, et cetera, by disreputable doctors and certain client groups.

I have a concern that the responsibilities seem to be scattered around state and Commonwealth agencies in such a way that there is no way of really sheeting home a level of accountability. It is very difficult for us to make good decisions about the merits and costs of the schemes.

Ms Winzar—I think one of the options for our department is to pay more attention to the fraud control mechanisms and sell those to concession providers. For example, it is obviously in the interests of the states to increase the level of fraud control around the concession program. They are not in a position to do it. There is no direct benefit to the Department of Social Security to spend that money. But, if the department were to introduce a much tighter regime for fraud controlling concessions, perhaps that is something which they could then sell on to the states. And that is certainly worth looking at.

Mr QUICK—If someone is gaoled for 12 months because they have ripped you guys off for $30,000 or $40,000, is there a mechanism in place whereby you pass the information across to the Health Insurance Commission or the Department of Health and Family Services or the state governments to say, 'Mrs X has defrauded us. Here is her file, she obviously claimed this, this and this, or she has had the potential to', and somebody like the HIC could go through and say, 'She was claiming to be a sole parent. She has all these benefits. She has had these things from the local doctor and they are all down there.' They can access them far better than anybody else. Is there a mechanism in place to do that? Or do you just worry about getting your own money back and saying, 'We have solved that problem. File closed. The others can do their own work'?

Ms Winzar—I am not sure of the answer to that question, but we can certainly find out for you.

CHAIRMAN—You suggested the possibility of developing better fraud control measures and maybe on-marketing that to other agencies. What measures would you have in mind?

Ms Winzar—One of those would be an on-line confirmation service. I think that would be the most obvious place to start. The second would be using smart card technology.

Mrs WEST—With students, are the DSS agents and officers the only people who distribute those cards? Are they the only agency? If a student needs a HCC card, is that who they go to?

Ms Winzar—Yes.

Mrs WEST—It is the only office?

Ms Winzar—Yes.

CHAIRMAN—The department's submission refers to pressure being brought to bear on the Commonwealth to further extend concession card access for retirees and to include state and territory concessions currently available only to pensioner concession cardholders. Could you elaborate on that?

Ms Winzar—We do get a number of letters from people who do not have a pensioner concession card, and some of them do have a seniors card. But many of those letters raise issues about lack of access to state concessions. The view often put forward by self-funded retirees is that they have made their contribution to their own retirement, therefore the state should acknowledge them by providing them with some concessional assistance. It is most frequently with issues like rates that we get asked to explain why they cannot receive rates concessions if they are a seniors cardholder or if they do not have a card at all.

CHAIRMAN—I must say that in my own area, with a very high retired population, that is matter that is constantly raised with me. Obviously one has sympathy for these people who have made such a contribution to what the country is and who seem, at the end of their working life, to get nothing. Are there any other questions?

Mr QUICK—What is happening in other countries? Are there any countries that are leading the world in developing a smart card? If so, where are they? I would be interested to know what New Zealand, Canada, the United States and the UK are doing. Are the Scandinavian countries miles ahead of us, as they normally are in some of these social equity things?

CHAIRMAN—I don't know whether 'ahead' would be the word, Harry.

Ms Winzar—I cannot give you an answer to those questions off the top of my head. But we did undertake to get back to you with some information about what DSS is doing at the moment about smart card technology, so we will include those questions in that information.

CHAIRMAN—Following on from Harry's question, what is the approach of overseas countries to this whole question of concession cards? Is this something that we have developed, or did we borrow the idea in the 1950s from somewhere else? Has it grown in other places the way it has here? Would it cost the economies of those countries the amount of money it costs the economy of this country?

Ms Winzar—Again, I have to confess ignorance on that front. But I guess I would say that the social security system in Australia is very different to that which operates in most other countries. The role of Safety Net arrangements in other countries is quite different, too. Whereas here, for example, we have a mixture of cash and non-cash provision, through the income support payment and the concession card arrangements, in other countries there are arrangements about rent vouchers or food vouchers which form an integral part of their social welfare Safety Net arrangements. I am not sure that we would be able to find you some information which would shed much light on concession provision in isolation, but we can certainly try.

CHAIRMAN—Could you perhaps come back to us on that and let us have a paper?

Ms Winzar—Yes.

Mr QUICK—You have an international section with reciprocal arrangements. With the benefits that you people pay in the concessions, what happens to the Greek lady from Dandenong who goes over to Greece, stays there for a while and comes back? In that international agreement are there reciprocal concessions available?

Ms Winzar—No.

Mr QUICK—There are not?

Ms Winzar—No; it goes entirely to income support payments.

Mr FORREST—It seems to me that the problems associated with establishing an online service are often overstated. I can walk into a little village in South Africa and I can withdraw money from my own account. The technology is available. This problem that people say there is about privacy, and so forth, is often overstated. I am a bit concerned that if that kind of access is not made available on the basis that it is only costing $3 million to administer what we have currently got, then that is grossly understating the cost.

You have said that the $3 million is just postage and preparation of the card. I think you have to make a realistic assessment of what it costs within the bureaucracy itself. If someone has to have a letter to authorise the validity of a card to get access to local government rates, and so on, there is obviously a lot of time associated with it. If a card expires it will be on the system. The person can have their own personal pin number that only they know. Medicare operates on the basis that the operator who accesses the information is recorded. If someone has an inordinate number of requests on a file they can be questioned about it. There are prudential controls associated with the way Medicare operates.

I do not see any problem with it. On the Internet I can access the parliamentary library. There is actually a firewall to prevent hacking. We can be clever about this. I think it is offensive that people abuse the charity of taxpayers and we should have a mechanism that manages it. Let us get into the technology and make that available and not understate the advantages. Let us make a realistic assessment of the capital costs to do that against what can be saved in administration.

CHAIRMAN—Would the department have a comment on what Mr Forrest said?

Ms Winzar—I would agree with the majority of those comments. The only observation I would make, I guess, is that in terms of Social Security spending a lot of money on infrastructure to control fraud in the concession card area we would also have to have a cost recovery strategy from the Health Insurance Commission or from concession providers at state or local government level to recover our costs.

Mr QUICK—It goes back to my point that if this were shared across agencies the cost to your particular agency would be a lot less than it currently is. If it were an inter-agency approach that would mean that there would be enormous costs right across. Looking at your submission, there are 17 pages of detail. Can we go back to my point of having an Australian citizen type of card—not having concessions for six states and two territories. This 17 pages would not be as frightening. No wonder people are rorting the system; it is so complicated. Why hasn't something been done? We can get photos from the back of Jupiter about the latest moon and we can have a colour photo six hours later in our daily newspaper but we cannot do something as simple as looking at this 17 pages of hieroglyphics and trying to sort it out across agencies.

Ms Winzar—The attachment to which you refer outlines the different benefits that are attributed to each different type of concession card by state and territory governments and that is where the difference in concession access lies. Fundamentally, it is a matter for state and territory governments to determine whether or not they are interested in uniformity of concession cards.

Mr QUICK—But surely this should be one of the parts of the COAG process because we are on about a leaner smaller government and putting responsibility back to the states. Then we can say to them, 'Look, you are not going to get ripped off with your Commonwealth-state housing agreement because there are people there playing silly twits with some of the concessions.' We can say to local government, 'People are rorting your rate structure because they are using out of date Health Care Cards'—or whatever it might be. The first thing is Australian responsibility and then all these things would probably fit into perhaps four pages rather than 17. If you are unlucky enough to be an aged person who always wanted to be close to your family and you left Nhill and went to Toowoomba, apart from all the hassle of relocating and establishing a new life, you are still Mrs X, Australian citizen, rather than a Victorian going to Queensland.

Ms Winzar—I think that approach would probably make sense for some types of concessions but I am not sure that it would make sense for all concessions offered across all states and territories. For example, those living in the Northern Territory might have significantly higher transport costs than those living in Victoria. We talked earlier about the differences in, say, electricity usage or utilities which have to do with climate and geography rather than any determination to be different on behalf of state or territory governments.

Mr QUICK—Yes, but we have other things, and I am going to be interested when I talk to the Department of Health and Family Services in that, for example, I think there was a state travel budget when I was on the breast cancer inquiry and if the service was not provided in your state and you had to go to another state, 'Sorry, you cannot access this travel payment because it is only for our state.' We have got these ridiculous things where there is waste and duplication across the country which could be wiped out virtually overnight if you had this card because, once again, you are an Australian citizen, there are some basic entitlements that you can access. Some will not and some will, but it will be easy to monitor. As John said, the cost will plummet and we will probably lose a few public servants who are currently doing the monitoring and trying to regain the money that has been ripped off, but I think everybody across state, local and Commonwealth government would see an enormous benefit.

CHAIRMAN—I suppose also that we are a federation and states have their own values and the complexion of governments at state and territory level would change from time to time and perhaps those states would feel that it should be up to them to decide, in accordance with the values of that particular government in power, just what benefits should be available to people in their own state and territory. So, while I think we can talk about these things, while we are a federation I suspect we are always going to have local differences.

Mr QUICK—They will be issues, I guess, that we will raise with state government. If you live in Mildura—the town either side of the Murray River—it makes sense to develop something strategic for that area rather than worry about whether you are governed from Melbourne or Sydney.

Ms Winzar—State boundaries are certainly one issue. The other issue which we have not covered so far is what will happen to concessions as governments increasingly privatise their organisations. So, for example, while the State Electricity Commission of Victoria used to provide concession cards to Victorian residents, now it is broken up into a whole lot of little bits which may offer variable concessions within the state and some of them may actually operate across borders. Again, a residence based concession does not make a lot of sense in that context.

Mr QUICK—They are questions we are obviously going to have ask state governments.

Mrs ELSON—I think my question has been half answered when John asked it before, but the concern I have is that recently I have had to talk to a number of nursing homes and their managers have said that they are very concerned with the amount of elderly who are admitted with a bag full of medicine and tablets—they actually come with a bag full—and when they check the bottles, they have been administered by about four different doctors. They have done the rounds because they are apprehensive that the government is going to cut out some sort of free medication or subsidy, so they build up. I just wondered whether there was a cross-check at all for that so that when they actually go to get their next prescription, it shows that they had had one the week before or something like that.

Ms Winzar—That is something that you would have to take up with the Health Insurance Commission for a detailed response, but my understanding is that they now have arrangements whereby if you try and re-script within a certain period—and I think from memory it is 28 days—the pharmacist is required to query you to find out why.

Mrs ELSON—Well, she said with some of these people they were a week apart and so forth, and I was getting the same story from a number of nursing home managers. And I was called to a house last week to an elderly gentlemen and he had a shelf all the way around his room and I would have said there were 200 bottles of different types of tablets that he has been storing up. When I looked at the date on the first bottle, you could not possibly have used them because they were out of date. And I just wondered if there was something, because that could stop a lot of wastage on our medical pharmaceuticals.

Mrs WEST—Following on from that, to help overcome the problem of incorrect entitlement numbers, the Pharmacy Guild have proposed that concession cards be barcoded with the card holder's entitlements. Would that be a workable option and what would be the relative cost? I suppose it is part of that package where we are looking into the smart card. Could that be barcoded onto their card?

Ms Winzar—It certainly would be another option. Technology offers lots of possibilities in this area.

CHAIRMAN—Do you see it would be an advantage for your department or one of the other involved departments to have total responsibility for issuing cards? If you see that it would be wise for one department to be responsible, which department would be best placed to take over those responsibilities currently being shared with great duplication and cost to the taxpayer?

Ms Winzar—I guess my first response is no, I do not think there is any great value in having one department responsible for issuing cards because the difficulty or the intensive workload is not around sending out the card to the customer, it is about assessing their entitlement in the first place. At the moment that is pretty much divided between ourselves and the Department of Veterans' Affairs because of our separate

customer bases. I cannot see that there would be any great value in, for example, us providing a card issuing service on behalf of that department nor for them to provide that on our behalf.

Mr QUICK—Is there anything that we have not asked you that you think we should and you would like to see us look at when we are talking to other departments and state and local government organisations?

Ms Winzar—What we really have not covered this morning is this issue of community service obligations on increasingly privatised or commercialised government services and functions. That does pose a big challenge for concessions provision generally and that would be a fruitful area for you to explore in your discussions with the states later on.

CHAIRMAN—Would you like to give us a paper on that?

Ms Winzar—We do touch on some of those issues in this paper but only very briefly, but if you would like us to do some more work then we can do that.

Mrs WEST—Is there anything from Mr Phillips? What would you like to contribute to this morning's summary?

Mr Phillips—I support what Ms Winzar said, thank you.

CHAIRMAN—Thank you very much for being with us this morning and for giving evidence. It would be appreciated if you could pass on to the secretariat through the secretary, Bjarne Nordin, details of extra information you are going to give to us resulting from the inquiry proceedings this morning.

[10.15 a.m.]

HARRISON, Mr Murray Robert, Branch Head, Income Support Branch, Compensation and Support Division, Department of Veterans' Affairs, PO Box 21, Woden, Australian Capital Territory 2606

McBOW, Mr Paul Leslie, Acting Director, Communications, Operations and Review, Income Support Branch, Compensation and Support Division, Department of Veterans' Affairs, PO Box 21, Woden, Australian Capital Territory 2606

RICKETTS, Ms Jeanette Gwenith Joan, Director, Policy Administration and Advice, Income Support Branch, Compensation and Support Division, Department of Veterans' Affairs, PO Box 21, Woden, Australian Capital Territory 2606

CHAIRMAN—I now call witnesses from the Department of Veterans' Affairs to be sworn in. Could we have a five-minute opening comment from the department. We have already received the submission and we have authorised its publication. It has been distributed to members of the committee so there may be some aspects of it you would like to clarify or emphasise and then we will have some questions.

Mr Harrison—I can probably be briefer than that.

CHAIRMAN—We would appreciate that.

Mr Harrison—In the interests of not wishing to duplicate information from the various departments, the issues that have been raised this morning and in the submission by Social Security are, to a large extent, similar to our issues. We responded simply in what our responsibilities were in this area rather than draw those issues out again.

The department provides three concession cards to our veteran community: the pensioner concession card and the Commonwealth seniors' health card which have been referred to already. The third is what we call a war widow's concession card which we provide for war widows who are not eligible for the other cards on an arrangement which varies between states. In some cases we provide a card and in some cases the state provides a direct benefit on information that we supply about who may be eligible.

A couple of things are relevant to Veterans' Affairs that have not been mentioned already and perhaps one or two concerns that we may have come across in our portfolio that, equally, have not been raised already. In particular, a number of questions are continually raised in Veterans' Affairs on uniformity. Our answer is generally along the lines that our job is to determine who is eligible and not who gets what concession. It is true to say that is not a very satisfactory answer to some of our constituents.

The other issue that has not been raised is one of our biggest headaches of simply the annual issue of such cards. That occurs at Christmas time each year. Our numbers are

400,000 or thereabouts in the recipients of cards. Add those to the 11 million that Social Security send, and they all go out at Christmas time when the pressure on mail is at its highest for the year.

The concern is if they are not issued on time by 1 January, and the question there is usually related to the travel vouchers that go with the cards. A lot of our pensioners, of course, like to take holidays at that time of the year and if the mail is in any way disrupted or if there is any delay to the production schedule, then we usually get quite a deal of difficulty at that time of year.

Mr QUICK—Why do you send them out yearly when, basically, the circumstances are not going to alter from year to year?

Mr Harrison—In arrangements that are made with state governments, it is not our choice necessarily to send them out yearly. The state and local governments are pushing for a yearly issue, primarily on the basis that they need to be sure—they are asking us to confirm on an annual basis—that people are, in fact, eligible. It is not something that we necessarily have a desire to do.

CHAIRMAN—Could you tell the state and territories that the department is only prepared to send them out at less regular intervals? As Mr Quick said, it is not as though you have people who are coming on benefits for a short period. They are a stable group. Why does it have to be calendar year when, as you said, there is tremendous pressure on the postal system at Christmas time?

Mr Harrison—I do not have a good answer for that except that that is the current negotiated arrangement with the state and local authorities. It is primarily related to the simplicity of administration. If they have a card that is a certain colour, they know that it is this year. If it is on a calendar year basis, they know that the travel vouchers were issued for that particular year.

There is pressure on us to delay that issue towards the end of the year as far as we can because they are concerned about people who may or may not be eligible between the point we produce the card and 1 January. They have been very concerned over the last year or two about duplicate issues of the rail vouchers and the cost of the concession itself.

There was a change the year before where we were in the practice of issuing replacement rail vouchers and the feeling was that that itself was being abused. The state rail authorities negotiated with us that they in fact be the only ones who issue the replacement vouchers. They are beefing up their administrative systems to try to get a better handle on whether or not that particular system is being abused.

CHAIRMAN—I read somewhere that there is now some pressure back on the

federal bureaucracy to reissue those vouchers because some of the state authorities do not want the administrative burden. Have you heard any comment on that?

Mr Harrison—The first time was last Christmas. The state authorities underestimated the reaction and the job at hand in reissuing those vouchers. Their reaction at the time was, 'We did not really want this level of activity.' I have not heard of any formal pressure, or we have not felt any formal pressure for that to come back to us.

Mr QUICK—Are state authorities so thick that they cannot read on a piece of card, which should be plastic, an expiry date? All my credit cards have an expiry date. How much simpler do they want it? My mother lives in Victoria and she is entitled to a concession on the train twice a year. She goes along and says, 'I am entitled to a concession on the train. My card does not expire until 1999'—as my latest American Express card does—and the rail attendant says, 'That is fine, Mrs Quick. Jump on the train or the bus.' Why can you not put them out every five years? What would the cost benefit be to your organisation if you sent them out every five years or every three years like they do with all the credit cards? How much would you save with those 400,000 times 45c, or probably more with the bulk?

Mrs WEST—We know where the problem lies with the December end of the year because everybody takes their holidays from 1 December to 31 December.

Mr QUICK—But once you introduce them for a three-year period all those excuses disappear. It is good for three years like everyone else's credit card. How much would you save?

Mr Harrison—Our estimation of the annual administration cost of these cards—and I hasten to add, it is the same issue as Social Security; it is the cost of the printing and the mail rather than the cost of the assessment of whether or not the person is eligible—is about $1 a card per year.

So you can extrapolate that to say that if we did that every five years, it would be $1 a card over a five-year period rather than a 12-month period. I cannot really answer the question because my personal opinion is that we should be able to come to a better arrangement that has a more permanent card.

CHAIRMAN—Could you have your department look into that and come back to our inquiry with a view on whether it is possible and the cost savings that would result?

Mr Harrison—As I say, from our point of view we would prefer to go that way.

CHAIRMAN—Could you briefly outline for the committee your department's historical involvement and responsibility for issuing concession cards?

Mr Harrison—Yes, it does raise a question about duplication of this type of activity across departments. I think we have been involved in it now for as long as Social Security. What we have not mentioned in the submission here is that we make a distinction between our health treatment cards and the concession cards. We have two cards now that cover health, conferring eligibility on our pensioners for different types of health treatment. That is Veterans' Affairs responsibility. As I say, we have been involved in it now for the same period of time as Social Security has. I think I would argue that one of our concerns is in relation to the holistic service that the Department of Veterans' Affairs is able to provide for veterans. Whilst it sounds practical and sensible to coordinate the administration of these cards in one department, it would mean for us, for example, that we would have to refer our pensioners to somewhere else in order to get a card or a replacement card that we are unable to do ourselves. I think this would undermine, to some extent, our ability to provide a whole service for our customers.

Mr QUICK—Something similar happened though in repatriation hospitals when they were amalgamated into state hospitals. There was all this outcry that the service was going to disappear and veterans were going to suffer and things. I know in Tasmania that has not been the case. There has been a happy amalgamation. Basically, I think people do not care where the card comes from, as long as they have got a card and they know they can go and complain to somebody if they think they are being hard done by. The Health Insurance Commission is surely the best organisation for monitoring and statistical retrieval, much better than any other Commonwealth department that I can think of. Why not give it to them and you guys can tap in?

Mr Harrison—I am sure it could be relatively seamless but there are some differences. We at the moment, for example, are able to produce a replacement card within 24 hours. It would take some days to go through another system somewhere else.

CHAIRMAN—It has even been suggested, I think in the 1980s, that the Department of Veterans' Affairs could be better off being together with the Department of Social Security as far as a more efficient administration of the work that you both do is concerned.

Mr Harrison—I think it is a political question, rather than a practical one, to be honest.

CHAIRMAN—I think you are right.

Mr QUICK—Mr Scott's letter says:

The design of the TC1 is jointly negotiated between DVA and the affected state. The TC1 is issued in New South Wales, Victoria, Queensland, Western Australia and South Australia by the department. The client information is supplied to Queensland, allowing them to mail their own card.

I would be interested to know why that is the case and why the Northern Territory and Tasmania have been excluded from that list of states and territories. What are they doing in those two?

Mr McBow—The Northern Territory has its own seniors card which it issues and Tasmania uses the health treatment card to establish the eligibility.

Mr QUICK—Why is Queensland allowed to do its own thing?

Mr McBow—Queensland probably is the most advanced of all the states in recording your entitlement and your use of concessions. Queensland, in actual fact, has a database which says this person has or has not used a concession in a year. We give the information to Queensland, but we also supply the cards and they simply mail them out. For us that is a wonderful arrangement and it saves us postage. We are quite happy for Queensland to do it.

CHAIRMAN—What would be the cost to the taxpayer of this ramshackle series of disparate arrangements?

Mr Harrison—I think the card we are talking about here is going to 30,000 war widows. It is not a big number to start with. The administrative cost is not large. As I said earlier, the necessity for a separate card for a small group is identified not necessarily by us, but by the state and local providers of the concessions. They wish to know whether we have got war widows. I take the question earlier about how difficult it is to work these things out. We have examples where some of these concessions are provided at obscure locations. A classic example is where you have the one pensioner concession card with, in one case, Social Security on the top, and in another case Veterans' Affairs on the top. At the point of service, the concession is provided to age pensioners, and if they have a DVA card, they are often denied that service because they are not an age pensioner. There is an administrative loop that tries to cover that in terms of saying that they are the same.

Mr QUICK—To me, it seems funny that you can replace a card in a day. But if you are a war widow on a TC1 and you move from state to state, are the benefits exactly the same?

Mr Harrison—No.

Mr QUICK—So we are really concerned about getting a replacement card in a day—that is the really important thing—but we are not really worried about ensuring that the war widows on the TC1s have got the same sort of service around Australia.

Mr Harrison—I would not accept the criticism that we are not worried about the fact that there are not uniform concessions around the country.

Mr QUICK—Are the War Widows Association or Legacy concerned about it?

Mr Harrison—Indeed, and a number have made representations.

Mr QUICK—I ask Mr McBow, from communications, operations and review: how is the department trying to ensure that war widows, irrespective of where they live in Australia, are getting the same sort of concessions? That seems a bit ridiculous to me.

Mr McBow—You have to go back and look at where these particular concessions came from. These were all granted by various state governments. There is no Commonwealth concession whatsoever involved in this. It is purely a state government arrangement. New South Wales, for instance, grants travel concessions to war widows and to disability pensioners with 85 per cent or greater disability. It has no arrangements whatsoever with the department; it is just something which the New South Wales state government has decided it will do.

Mr QUICK—So because they are designated war widows, the department feels an obligation that they should be involved, or should we just say, 'Look, you're war widows and you're this little group that hopefully is not going to get any bigger; we will give it to the states and that will be one less card'? You are also issuing 2,500 CSHC cards, which is another low volume card. The cost benefit for that must be a bit disproportionate to the number of people you are serving.

Mr Harrison—As I say, I do not accept that we are not concerned about that. I guess we are not able to solve the problem. There have been a number of letters over the years from our minister to state ministers in terms of questions of uniformity of the concessions that are available.

Mr QUICK—So in the COAG process—we hear wonderful things about how great COAG is, and Hilmer and all this reform—where is it in the list of priorities? Also, linked in with that, you probably heard us question DSS about an interagency approach and a cost benefit to all departments. I do not know whether it is at your level, Mr Harrison, or someone further up, at the assistant secretary or secretary level. What are they doing in the department to talk to DSS, the Department of Health and Family Services, and whoever else might be involved—the HIC—to say to the state governments, 'This is a priority. It is something that we should have a national approach to, rather than a haphazard state approach'?

Mr Harrison—I won't be offended, but I am at the assistant secretary level.

Mr QUICK—Sorry, this just shows you as a branch head.

Mr Harrison—I guess that from our point of view we have only recently become aware of the committee that was referred to earlier by DSS—the Community Services and

Income Support Administrators Committee. That is the bureaucratic response, I guess, to dealing with these questions. It is something we have only recently become aware of and we are now attempting to be represented on that committee to deal with that.

Mr QUICK—Can you tell us who makes up that committee?

Mr Harrison—I don't know. I am sorry.

Mr McBow—State governments, DSS and Community Services and Health.

CHAIRMAN—Perhaps you could report back to the committee on the matters which Mr Quick has raised. In that report you might include any coordinating mechanisms with other Commonwealth departments which issue concession cards themselves.

Ms ELLIS—Can I briefly mention that the ACT is also missing from that last paragraph in Mr Scott's letter. I would like to know, as Mr Quick asked about Tasmania and the Northern Territory, and as the ACT is not there, whether they are covered in any way through this TC1.

Mr McBow—The ACT has the same arrangements as New South Wales under some agreement between the ACT government and New South Wales.

Ms ELLIS—Could we have that clarified in the information that comes back, please.

Mr McBow—Yes.

Ms ELLIS—I assumed from seeing New South Wales there that that may have been the case but it would be good to have it clarified.

Mr QUICK—I think we received evidence that people in the ACT cannot access New South Wales rail entitlements.

Ms ELLIS—Exactly.

Mr QUICK—And if they are under the same arrangement—

Mr McBow—They are actually issued with New South Wales rail travel vouchers.

Ms ELLIS—They are? That is a bit contradictory.

Mrs WEST—Could you describe for the committee the entitlement differences between concession cards issued by the DVA and those issued by the DSS?

Mr Harrison—There is no entitlement difference in terms of the pensioner concession card or the Commonwealth Seniors Health Card. The issue there, in terms of the income and assets test that is applied to both the pensioner concession card and the Commonwealth Seniors Health Card, is the same. The War Widows Concession Card is available for war widows who are not in receipt of what we call income support supplement, which is an income support type payment associated with the war widows pension. If they are not receiving the income support payment, in other words, they are not income and asset tested for a pension, and they are a war widow, which equally is not income or asset tested, they are then eligible for the War Widows Concession Card. That is the only distinction.

Mr QUICK—What do you see as the main obstacle to having a smart card which covers everybody, so that in the small local town in western Victoria, they can go in and swipe it and it comes up 'accepted' for whatever claim it is?

Mr Harrison—I think there are two answers, one of which is probably Veterans' Affairs specific. Without having researched the question fully, there is the cost relating to the readers. I think that is the major cost in terms of introducing such technology. Perhaps a lesser but equally useful option would be the bar code option that was mentioned earlier, which does not require such an investment in the readers at the other end. The Veterans' Affairs answer is that we have to recognise that our pensioners' average age these days is around 75. Perhaps they are not as familiar with that technology as young people are.

Mr FORREST—Not just that age group.

Mr Harrison—We simply have to be concerned about that. There are opportunities that no doubt arise through the Internet and other technology that is available these days. Our people are getting old and frail.

CHAIRMAN—When the previous witnesses were here we spoke about the possibility of cashing out the benefits contained in cards. I would value any comments you may have in relation to that. Also, how would you feel about the possibility of having, instead of a multiplicity of Commonwealth cards, one Commonwealth card with the same benefits to all people who are recipients? How would you see this assisting in budgetary outcomes?

Mr Harrison—I think we would have the same comments in relation to the cashing out option. It clearly would be a simpler, easy to administer option, a cheaper option. I guess the fundamental point, though, is that the administration is a very small expense in relative terms to the concession value itself. But I guess we would have the same comments—you tend to average out the concessions that are available and perhaps reduce the specific need and specific circumstances, or reduce the ability to address the specific need and specific circumstances. There are people who, if the concession is available at the point of sale, so to speak, are more readily able to access that concession

than if that is not the case.

CHAIRMAN—And on the question of one card?

Mr Harrison—In terms of administration it would be simple. The only real issues for us in that would be the special recognition of veterans in the community; there may well be a reaction along the lines, 'We are not considered special any more.'

Mr QUICK—There are red and yellow DVA cards are there not? The old TPI, or whatever they are called these days, have a special entitlement. Then you have 100 per cent, and grading backwards.

Mr Harrison—Yes, we had four cards which we rationalised to two. There are now gold cards and white cards. The gold is a card that accesses treatment eligibility for all conditions; in other words, we will take responsibility for the treatment of any condition. There are a number of qualifications to get that: one is TPI; another is if you are receiving a disability pension and you have any income support payment at all; and another is if you are a war widow. There are a number of different entry points to the gold card, which treats everything.

The white card is what we call a specific entitlement card and it is related to a specific disability that we accept responsibility for and will treat. We now only have those two.

Mr QUICK—If you are a war widow of an ex-TPI or a deceased TPI, are the entitlements different from a TC1?

Mr Harrison—Yes, the gold card is separate from these concession cards. If you are a war widow you get a gold treatment card from us. Under that we take responsibility for your health care costs. Some state and local government authorities take that card and provide concessions on the basis of the fact that you hold that. We also provide a pensioner concession card to war widows as well as the gold card to those who qualify; that is, those who are getting a war widow's pension and some income support payments. We also provide the TC1—the war widow's concession card—to war widows who also have a gold card because they are eligible for a war widow's pension but who do not get an income support payment.

Mr QUICK—A war widow with a gold card who lives at Manangatang in Victoria goes to the local shire and says, 'Look, I would like a cut in my rates,' assuming that they would get something, if they were covered under DVA. If they had a choice of DVA or DSS and, say, they chose DSS—a war widow's card—what difference would there be between what DSS put out and what DVA put out? Is it the same card or are they different things? Do they look different?

Mr Harrison—Yes. We are making the distinction between the health entitlement card and the concession entitlement card. If you take your gold card to the local council and say, 'I would like a cut on my rates,' some would say, 'This does not confer concessions; this is a health card. What else have you got?' Some others, on the other hand, may well say, 'Yes, we know that this tells us that you are a war widow so we will give you a cut on the rates.'

Mr QUICK—So if you are a war widow and take the DSS card, you would only have to show one card?

Mr Harrison—I do not think war widows would have a DSS card these days.

Ms Ricketts—Yes, they can.

Mr QUICK—My late father was a TPI. He has since passed away and my mother is a war widow.

Ms Ricketts—She has a war widow's gold card from the Department of Veterans' Affairs. All war widows have that gold card. In addition to that, there is an income and asset tested additional payment. It is either paid through the Department of Veterans' Affairs and that is called an income support supplement, or for war widows who were in payment prior to 20 March 1995 there is a frozen rate of age pension that is paid by the Department of Social Security. That is a capped income and asset tested amount and that gives them access to the pensioner concession card.

So it might be a pensioner concession card that says that it is issued by the Department of Veterans' Affairs because you get your income support supplement from Veterans' Affairs, or it might be a pensioner concession card which looks exactly the same but has DSS on the top because you elected to continue to receive that income and asset tested component from the Department of Social Security. There ought not to be any difference in the concessions that are available on that PCC card.

Mr QUICK—Okay. What if my mother, who is frail and is 80, decides to go along to a 19-year-old clerk at Nhill and say, 'What about the rates and things I've got to pay?' It is complicated just listening to it here. For a frail aged person, we are talking about concessions and what you can get. It ought to be much simpler, surely.

Ms Ricketts—Yes. I guess the issue is that, for a war widow, what Veterans' Affairs provides with the gold card is full medical treatment, not concessions as such.

Mr QUICK—But, rather than having two pieces of plastic or cards that you put out every year, you should at least make a move to having one.

Ms Ricketts—I guess the issue is that a war widow need not necessarily be

financially disadvantaged. There is no income and asset testing for the payment of a war widow pension. One can be quite well off and still be eligible.

Mr QUICK—But we have only at the moment got 30,500 of TC1s. Right?

Mr Harrison—No; that is one of the small groups of war widows.

Mr QUICK—Okay. How many in the other group? There are going to be a lot more of them.

Mr Harrison—It is about 140,000 or 150,000.

Mr QUICK—And that number will be going up dramatically in the next five or 10 years, as the men die sooner than their spouses do.

Mr Harrison—Yes.

Mr QUICK—Are you making moves to simplify it at all, just within your department?

Mr Harrison—As was just mentioned, there are those local government and state government authorities who would argue that one card saying you are a war widow does not mean that you should in fact get some of these concessions, because it is not income and asset tested. We make the distinction. The gold card gives you health treatment, and we will look after that. The other card says that you have been income and asset tested and are within the guidelines for concessions. But, frankly, the difficulties arise as to whether you are in Nhill or Manangatang, because they come up with different concessions that are available.

Ms ELLIS—I want to go on from what Mr Harrison said a moment ago about the age group you are dealing with. I personally have fairly strong feelings about how we deal with the elderly. Sometimes we make assumptions that they can grasp things that they cannot. How important do you believe it is for consultation with that user group—both your people and also DSS people, for that matter—when any consideration is being given to changing to a more high-tech approach to concession identification? I am not against a high-tech approach at all but I believe it would be terribly important to involve that group so that we actually understand what they may be able to understand to use. Do you have a view on that?

Mr Harrison—Definitely. The answer is that we value that input very highly, and our history and record is that we do consult very widely with the client veteran group before we make such changes.

Ms ELLIS—In relation to any move towards the use of PIN numbers or such,

which has been mentioned previously this morning as a possibility, would it be of value to maybe consult with the banks and get a view of their user analysis of PIN numbers and fast cards with the banks, in terms of age groups? Would that give us an idea as to how readily they may or may not accept such technology?

Mr Harrison—That is a good suggestion. I would add that we would like to throw this into the equation. If you start talking about questions of the use of smart cards, it is sensible to consider issues in relation to income support payments other than concessions. If you have a swipe card with some intelligent information, it can then also talk about pensions and, for that matter, access to our health treatment eligibility. The whole question of smart cards and their use is a big one for us and it goes outside the issue of concession availability.

CHAIRMAN—The Department of Health and Family Services has proposed that the legislative authority covering concession cards should transfer to the departments responsible for issuing those concessions cards. Under this proposal, legislative authority currently under the National Health Act 1953 defining persons receiving a service pension or income support supplement would be transferred to the Veterans' Entitlements Act 1986. Do you envisage any administrative difficulties with such a proposal?

Mr Harrison—No.

CHAIRMAN—And what other suggestion would you put to the committee about overcoming current problems relating to the complexity and unwieldy nature of the current system?

Mr Harrison—I do not know that we can add anything to the discussion today. The primary reason, certainly in my mind, for the level of complexity is the need to distinguish different categories of people who are in receipt of payments at various levels and how that relates to local offers of concessions on the ground in all sorts of different places—whether it is rates or the local footie ground.

Certainly, as federal bureaucrats, we would argue that a straightforward, single, national system would be the way to go. But you can only do that in terms of a core level of concessions that will, no doubt, be out of date within weeks, if not days.

Mr QUICK—Before you got involved with DSS, was your system any less or more complicated to administer and understand?

Mr Harrison—It was probably more, I guess. I should not say that, should I! It is a difficult question to answer because we, again, have a number of different categories of pensioners. It depends on which point you go back to as to what level of concessions and what the difficulty of administration was at any one point.

Mr QUICK—At least you took the step of amalgamating and limiting the number of cards, whereas DSS seemed to invent new categories and printed cards. Following on from that, what are other countries doing—say Britain, New Zealand, the United States, Canada—for their veterans? Are they further down the track or are we leading the world in complexity of cards and concessions?

Mr Harrison—I think I can say safely that we are leading the world in terms of the generosity of the repatriation system. Whether that means that our concession availability is more or less complex, I frankly do not know. Not so much in the veterans' area, but I understand that the French are in front in terms of the use of smart card technology, but we have not done any great research on that to be honest. Equally, on the availability of concessions, particularly in those countries you mentioned, we know the sorts of pensions that they pay and the sort of health treatment that they provide, but I do not think we have delved very far in terms of the concessions that they offer.

CHAIRMAN—Is it possible for you to get that information for us?

Mr Harrison—We can try. We actually have some very good links to America and Canada, for example, on the Internet these days, so that should still be easy.

Mrs WEST—Do you have a calculated number of people who are currently receiving concessions through your department?

Mr Harrison—Yes, we do. We issued 406,200 pensioner concession cards last year. In December 1995, we issued 2,500 only Commonwealth Seniors Health Cards, and 30,100 or so War Widows Concession Cards.

Mr McBow—In addition to that 30,000, there is also the number that Queensland issues, and Perth and the Northern Territory issue their own cards as well. So that is the disparity between about 80,000 war widows that we have on PCC issues and then the other around 70,000-odd that are picked up through TC1s or their equivalents in the various states.

Mr QUICK—What does TC1 stand for?

Mr McBow—It comes from the old transport concession which was a pre-1993 card. When we pulled them out of the system and went into the PCC the states came back to us and said that they just need something to be able to recognise these people and give them a concession.

Mrs WEST—That PCC, is that male and female?

Mr Harrison—Yes.

Mrs WEST—Have you got a breakdown on male and female? Could you get that to me later on.

Mr ROSS CAMERON—With the War Widows Concession Card, the non-means tested one, do we pick up all health costs there? What level is it? Is it the equivalent of private health insurance?

Mr Harrison—Again, it is important to make a distinction between the eligibility for health treatment and the eligibility for concessions. War widows access their health care under their gold card that we issue to anybody who is a war widow. That is not means tested; that is dependent on whether or not the death of the veteran was due to service and that is the only criterion.

Essentially it is a private patient scheme but it can access all sorts of health care that is reliant upon the local doctor determining whether or not it is appropriate. In some cases a level of prior approval is needed. The doctor gets in touch with us and says that he wishes to do X, Y or Z and we either say yes or no or he might get it somewhere else. But essentially it is reliant on the local doctor to determine the health care needs and we take responsibility for the cost.

CHAIRMAN—If there are no further questions I will invite you to tell us anything else that you have not told us already that you think would benefit our deliberations.

Mr Harrison—I do not think there is anything we have not covered, Mr Chairman. As I say, there are the two items that we might introduce that social security did not. The issues that Social Security raised are equally as relevant to us. The two items are that, firstly, there is perhaps a different group of people here that are now moving into the frail aged category that may require some different level of treatment. Secondly, we would be concerned as a department to not be able to provide that holistic type of service to our veterans if we were to split up bits of the administration around other departments.

CHAIRMAN—Thank you very much for coming to give evidence. We may want to get you back after we have received the further information you are going to send to us but at this stage, thank you very much.

[11.29 a.m.]

TREVETHAN, Mr Morris, Manager, Government Programs Division Health Insurance Commission, 134 Reed Street, Tuggeranong, Australian Capital Territory, 2900

WATZLAFF, Mr Ralph, General Manager, Professional Review Division, Health Insurance Commission, 134 Reed Street, Tuggeranong, Australian Capital Territory, 2900

WOOD, Ms Jacquelyn, General Manager, Government Programs Division, Health Insurance Commission, 134 Reed Street, Tuggeranong, Australian Capital Territory, 2900

CHAIRMAN—I now call witnesses from the Health Insurance Commission to be sworn in. Welcome and thank you for coming. Would you like to outline in five minutes a summary or some particular points out of your submission which you would like draw to our attention. We have received your submission. We have circulated it to everyone and hopefully we have all digested it.

Mr Trevathan—Mr Chairman, members of the committee, the document that we submitted—which, as pointed out, is a sister submission to the HIC information and telemanagement inquiry submission—sets out briefly the position as we see it in terms of having to administer the Pharmaceutical Benefits Scheme and the complexities that arise in relation to entitlement. I believe it is interesting to note that, going back before the Pharmaceutical Benefits Scheme, the scheme that was to be put in place was a medicine for pensioner scheme and, at the initial program, the pensioners were certainly very much part of the PBS and were a separate part of the schedule as I recall it at that time.

Certainly complexity entered the process when the entitlement groups came along. I can well recall that prior to that the medical practitioner entered the pension number onto the prescription and things were flowing along quite nicely. But the complexities that arose when the concessional groups came in led to uncertainty as to whether entitlements still existed and placed a different load upon the medical practitioner. At that time the process then started to be cast more towards pharmacy and the administering bodies, and it became a little bit of a point of contention on how the process would develop.

In terms of moving to the point of handling of entitlement, that has to be considered, I believe, hand in hand with handling the processing of prescriptions because really that is part of what it is. The importance of entitlement now in administering the programs is higher than it has ever been.

In terms of the history of the Pharmaceutical Benefits Scheme, there was a failure, I guess, in terms of trying to introduce, early in the technological change of computerisation, a processing system that relied on a different mode of entry. That led to

difficulties in processing, which some of the members may recall, in terms of industrial hazards with RSI and the like. Turning, I guess, adversity into opportunity, the then department moved quite quickly to introduce a standard for collecting the electronic form of the data from pharmacy.

So that happened in this country at a very early stage in terms of the Claims Transmission System. That rolled forward and most pharmacists came onto that, either voluntarily or being encouraged with certain incentives, so that we had fairly total coverage, when a pharmacy became computerised and they were giving the claims data to us electronically.

In the document that has been submitted, the process of moving to the Health Insurance Commission and some of the initiatives that were attempted at that time are put before the committee. One of the components of the move to the Health Insurance Commission was the requirement to better handle entitlement. The commission moved to address that with an interactive device in pharmacy that would enable the rapid assessment of the patient's entitlement—really a one-card system—and working with the agencies that provided the definition of the patient's level of access, electronically feeding that information to the Health Insurance Commission, and then that being accessed by pharmacy in real-time. It is my belief that the situation has not really changed, the demand to do that is still there, but the technology has moved to make it probably a thing that should have been achieved by now in a more effective manner.

In considering the process, I would put to the committee that other things have moved on in terms of the position of eligibility, and this is why the submission is twinned with the Telemedicine project in terms of a sister submission. While our client in terms of the Pharmaceutical Benefits Scheme is the community pharmacy, the demands certainly are upon the Pharmaceutical Benefits Scheme and processing from private hospitals. The committee would be aware that the Safety Net scheme also includes public hospitals, and other program requirements, including highly specialised drugs and drug monitoring, are spreading that need to be able to identify the flow of prescription medicines across other delivery groups than the community pharmacy.

CHAIRMAN—I am sorry to interrupt. Do you understand the community pharmacy to be the ordinary pharmacies we have in shopping centres?

Mr Trevathan—When I say community pharmacy, that is to whom I refer.

CHAIRMAN—That was my understanding, too, but I just wanted to make sure.

Mr Trevathan—Many of the other aspects in terms of card level and eligibility have been addressed by previous groups and departments giving evidence to the committee. I will leave my opening statement there.

CHAIRMAN—It seems to me that the system which exists in British Columbia with this PharmaNet computer network is ideal. It has certain encouragements built in for pharmacists to alert the appropriate authorities when people ought not to receive medication. It just seems a win, win, win situation. It is a win for revenue, a win for health, a win for the pharmacists and presumably a win for the patient. How close are we to doing something similar to that? There is no point in reinventing the wheel.

Ms Wood—I was visiting British Columbia about two days after the installation of that system, and I agree with your comments there. We are in a position within the Health Insurance Commission to move to that in a reasonable time frame. There are legislative and program issues that need to be addressed before we could move totally to that system. If it was just the technology there would not be the problem, but there are the privacy concerns that need to be addressed within the Australian community, and I believe, of course, some problems within the New Zealand program at the moment.

CHAIRMAN—Is that not covered with the password arrangement in British Columbia?

Ms Wood—Yes, it is. It is left to the individual in that situation to decide to put a password on their record. I understand that less than half of one per cent of the population have actually done that.

Mr QUICK—You mentioned legislative and program problems. Can you expand further?

Ms Wood—I think in the privacy thing at the moment we are not able to communicate information that is gathered to any outside source at all. That is under our section 130. The British Columbia system allows a person's drug history to be accessible to the pharmacist.

CHAIRMAN—Unless passworded off.

Ms Wood—Unless passworded off. At the moment that would not be possible under our act.

Mr Trevathan—Section 135A of the national health insurance act certainly has constraints on how information is handled. They are quite tightly controlled. A new legislative approach would be required. Certainly the technology is there to handle the dialogue and to handle the transcription encoding and securely do that. That is a technical matter.

CHAIRMAN—Is the Health Insurance Commission currently putting recommendations to the Minister for Health and Family Services that the necessary legislative changes should take place to enable a British Columbia style system to be

implemented?

Ms Wood—Yes, and our submission on the Telemedicine is one of those avenues that the Health Insurance Commission is using. We are also working quite actively with areas like the Pharmacy Guild, the AMA, the RACGP—all these organisations—because I believe there are significant reductions in the program cost of medicine. Papers from the British Columbia thing it was based on, I think, found that 30 per cent of acute admissions of people over 65 were due to inadvertent drug reactions. That is a huge program saving. The other area that the HIC sees as of great assistance as a total system is not just the pharmaceutical one of British Columbia but the whole health delivery network a la German or Netherlands and possibly the French system; you then get the full treatment as well as the drug.

CHAIRMAN—Could you just tell us about the Netherlands, the French and the German systems that you mentioned?

Ms Wood—I had a fairly short presentation on it just recently but it is using smart card as well as a full Telemedicine type platform and the community in a total health access and information system, so that you have the insurers, the providers and the patients all working in one health care type system. The smart card allows the identification and the entitlement verification. One interesting aside: the person who gave us the presentation pointed out that people over 55 are even doing away with the PIN; they would rather just let the health professionals have access to their health status so that they get correct care.

The German one was started in 1993 and it is only two stages along. The Netherlands is the most advanced but they also use ICD 10 identification of disease and have put that on computers and will only pay benefits from their private companies, I think, if that information is available. It allows a full system where the individuals can allow a provider to access their information and de-identified data can be used for health planning and outcome.

Mr QUICK—Does it cover their veteran community as well?

Ms Wood—In Germany, I do not know. I would presume it does because I think the person was saying it was 73 million cards.

Mr QUICK—The presentation was made to you. Is it likely to be made to the Social Security and Veterans' Affairs departments so that they know what is going on or do they have to hope that someone in their wisdom will get around to showing them some of these technological wizardries?

Ms Wood—I understand this presentation was made to a wide section of the Australian community. The presentation to the HIC was just a short segment at the end of

a week of a visit of this person. I can get the information and let you know further.

CHAIRMAN—I understand that pharmacists are not reimbursed for dispensing medication that is incorrectly dispensed at the concessional rate or recorded against an incorrect concession entitlement number. We have had some evidence previously that sometimes when replacement cards are issued by DSS they put the wrong number on those cards and pharmacists who simply fill in the information that is on the card could well not receive reimbursement from the Health Insurance Commission. To what extent is this a major problem? For example, over a year what percentage of PBS claims are not reimbursed because of being dispensed incorrectly? Of course, there is another problem that pharmacists face: some of the cards issued by the department become so worn that they are unable to read the particulars. A pharmacist might, with the best will in the world, dispense items, having input the information that he thinks is right. But when you get it, it is not and he or she misses out. To what extent is this a problem faced by pharmacists?

Mr Trevethan—The problem is intrinsic to the method of handling entitlement on the card based system that we have now. I have not got processing figures in front of me on the extent to which it happens. I can possibly get them for you. It is true that at processing we check the validity of the entitlement number—in other words, its construction—and then we check that it is valid at time of supply. We will reject claims that do not fall within those parameters. The pharmacist that gets that claim rejected—and I would expect that these are the ones to whom you refer—would have been expected to validate the prescription regarding the entitlement of the patient at the time of supply.

The question is indicating that they are facing difficulty because the lettering on the card has been destroyed, or the card is incorrect. For the latter, I would expect that that is a very small incidence. For the former, when they have, in fact, perhaps lodged a claim when the entitlement was outside the entitlement period, I suspect that there would be a higher incidence. But it is my experience that the pharmacists are handling that aspect very well.

CHAIRMAN—If, for instance, a particular prescription or a particular medication cost $200 and it is being supplied at $2.70, to what extent would a pharmacist be out of pocket if he submitted a claim, and the claim is wrong, and it is rejected by you? Is the pharmacist out of pocket for the difference between the cost of the medication—namely $200—and $2.70, or—

Mr Trevethan—The general patient contribution level, the $2.70 and the $17.40. I would anticipate that they would resubmit that in the general bundle after it was rejected.

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CHAIRMAN—So essentially, there would be a $14.70 loss, rather than a $200 loss.

Mr Trevethan—Yes. That is correct. I have just been advised by my processing people that if the pharmacist endorses the script—in other words, where the pharmacist has a fear that there may be something untoward in the prescription—and the prescription card is sighted, it is paid even if it is wrong. In other words, the pharmacist verifies on the prescription that the card has been sighted and that it is in date, and we will pay the prescription.

Mr FORREST—On that point, you said that you check the validity of the concession entitlement number. How do you do that?

Mr Trevethan—That is done at a couple of levels. That is intrinsically in the pharmacy software system.

Mr FORREST—So you do it electronically?

Mr Trevethan—No. The electronic step was the one that was not put into fruition when we moved across. In fact, we have constructed an algorithm, or given the algorithm to the pharmacy software suppliers and they will check the card and the number type to establish that its construction is correct. In other words, it is checked to see that it appears to be a valid number. Many pharmacists sight the card and make the entry to their patient database within their pharmacy indicating the life of the card, so they may not sight it on each prescription being presented. It is for the pharmacist to sight the card.

Mr FORREST—In other words, you have to get regular updates from the Department of Social Security?

Mr Trevethan—Yes; we get daily updates.

Mr FORREST—Electronically?

Ms Wood—Yes. Once the script comes in we then process it and verify that it is valid against data that we take electronically from the Department of Social Security.

Mr FORREST—In other words, the capacity is there electronically. Is that sent to you by telephone line?

Mr Trevethan—It is loaded through fast line from DSS.

Mr QUICK—And that covers the most remote areas in Australia?

Mr Trevethan—In a sense. The committee might understand that the process we are involved in—the one that has evolved between the program, HIC and pharmacy—is one where the pharmacist in fact creates the electronic claim record as part of the process of dispensing the medicine. So if the pharmacist is at Blackall or Port Hedland, it does not

matter—the software system is the same. That software is freestanding; it is not in communication with us electronically. The pharmacist enters the prescription record and the entitlement information as part of the process of making up the prescription for the patient.

When the time comes to make the claim for payment under the Pharmaceutical Benefits Scheme, the pharmacist currently does two things. The pharmacist aggregates the prescriptions or the bits of paper which represent the physical claim and downloads onto an ordinary floppy disk the electronic form of the claim, and sends both to the Health Insurance Commission. When they are in the Health Insurance Commission, the computer disk is put into a simple PC and uploaded to our system.

It then goes through background processing which will check many of the parameters. It will check entitlement; it will check against cost; and it will check whether the prescription is an authority and has been entered in the authority database. It will then be left in that state for secondary processing when an operator comes and takes the physical claim and then calls for the electronic notings which have been made on the claim to physically check through and verify the questions that have been raised by background processing. Having passed through that stage, the claim then goes to payment. It is the electronic records of that claim that then flow forward into our archive and flow forward into the health department for the pharmaco-epidemiological data or the management data that relates to the program. That is basically what happens.

Mr FORREST—My point is that you already have an intelligent communicating link with the Department of Social Security to be advised of the eligibility of the concession number. In earlier evidence today it was said that it was too costly for them to establish this kind of networking. But here we have an example where it exists. You have made access to the eligibility of that concession number electronically, using the telephone system. That is right, isn't it? Is it interactive?

Mr Trevethan—With respect, it is not a network. What happens is that the DSS and DVA just give us at one time each evening a tape or an interface which enables us to bring our records into line with theirs. That then becomes the new set of records against which we process our claim. It is not a system that goes out and relates to the various pharmacies around the country. The information that they give us certainly must be an aggregation of the information that is coming from their distributed sites about the changes of the person's entitlement.

Mr FORREST—Anyway, it is close.

Mr QUICK—It is only a stage, obviously, that you are working through. How often are disks sent to you from the pharmacists—weekly, monthly, daily?

Mr Trevethan—Basically the claims used traditionally to be once a month. Many

of them are now coming in twice a month.

Mr QUICK—How many do you receive?

Mr Trevethan—We have 5,000 pharmacies, so we would be looking at around 6,000 claims a month.

Mr QUICK—Six thousand disks a month?

Mr Trevethan—Yes—claim lodgments a month.

Mr QUICK—Do you send the disk out? Do you send each pharmacy a bundle of 12, or do they buy their own?

Mr Trevethan—We have been returning them to them because it is their data. It is quite an awkward process in terms of current technology. We are certainly looking at storing them forward at the minimum stage of handling the process electronically by modem.

Mr QUICK—So what is the next step? Will they all be linked? We hear about doctor shopping. A 19-year-old drug addict in Sydney can go around the doctors in Bankstown. Can you go across so that when the pharmacies in Bankstown, or Lidcombe or wherever it might be, send their stuff in you can say, 'Hey, this person has gone around.'

CHAIRMAN—I might just interrupt there. That problem would be picked up with that British Columbia PharmaNet arrangement.

Ms Wood—That is right. And the identification, because the concessional area of the pharmaceutical is very positively identified that is using the concession card number.

Mr QUICK—But we do not do it at the moment. That person makes six different visits—

Ms Wood—There is concessional eligibility and there is general eligibility. The unique identification for the general patient has just come in in the recent budget legislation, where they are introducing bringing the eligibility in line with the Medicare eligibility so that they need to be an Australian resident to be entitled to the general eligibility on PBS. This is the first step in looking at getting unique identification there, and not all doctor shoppers at the moment are concessional patients, are they?

CHAIRMAN—So to pick up on Mr Quick's question, if a guy went to 10 doctors at Bankstown, got 10 different non-concessional prescriptions and paid the $17 or whatever it is, that person could come away with 10 different scripts from 10 different

chemists presumably filled, and at the present time we have nothing in place to stop that.

Ms Wood—There is margin, but the matching up is on names, so they could change one letter in the name. It is much more difficult to monitor. We do manage to collect quite a lot of information, but it is not as comprehensive as it would be if the Medicare card, say, was used for pharmaceutical eligibility as well.

Mr QUICK—How common is that? Is that a common occurrence? Do we know or don't we know?

Mr Trevethan—Doctor shopping is a difficulty that we have identified.

Ms Wood—Ralph Watzlaff is the Acting Manager of our Professional Review Division. Perhaps he could comment on that.

Mr Watzlaff—In relation to the Pharmaceutical Benefits Scheme, we have a number of strategies that we deploy to identify abuse of the system. Perhaps in general terms I should start by saying that we have a random audit process and in that context we draw a random selection of claims. That gives us an idea as to the extent of fraud on our system in general. In the last two years that we have run that process the indications have been that our level of fraud and abuse is less than two per cent.

We also run what we call the 'purpose based audit process'. That identifies areas of potential abuse within the context of the PBS. Among the areas that we look at there are Safety Net card holders and doctor shoppers. In relation to Safety Net card holders, our process is that we identify those people who are claiming a large number of items per annum. In terms of the Safety Net, we look at those who seek more than 300 items per year. In relation to doctor shopping, we did a minor and small pilot last year. We looked at people who had seen more than 30 doctors in a year. That is not our definition of a 'doctor shopper'; we believe that people can be doctor shoppers even if they are seeing a much lesser number. But just in terms of our resource constraints and so forth we tended to focus at the higher level.

As a result of that Safety Net and doctor shopping audit, we found that basically there was a large amount of hoarding. Our strategy is to intervene and counsel the person, and that works in a large number of cases. So our cost for each intervention is around about $300 and our impact in terms of the change in behaviour, measured 12 months later, is a lesser amount of claiming of around $2,500 for each intervention, using our best practice methodology. We believe that our purpose based audits on Safety Nets have been working, but we would like to extend them further because we recognise that the problem is one of considerable dimensions.

In the recent budget there was a specific allocation given to the HIC in relation to doctor shopping. In that context, we are presently in the process of developing our project

plan and doing our recruitment action to seek to deal with as many doctor shoppers as we possibly can. Our prime strategy is to try and get the people under proper management. We have had discussions with the AMA, within the last month, about that subject.

It is of concern to the profession at the local level, as well. A number of divisions of general practice have recognised this as being a specific problem and have sought to bring the pharmacies and the prescribers together to try and control abuse.I think Bankstown was mentioned a moment ago. There certainly is a project at Yagoona—which I suppose is west Bankstown—where the prescribers and the pharmacists are trying to work together to identify those people who are at risk. Similar things have been done in Perth and St Kilda. I think they have been done in south-east Melbourne and Bendigo, as well.

But the problem is one of considerable complexity because many doctor shoppers do not just stay in the one locality. We have a number of instances of people moving from state to state. Our present record holder, in this context, we have listed as a person in Queensland. They have got a residential address in the Blue Mountains and they are actually busy at the moment in Warrnambool. These people do get around.

CHAIRMAN—They are busy doctor shopping in Warrnambool?

Mr Watzlaff—They are. They move, and we use map info and other products to identify the way in which they move from place to place. At the top end of the spectrum it is very difficult to deal with these people by way of counselling and we do have recourse to prosecutions in some cases. Within the last 12 months we have prosecuted six people. We have prosecuted them on the basis that they have made false representations as to their states of medical health.

CHAIRMAN—Six is not very many.

Mr Watzlaff—No, it is not very many. These people are quite hard to find. Indeed, I think we have some people whom we have prosecuted two or three times.

I think some of the orders being made are quite interesting. We had a recent case in Perth where the magistrate ordered that the person should present to one doctor and one doctor only and should do so with their supervisor. That is what we really would seek to do: to bring these people under proper medical management, because only then can their underlying problem be addressed. I think there is a limit to how far one can employ the criminal law in this sort of context anyway.

So we are extending our pilot project on doctor shopping and we hope to be doing around 2,500 interventions within the next 12 months. The outcomes that we have had in the past have been quite successful, as I mentioned, and we have every reason to think that we will be similarly successful as we intervene in the 12 months ahead, although the

figures I mentioned earlier—about 2,500 on the PBS on each intervention—may water down as we work our way down the list. It may not be possible to achieve the same sorts of savings as we work down through the list of people that we have.

Mr ROSS CAMERON—It is a question I raised earlier with the DSS. I note your estimate of two to three per cent in relation to fraud. It seems to me it must be a fairly confident estimate if you are prosecuting only six people a year and yet you are getting an average saving of $2,500 per intervention for counselling.

A constituent came to see me under cover of night, if you like—an officer in the Australian Customs Service—with a problem and said, 'We set up this X-ray equipment at Sydney and Melbourne and our objective was to better identify incoming narcotics in baggage handling. We examined some of the outgoing baggage and what we found was not prohibited substances but huge volumes of legal prescription drugs.' I asked him, 'When you say "huge volumes" what are you talking about?' He said, 'Well, our assessment of the volume of this stuff going out was a minimum of $30 million a year fraud against the Commonwealth.'

His argument was that there was a group of doctors, pharmacists and patients who were collaborating to defraud the system by exporting large quantities of prescription drugs to other parts of the world—getting them at cost in Australia and selling them at a substantial premium in other parts of the world. Is that possible and what sorts of assurances can we have that it is being remedied?

Mr Watzlaff—Indeed, it is possible. What we have done in that direction is that we raised this matter with the Customs Service 12 or 18 months ago and we raised it by providing Customs Service with information we had. We indicated our concerns about this as an issue and we have also conducted some investigations of our own. We have 32 briefs with the DPP in Sydney where we are alleging that there is a breach of the National Health Act in respect of the improper disposal of these pharmaceuticals. We have also worked with the Federal Police and we are anxious to work further with the Federal Police in identifying drugs that have been taken out through the airlines as well. We have also made contact with some of the freight forwarding organisations to try to identify the situations where drugs may be taken out of the country.

We have also made contact with various postal authorities—the local postmaster—to try to identify situations where drugs are being taken out of the country. There is no doubt that this is happening. The extent of it is very hard to estimate and one needs to distinguish the fact that there are some circumstances where it is quite proper for people to take their own medication out of the country. One does get the impression that this is a matter that goes beyond occasional use and that there is some racketeering going on in respect of it.

We have other matters under investigation that have not been finalised and that we

are working through. We would hope that they would lead to more matters being identified for possible prosecution, but we are anxious to work with the customs department. We have had various discussions with them, but it is dependent upon the medication being seized. One needs to differentiate situations where the labels are left on drugs where we can seize them—we have done that on a number of occasions—from situations where they are expired drugs and they are being taken out under other arrangements. It is a problem. It is very difficult at this point to say what the extent of it is. We do have prosecutions and investigations on foot and we are trying to work with the various migrant communities to try and ensure that they are aware of the prohibition that is in the National Health Act about improper disposal.

Mr ROSS CAMERON—This chap said to me that his concern was with the cuts to the Customs Service which this government was implementing. His understanding was that the X-ray process was not going to be funded any further and that this would just be allowed to continue unchecked.

Mr Watzlaf—Customs have not raised any concern with us about this from that direction. It was our belief that they were identifying this as a problem, and they do give us information from time to time.

CHAIRMAN—Could you take this matter up with Customs and report back to the committee, please?

Mr ROSS CAMERON—I wrote to the minister about it some months ago. I do not think I received any response. The only other question I have is: how do you then calculate the figure of three per cent?

Mr Watzlaff—We pull claims out of the system at random, we then check as to whether or not that has been a valid claim or whether there is any abuse or fraud attaching to it. From that assessment we have a figure as to the extent of leakage in our system. It is a random process, the number of claims we do is in the range of 1,000 to 1,500 per annum, so it is a small sample. But it does give us a feel for what sort of abuse there is in the system. Those things are identified: they may be internal controls that are not working; they may be external frauds which are being perpetrated on us. That leads to further action being taken in consequence of that material.

Mrs VALE—I would like to return to the doctor shopping that you were speaking of before and the fact that you used the criminal law. It does seem to me that that is a very brutal form of detection when you consider the costs of your prosecution and your costs of surveillance. I have been reliably informed that in England patients have to register with the doctor of their choice and I understand that it is one doctor. Allowing for the differences in our particular health systems, would you see such a system as that helping to prevent doctor shopping at a more direct level?

Mr Watzlaff—Yes, I believe it would. I mentioned the orders being handed down by the magistrate in Perth about bringing the person under proper medical management. That is the ideal objective. The difficulty, however, is that there are some people for whom one needs to enforce that in a way that may be seen to be somewhat brutal, to use your phrase.

Some people really cannot be brought under control by any other means; at least that is our experience. There are not a large number of people in that category but there are some. Some are extremely devious in the way they use the system; they are not amenable to counselling in the ordinary way. That is a very small percentage of the people we have. If there were other means to achieve the same objective we would certainly take them, but at the present time there are not.

Mrs VALE—If a person had to register with a doctor of their choice that register would be perhaps on a computer so that any new doctor could check whether or not that person had been registered.

Mr Watzlaff—Yes. If you moved to an interactive system you would certainly be in a position to do that. The drawback partly with registering with a particular doctor is that no particular doctor is an expert in all areas. You would at least want to maintain some degree of flexibility if you wanted to go and see a particular doctor for a particular purpose. He might have expertise in an area that your own GP does not.

Mrs VALE—I am sure you would probably find—and I am sure that Mr Watzlaff would agree—that a lot of doctor shopping is just basically for GPs; generally it is not for your specialist kind of doctor.

Mr Watzlaff—That is correct.

Ms Wood—If you use a full interactive system with the identification and the eligibility then people have the freedom to move from doctor to doctor as they wish but the doctor can bring up the history and find out. It does allow that patient freedom of choice in circumstances where they just wish to change. It also picks up the shopping without needing to register.

Mrs VALE—I think there would be a way that you could build in flexibility if you wanted to change your doctor for one reason or another. I think that that would just need an administrative solution there. But to me it seems more direct.

Mr Watzlaff—Yes.

Mr FORREST—The inquiry is about collecting evidence to overhaul the question of concession cards. Probably the debate we are having is more relevant to the inquiry we will be hearing evidence on tomorrow. It is interesting and a fascinating question but it

makes the point about the need to get a British Columbia type system implemented. I would like to get back to the issue of concession cards if we could.

Mrs WEST—Your submission states that patients should have control over their health information and that informed consent to access relevant personalised health information is the key to effective coordination of health services. How does the Health Insurance Commission envisage that a national health communications network would enable patients to have control over their confidential health information, taking into account the privacy principles of the Privacy Act? This is one little hurdle I suppose you would have to look into.

Ms Wood—That was what I alluded to earlier, but it seems to me that if I as a patient wish my medical information to be available to the doctor I have visited today and I have that right then it overcomes a lot of what the privacy protection is about because I am making my information available under my choice. Even in the Health Insurance Commission, where there is express patient wish to have their information released to a certain person, we are able to do that.

Mrs WEST—It would be equally acceptable that other people would not want their information accessed and used. They would have that option.

Ms Wood—That is what we should be aiming for and that is one of the advantages of the British Columbia system. It does give the patients the right to inhibit access to their pharmaceutical history.

CHAIRMAN—Given all the discussions you are having with the Health and Family Services Department, how far away are we from such a system? When will all the obstacles you have mentioned be swept away in the interests of good government policy?

Ms Wood—That is really a very difficult question. Technologically, if that sort of system were accepted and there were a will in the community for that sort of system, we would need probably 12, 15, 18 months to develop it. There would be a lot of discussion and community consultation that would need to be done, both at a political and administration level, and there are a lot of stakeholders. There are pharmacists, doctors, pensioners, people who have a concern about technology, and there are privacy and hackers—there is a range of issues.

I am not saying that it is impossible to overcome it, but I think that these things that need to be addressed should be looked at. With goodwill, it has been under discussion in the public arena for a number of years and I think AHMAC was looking at using a unique identifier. If you are going to have a health system that is open like this, you do need a unique identifier because all of them hinge on eligibility.

CHAIRMAN—Could you report back to us as a committee on how you think

progress is going and when we are likely to see something positive?

Ms Wood—Certainly. Part of our submission tomorrow also does address this.

Mr FORREST—I was impressed with the fact that the commission has established an electronics commerce team and is involved in consultations. It seems to me that the biggest problem that the public have about this whole concept is this issue of privacy. Is the Privacy Commissioner involved in any of your discussions? If not, will you do that?

Ms Wood—The Health Insurance Commission certainly talks to the Privacy Commissioner. The Health Insurance Commission administers government policy, it does not set government policy and it does not generate legislation. The Department of Health and Family Services is the policy department under the minister for health. My understanding is that the department and the minister certainly are committed to this scenario and do envisage that consultation at an early date with the Privacy Commissioner is a cornerstone of promotion.

CHAIRMAN—Have you made any dollar estimate on the cost of doctor shopping?

Mr Watzlaff—We have not because, in terms of the resource, we can look at people who have seen more than 30 doctors a year and we can say that there is a good suspicion that they are doctor shopping. When you come further down the spectrum, it is very hard to distinguish, based upon the drugs that are being taken and things like that, who is doctor shopping and who has genuine medical need. So it is very difficult to put a financial figure on it. We have not got to that point at this stage, but at the end of the process no doubt we will.

Mr ROSS CAMERON—On this issue of fraud based export of pharmaceuticals: when I asked a Customs officer if they confiscated goods that they reasonably suspected of being fraudulently exported, he said they did not have power under the crimes act or the customs act because they were legal drugs. I am interested to know whether there is a systematic search for this practice at airports around Australia and is there a power giving Customs officers the authority to confiscate drugs they reasonably suspect of being fraudulently exported?

Mr Watzlaff—I believe that is a matter of legal debate, but I will obtain the legal opinions that are relevant to this issue.

CHAIRMAN—I might just ask our witness if there is anything else he would like to tell us?

Mr Trevethan—I think it is probably clear to the committee that the current

processing system that we are working with is efficient as a batch processing system, so the effective delivery of the record for use is four or six weeks after it has been processed at the pharmacy. What you are looking at in British Columbia or any of these other models is bringing that process right up to real-time. That has completely different connotations in terms of how you manage programs and the problems you are wrestling with.

Mr FORREST—Earlier it was said that *Electronic Commerce: A Strategy for Health* could be presented to us. I would be interested to see that. It is a 30-minute presentation. Is that an audiovisual presentation?

Ms Wood—Yes, by our electronic group.

Mr FORREST—If I could suggest, Mr Chairman, perhaps we could be presented with that at one of our committee meetings.

Ms Wood—Would you like us to bring it along tomorrow?

CHAIRMAN—We would not have time on our program tomorrow to look at it, but perhaps at one of our regular committee meetings—we meet every Wednesday when the House is sitting and we normally get some people in from departments or government agencies—I personally think that would be an appropriate subject.

Thank you very much for coming before us today. If we have any further questions, we will certainly get back to you. With respect to the matters that you are going to get back to us on, if you could pass on any further submissions or information to the Secretary, he can then convey that to the rest of the committee.

Luncheon adjournment

[1.32 p.m.]

BLAZOW, Ms Judy, Acting First Assistant Secretary, Disability Programs Division, Department of Health and Family Services, GPO Box 9848, Canberra, Australian Capital Territory, 2601

GOREN, Ms Ruth, Assistant Secretary, Office of Disability, Department of Health and Family Services, GPO Box 9848, Canberra, Australian Capital Territory, 2601

GRAHAM, Dr David, Manager, Pharmaceutical Benefits Branch, Department of Health and Family Services, GPO Box 9848, Canberra, Australian Capital Territory, 2601

CHAIRMAN—I now call witnesses from the Department of Health and Family Services to be sworn in. Welcome. I was wondering whether one of you would like, on behalf of the three of you and the entire department, to give us a five-minute introduction to your submission. We, of course, have received it. We have published it, we have circulated it to all of our members, we have all read it and we have all digested it, but there might be some points that you want to elucidate at this time which will help us to focus the questions a little later on.

Dr Graham—Thank you. I do not know whether it is going to be for five minutes but I will give a brief introduction.

CHAIRMAN—Let it be not more than five minutes.

Dr Graham—I would just like to point out that the Department of Health and Family Services manages a number of community service and health programs. The ones of relevance to this committee are, in particular, the disabilities program and Pharmaceutical Benefits Scheme, because concession cards give access to the concessions provided through those programs.

The department is not involved in establishing the eligibility of people for the cards or in the issue of the cards. The department's role is, in effect, limited to comment—through the normal parliamentary processes—on policy changes to eligibility for cards, which may have a resource implication to our programs. We also have, on occasion, convened multilateral meetings with the various stakeholders to discuss any marketplace difficulties that have been encountered with the cards. That includes such things as the legibility or durability of the cards.

CHAIRMAN—Have you had many comments on the durability of the cards?

Dr Graham—In the past we have, on many occasions. There was concern, particularly through community pharmacy, that some of the cards basically disintegrated

during the time. One of the requirements for community pharmacy is that they assure themselves of the eligibility of the person. For instance, one of the problems was that the entitlement number was on the crease of the card and, if that was folded several times, the number became very difficult to read. We have had meetings with DSS, DVA, the Health Insurance Commission and the Pharmacy Guild on matters such as that. These days we do get the occasional concern. For instance, it may be a plasticised card and some of the printing comes off. But we find that DSS responds to that very positively and tries to correct the concern.

Legibility is a bit of a difficulty because that really depends on print size and there is only so much space. But in other areas I think we have made good progress on responding to the concerns in the marketplace. That is enough for my opening remarks.

CHAIRMAN—Thank you very much for the brevity and substance of them. Could you outline for the committee members your departmental responsibility for concession cards, your relationship with issuing departments such as the Department of Social Security and the Department of Veterans' Affairs and, also, whether you could suggest a streamlined procedure so that we have not got so many fingers in the pie? By having a more consolidated process we might be able to save taxpayers money and be more efficient.

Dr Graham—There are possibly two aspects there. One is the number of cards. There is a range of cards at the moment. I will speak from Pharmaceutical Benefits Scheme point of view. Really, the cards give entitlement to concessional benefits under the Pharmaceutical Benefits Scheme. So, from the point of view of giving access to our scheme, whether it is one card or four cards really does not make any difference. The one card could fill that bill. There are, of course, other complications around that.

Ms Blazow—It is a similar situation in the disability programs area. In terms of Australian Hearing Services the range of cards gives eligibility to the hearing services allowable through that agency, and whether it was one card or a number of cards would make no great difference.

Mr QUICK—What will happen when most of the Commonwealth Department of Health and Family Services programs are put back into the states, as is proposed? What is going to happen to the issue of concession cards then? Aged care and disability are two cases where the services are going to be handed over to the state and, unlike Veterans' Affairs when repatriation hospitals were handed over to the states and in most cases the actual people involved in repatriation went across to the states, in this case the programs will be handed over but the expertise from the Commonwealth department will not go across with them. What problems do you envisage there?

Ms Blazow—My understanding is that the states already acknowledge the cards for many concessions that they also offer under their programs administered by the states

now; so I am not sure what their attitude would be if they assumed responsibility for administering aged care services and disability services and whether they would continue that.

Mr QUICK—One of the points I raised today was the fact that we do not have an Australian citizen's entitlement. Each state is different, and there are concerns that, if you hand programs back to various states, for an aged person in Queensland, say, the service or the entitlement they get might be totally different from what an aged person would get in Tasmania. If we are having concession cards—and the entitlements vary, even now, when we have a Commonwealth and a state responsibility—how do you see things changing?

Dr Graham—I am not sure if that is a matter of the different cards. That really is a matter of how the services are delivered once the COAG process reaches some sort of outcome.

Mr QUICK—You talked about multilateral meetings. What sort of things have been discussed, not just at inter-agency level but with state government and also local government—who are expected to assume some responsibility because they are providing some of the services that people ask concessions for?

Ms Blazow—With respect to disability, we are having discussions with the states now about the future of what is called the Commonwealth-State Disability Agreement, which codifies what the states are responsible for and what the Commonwealth is responsible for. That agreement expires in June 1997 so, in the lead-up to that at present, we are looking at what options there are for the future of disability services and responsibilities of the two levels of government. It is very early days yet, and the issue of concession cards has not been discussed at this stage, but we can certainly take on notice that that would be an issue in terms of the future entitlements that are attached to those cards.

Mr QUICK—In this committee's deliberations, in the last parliament, on the management and treatment of breast cancer, we heard instances of where travel entitlements were not carried across states and, if the service in, say, the Northern Territory was not available and you had to access services in Queensland, you could not access that travel entitlement to enable you to go and access the service. The whole issue of concession cards and national rather than state entitlements, seeing that the Commonwealth is handing many of the services over to the states, should be one of the pre-eminent things that ought to be discussed.

Ms Blazow—It is an issue that attaches to the terms and conditions if there is a hand-over to the states of responsibility for managing services. It would be an issue of the extent to which the Commonwealth put conditions on that money in relation to all sorts of details. It certainly is an issue that is not resolved at the moment.

CHAIRMAN—My question was basically to find out the number of departments that were involved in the question of concession cards. Would it be sensible to have one department handling this, instead of three?

Dr Graham—Which are the three? I am aware of DVA and DSS issuing concession cards.

CHAIRMAN—You obviously have some involvement, because a lot of these benefits are currently placed in your act, are they not?

Dr Graham—Yes; and that is something we have suggested in our submission. I agree with you that it would be more administratively efficient for those sections of the act to be transferred to the area that is responsible for issuing the cards. Primarily, in the case of the Pharmaceutical Benefits Scheme, that is the DSS. At the moment, if they want to change a part of our act that deals with the eligibility criteria, their minister would need to come to our minister and request permission to change, although we would really have very little knowledge of the basis of that change. So, I think it is a bit of a carry-over from the past.

CHAIRMAN—It is just an historical accident?

Dr Graham—I am not sure how much it is an accident but, certainly, when the legislation was being developed, that was probably the convenient spot to put it at the time.

CHAIRMAN—Are there currently coordinating mechanisms in place at the Commonwealth level to manage concession cards? One of our members asked if there was a coordinating committee to try and manage these responsibilities which are now spread over so many departments.

Dr Graham—I mentioned in my opening address that it is more an informal arrangement where if we become aware of problems we do convene a committee between the various departments to look at these issues. The matters have been more around issues of the practical use of the cards rather than the policy behind them.

Mrs WEST—Submissions to this inquiry have proposed that free or subsidised hearing services be extended to low income earners who are not currently eligible. Could you briefly describe the Hearing Aid Scheme and the eligibility conditions?

Ms Blazow—Australian Hearing Services currently provides services for audiology testing and provision of hearing aids for people who have various of the concession cards. I am not sure what you mean by low income earners because many of the low income earners would have those cards.

CHAIRMAN—Going back to my question, you said that you would be happy to have responsibility transferred to DSS and DVA. What administration savings would you estimate could be achieved by such a transfer?

Dr Graham—I doubt if there would be major administrative savings other than in the sense of efficiency. At the moment it is a fairly tortuous route for the legislation to be changed. It is fairly unusual in that we run the program but we have no knowledge really of the changes that are occurring in our legislation because the eligibility criteria have been decided elsewhere. I think it is more in an efficiency sense rather than a cost saving sense.

Mr FORREST—Returning to the hearing aids question, the entitlements are listed at attachment A and then there is the eligibility. It is basically applying to people over the age of 60, travel recipients and mature-age allowees. So it is generally directed more to the older group who are on pension cards. The suggestion has been put to us that it ought to apply for younger people. I would be interested in your comments on the provision of those services to existing cardholders via Australian Hearing Services. I am hoping that you can assure me that this is delivering the best technology at the most economical cost, and how that is tested.

Ms Blazow—I may have to take that on notice. I am not an expert on audiology or the hearing service. I am in a division which is setting policy for the operation of available free hearing services but I am not a technical expert. To give technical assurances I would prefer that I take that question on notice.

CHAIRMAN—If you get back to us with further details, that would be very much appreciated.

Mr QUICK—Returning to this idea of multilateral meetings and COAG and benefits: under Commonwealth concessions—the pensioner concession card, the Health Care Card, the health benefits card and the Commonwealth Seniors Health Card—is mentioned the dental scheme. Has that disappeared off the face of the earth as a result of the August budget? In your multilateral meetings, what are the states doing to ensure that all those cardholders which number many millions are going to get some sort of dental service, or is it all up in the air?

Dr Graham—The dental program at the Commonwealth level is being discontinued. I am sorry I am not aware of what arrangements the states are putting into place after the Commonwealth Dental Scheme finishes.

Mr QUICK—So that was an arbitrary decision brought down by this government and was not part of multilateral discussions about COAG and who should assume responsibility for what?

Dr Graham—It was a decision within the budget context, yes.

Mr QUICK—Will it be raised in subsequent meetings with COAG when aged care and disability and other services are handed over to the states as to your department's sense of priorities regarding whether this should continue to be a concession which is given to all of those concession cardholders; or are you not really worried as it is gone and it is not your responsibility any more?

Dr Graham—It is a decision by government. I am sure the states are free to raise that issue with the government if they want to do so.

Mr QUICK—As a department, you administer that program?

Dr Graham—Yes, we do.

Mr QUICK—Are you keen to see that it is taken up by various state health ministers, seeing that it is a right and entitlement to many millions of Australians?

Mrs WEST—Yes, I think states will take up the—

Mrs ELSON—I checked that out. The states put the funds into the dental hospitals and that money that came forward was only a plan that went over three or four years to take the waiting list down, but it was not a thing that was going to be there forever.

Mr QUICK—I am just saying that as a department that was responsible for a dental scheme which has now disappeared—

Mrs ELSON—It has not really disappeared. It has always been in the state.

Mr QUICK—As a concession?

Mrs ELSON—Yes. It is still there as a concession. You can go into any public hospital and use the dental system.

CHAIRMAN—My understanding is it was only introduced—and correct me if I am wrong—in about 1993 or thereabouts and it was designed, as Mrs Elson said, to reduce the waiting lists for dental treatment. That program has in fact achieved its end, the lists are now shorter, but I gather that the former government, had it been re-elected, was going to phase it out, anyway.

Mrs ELSON—It was not re-financing it, anyway; it was never planned to re-finance it.

Dr Graham—That is correct, Mr Chairman, it had a four-year life and it is being

finished slightly earlier than what was expected because it had achieved the outcomes it sought.

CHAIRMAN—What impact will the decision to replace the Health Benefit Card with the Health Care Card have on the availability of hearing services, if any?

Ms Blazow—I do not think there is any impact, to my knowledge. The card is simply a substitute—one card for the other. That is my understanding. I could be wrong. DSS is the expert on the relative eligibility criteria for the various cards. Whether some people will actually lose a card as a result of substituting one for the other or whether it is just a direct transfer, I am not aware that there are issues there.

Ms ELLIS—Could I just go back to the dental thing very briefly? Would it be possible to get information from you for the committee to look at as to the location of the public hospitals that do impart dental care under any scheme, be it state or Commonwealth as it was? I have regional and outer areas particularly in mind in asking for that information. Also, what will be, at the time of cessation of the current program at Commonwealth level, the existing waiting list? Is there any way of knowing, without asking you to go to too much trouble, the locality origination of those waiting lists, vis- a-vis a comparison as to what degree they are remote from the hospitals? I just want to get a feel for where that system will now sit in real terms for the consumer. If the last part of that question is really technical and too difficult, I am willing to take that, but if you could find that information, I would be very grateful.

CHAIRMAN—Nothing is too difficult for the Commonwealth bureaucracy.

Mrs VALE—It has been suggested to the committee that the Continence Aids Assistance Scheme has a similar impact in providing assistance as other concessions and should be extended to Child Disability Allowance recipients and to people over the age of 65 who were former users of the scheme. Could you advise the committee as to the estimated cost of extending eligibility for the Continence Aids Assistance Scheme as proposed? Do you have any other suggestions for improving administrative efficiency and reducing the complexity of the current system of concession cards?

Ms Blazow—The Continence Aids Assistance Scheme came about after a study that looked at the costs of disability. The cost of incontinence and the necessary appliances that are required by incontinent people was considered to be quite a high additional costs particularly for those people with incontinence who were in employment. So the Commonwealth started the Continence Aids Assistance Scheme in lieu of an additional cash benefit because it was identified that there were certain benefits in the scale of purchasing available to a scheme of buying the aids in bulk and then distributing them to clients who needed them.

So that is the background to the Continence Aids Assistance Scheme, which meant

that it was directly linked to people pursuing employment. That is why the age range was post-school, basically, through to retirement age. However, it has been recognised that these are very sharp cut-off points. For example, we have had cases put before us where people have continued employment beyond the age of 65 and they have raised this issue of a very sharp cut-off point of 65. However, it would cost more money to extend the age ranges, so it is a matter really for the government to consider in the context of the financial implications. But it is an issue that we are aware of.

CHAIRMAN—There has been a suggestion that instead of having concession cards, what we could do is cash out the benefits and perhaps increase benefits to people. For instance, I think it has been suggested that the average cost of a concession card is about $1,100 per person per year. Some would use it more, some would use it less. How do you think cashing out would work? Do you think it would be the right way for government to go? Do you think it would reduce a lot of complexity in your department and others? Do you see it as being a viable option?

Dr Graham—I think it is a complex question. In terms of the Pharmaceutical Benefits Scheme, it has a system of co-payments, so the person has to pay, which is partly a user-pays principle, but partly a price signal. That has been found to be relatively effective in containing the growth of the scheme in the sense that people then have a cost signal to consider whether or not they really need that medicine. In terms of cashing out, if that price signal is taken away, there is a likelihood that the Pharmaceutical Benefits Scheme could be more heavily used. Therefore, it could be a greater cost to the community and the government.

CHAIRMAN—But by cashing out, it would mean that instead of having all of these concessional arrangements, presumably you would still have the Pharmaceutical Benefits Scheme, with people paying $17.40 for a script, but you would, in effect, compensate people by way of a lump sum and you would do away with these concessional scripts of $2.70. How could that possibly cost government more, because in effect you would have the $17.40, which surely would be a greater inhibition than the $2.70?

Dr Graham—Your thought would be that if a person went to a pharmacy, they would still pay the co-payment?

CHAIRMAN—Except it would be the co-payment at the rate that the average member of the community pays at the present time. I am just interested in your views on it.

Dr Graham—If a pensioner or a concessional person is paying the $17.40 out of pocket, that would certainly be a very big cost barrier to that person having access to medicines.

CHAIRMAN—No, but the idea is that you cash out the benefits. We have seen a submission from the Department of Social Security which said that, if you look at the average use of these cards across the client population, the average cost per person is about $1,100 or thereabouts. So if, for instance, you boosted pensions by $1,100, removed the concessions and then allowed pensioners who would have been already compensated because of the higher pension to access the scheme in the same way as other people do currently, what I am interested in is your view on whether you would see this as being cost efficient in the longer run; whether you see it as being viable for government.

Dr Graham—I think there would be the cost barrier to people. It would be very difficult to give them access to the scheme at the higher price signal. I think they would find that quite a barrier, even if they are getting that through their pensions. The pensioner at the moment gets a Pharmaceutical Allowance within their pension to compensate for the co-payment that they pay under the scheme. That Pharmaceutical Allowance tends to get incorporated into the pension. So the fact that they have received compensation through another mechanism tends to be forgotten in the course of time.

CHAIRMAN—With the four cards, soon to become three, that are currently being issued, my understanding is—and previous evidence has borne this out—that most of the benefits payable by the Commonwealth with respect to each of the cards are essentially the same, at least the core benefits. Yet we are issuing three or four cards and the states use these various cards in different ways to grant some benefits to some people and not to others. Do you see that there would be a lot of saving if in fact we had only one Commonwealth card, rather than three or four?

Dr Graham—I think, as we indicated earlier, that access to our programs could be achieved through one card. That certainly would be more efficient in terms of issuing the cards, I would consider, without doing any cost effectiveness analysis. I think that it would be less confusing to the community. There is the complexity that different benefits hang off each card. That does make it more complex.

The other purpose of the card, of course, is the identification number on the card so that people can be identified as being eligible for a certain benefit. If there were one common numbering system as well as one common card, I think that this would, in fact, reduce a lot of complexity for a group such as the Health Insurance Commission who is paying, in the case of the Pharmaceutical Benefits Scheme, a payment on the claim from the chemist. So, I do feel that there would be quite a number of benefits in having one card, rather than a multiplicity of cards.

The cards have been rationalised over the years. There were four cards under the DVA scheme and two of the pensioner cards have been condensed into one at this point in time. The Health Benefit Card, of course, is being considered for rationalisation as well. So there is a move in that direction and I think the Department of Social Security is trying to achieve that.

Mr QUICK—We heard today from DVA that the states want a card every year and that that is what the DVA gives them. So back to this discussion of Commonwealth and state under COAG: should not someone start pushing some buttons and say, 'We are—or are not—in favour of one card, and that rather than pussyfooting around, let us go and do it.'

Dr Graham—I am not aware of the reasons for the states wanting one each year. But different cards have different lengths of lives, too, because—

Mr QUICK—But everybody in this room has a credit card that has an expiry date that certainly extends over one year. The reason that that is there is to save some money for the company because it is concerned about profits. Basically, government is concerned about profits, and the profit it makes can be put back into additional programs. I am asking you in these discussions: who is driving it? Is it the Commonwealth or the states? Someone should say, 'One card makes sense. Let us draft the legislation and push it.' But no-one seems to be doing that. None of the departments we have spoken to today—you, DVA or DSS—seems to be pushing for that. And yet we have heard evidence of countries overseas that are doing it. Even one province in Canada has gone ahead and done it. It has sorted out all the privacy hassles and has done it. Why are we lagging behind?

Dr Graham—Certainly, there is a move in, say, Europe towards using a smart card, or an identification card, as a national health card. In a way, that has a different purpose from some of these concession cards which may be a concession only during a certain period of time when the person qualifies for that concession. A national identification card, maybe something similar to the Medicare card, is something that the person holds. I think that there is potential in the longer term, provided that privacy issues can be sorted out, for a longer term card that has got other information on it.

Mr QUICK—But a lot of the client groups never change. The veterans never change; they are there permanently. The pensioners, people over 65, are there. They are not going to suddenly change their circumstances. So why have we not rationalised some of these things?

Dr Graham—I think that you have a point. But I think there is—

Mr QUICK—We see people with titles such as operations and review, policy administration and advice, and government programs division. Is anybody in any of the departments looking at what is happening overseas and saying, 'Germany has got a fantastic thing.' Apparently, someone in the last group of people in the HIC saw some whiz bang presentation saying, 'This is what they are doing.' But somebody else said, 'We have not seen that.' Everybody is reinventing the wheel.

CHAIRMAN—I think that the witnesses from the Health Insurance Commission said that there would have to be an amendment to your act to permit them to implement

what has been already implemented in British Columbia. They tell us that they are making submissions to your department. I am just wondering how long it will take for your department to respond positively.

Dr Graham—I think that some of this discussion will come up in your consideration of the information technology. The privacy issues are fairly strict in Australia. They are very strict, I think, in terms of international standards, in the sense that there does need to be some debate, I believe, about some of the privacy restrictions that are in our legislation at the moment which put very strong barriers against releasing information to a third party. We have covered some of that in our submission that I think will be considered tomorrow.

CHAIRMAN—Are you aware of that program in place in British Columbia?

Dr Graham—Yes, the PharmaNet. That is an interesting program in the sense that it networks doctors and pharmacists with a central database of medical records. It did provide certain ways in which people could protect their privacy if they felt it was necessary. The outcome was that very few felt that they needed to put into place pin numbers to actually encrypt their information so there was only limited access. It is an interesting example. Australia has a long way to go in public debate about some of those issues before it can reach that situation.

CHAIRMAN—What changes would have to be made to our privacy legislation and otherwise to enable the implementation of the same system as has been operational in British Columbia?

Dr Graham—Parts of the Privacy Act, the Health Insurance Act and the National Health Act cover privacy. Presumably substantial sections of those acts would have to be redrafted to allow that to occur.

CHAIRMAN—Would your department look at that favourably?

Dr Graham—It is a much broader issue than that. For instance, one of the committees we run in our area called the Australian Pharmaceutical Advisory Council has been looking at the privacy issues around the use of medication data. That very much uses a partnership approach between the major stakeholders, the health professionals and industry to some extent, the consumers, very importantly, and governments. That sort of discussion has to occur before there is a top-down approach from the government on this sort of issue.

Mr ROSS CAMERON—I asked Mr Trevethan from the HIC about this problem of fraud and, in particular, the export of pharmaceuticals obtained corruptly under the pharmaceutical benefit scheme. I asked where a Customs officer derives a legal power, for example, to seize pharmaceuticals going out of the country that he might reasonably

suspect as a fraudulent transaction. He indicated that there was some confusion or debate about whether a Customs officer would actually have that power, considering that the pharmaceuticals themselves were not narcotics or prohibited substances but legal drugs. Can you clarify whether a Customs officer has that power and where it comes from?

Dr Graham—There is not so much confusion as a lack of clarity about how much power a Customs officer would have. In fact, the lawyers within the Health Insurance Commission are looking at this very issue at the moment. It comes down to whether or not that pharmaceutical is the property of the person. It may have been issued to that person and maybe in large quantities and in their possession.

There is a provision under the act that it is inappropriate for a person to misuse that medicine for the purposes intended. So if it was prescribed for one person and that person handed it on to another person to use as a medicine, that would be an inappropriate use of a pharmaceutical benefit.

But the fact that a person has a suitcase full of pharmaceuticals, which may have that person's name on the label—the person holding the suitcase—it would be then very unclear whether the Customs officer could intervene. There might be quite an irrational and inappropriate use of medicines in the quality use sense, but it would hard to prove that that person was actually misusing that scheme.

We do have a range of interventions being developed, particularly through the Health Insurance Commission, to try to control that behaviour, or fraudulent use of the scheme. The Health Insurance Commission computers are very sophisticated in monitoring individuals and identifying such things as doctor shopping and pharmacy shopping.

Doctor shopping is where a person goes from one doctor to another and gives the same story just to get the large quantities of drugs. Quite often these will be people who are trying to obtain narcotics or benzodiazapines, drugs of dependence of one sort or another. In other cases, they may be people who are collecting up a large range of drugs to take overseas and put them on the black market or whatever.

With pharmacy shopping the same can occur. In both cases the pharmacist and the doctor might be quite innocent victims of the person who is doing this type of activity, or there may be some collusion between the patient and the other two. The HIC is trying to identify those and produce interventions; in fact, they were given extra money in the last budget to do that.

Mr ROSS CAMERON—So there may be different management things the HIC needs to do, but a Customs officer effectively has no power that he can rely upon to intervene at that point?

Dr Graham—He has limited power, and the Commonwealth is now looking to see

if we can have more bite in our legislation in situations like that.

Mr ROSS CAMERON—It seems like a pretty massive hole, does it not? Customs' estimate is a minimum of $30 million a year.

Dr Graham—It comes down to the fact that no-one is quite sure. There certainly is a problem there; how major it is we are not certain. The encouraging thing is that within the last year there has been very much an awareness of this within the Commonwealth circle such as Customs and the Health Insurance Commission, so they do have an active program now of trying to solve some of those problems, just as in the last budget the proposal was introduced to use the Medicare card as access to the Pharmaceutical Benefits Scheme. Until that point of time, any overseas visitor could come to Australia and have immediate access to the Pharmaceutical Benefits Scheme, the difficulty being a pharmacist deciding who was a resident and who was not a resident at the point of dispensing. The requirement under the budget initiative is that where the pharmacist is in doubt they can request to see the Medicare card, which in most cases is an indicator of residency status.

Mrs WEST—Do you have an age range breakdown in your department on who is currently on concessional benefits?

Ms Blazow—The only area affected in my area is the hearing service. I believe that the hearing service could provide information on how many card holders are using that service, but I would have to take it on notice.

Mrs WEST—Do you cross-reference on who is using what concession cards and who is entitled? Do you get together on cross-referencing your information and data?

Dr Graham—In the department we have de-identified data on pharmaceutical benefits. There are very strict confidentiality requirements. The claims go into the Health Insurance Commission and they certainly have status cross-checking with the DSS database and the Pharmaceutical Benefits Scheme, but within the department we do not. We do get de-identified prescription data coming across which we can analyse. We can request information about concession card holders and their demographic distribution or whatever from the DSS, but we do not get it on a routine basis.

Mr QUICK—I am interested in your submission about a market research project by the HIC dealing with rural and remote Aboriginal and Torres Strait Islanders. Can you give us some further details about how the commission and your department plan to ensure that people in areas such as Broome and Kununurra that I visited the other week can access all the entitlements to which they are entitled as Australian citizens, and whether this will be a magic pin number that they can carry around in their head or a piece of card. We all realise they are not part of our society as far as carrying cards and wallets around. Could you give us a brief outline of what you propose to do as a

department to ensure that they do maximise their entitlements.

Dr Graham—It is a difficult problem, as you are probably well aware. The major issue—and I could talk more from the Pharmaceutical Benefits Scheme side of things but the same principles apply—is that some Aboriginal people lose their cards and then of course they do not have access to the concessions that they might have under it and issuing another card is not the real answer. So part of the purpose of the Health Insurance Commission survey is to find out how big the problem is and, at the same time, try to come up with some solutions around how to respond to it.

The department also is very concerned about access of isolated communities to pharmaceuticals. We are developing a project at the moment where we are looking at such things as supply and storage information that goes along with the pharmaceuticals as well as access through concessions. We do have a range of other alternative mechanisms within the department which we have used on occasions. We can, for instance, cash out money in an isolated community and allow the community to run that fund to supply the pharmaceuticals. We have the Flying Doctor Service medicine chest in the isolated farms or areas, where people can have access to subsidised medication through a resource that they hold on the spot. So we will have to look at these, see exactly what the problems are and then look at other models to see if they will or will not fit that circumstance. We do have, as I mentioned earlier, the Australian Pharmaceutical Advisory Council, which advises the minister on pharmaceutical matters. It is particularly interested in this issue and NACCHO, the Aboriginal organisation, is a member of that council and is exploring these issues with us.

Mr QUICK—And with their concept of privacy and their communal attitudes to life, how do we impose a privacy regime that is basically Anglo-Saxon in concept? You would have to work through those issues as well.

Dr Graham—Yes, it is a fascinating, challenging and disturbing area which we have to work through.

CHAIRMAN—We are almost out of time. I was just going to ask Ms Goren if she would like to say anything.

Ms Goren—I think my colleagues have covered the issues. I am happy to answer questions, but I was just here in support of them.

CHAIRMAN—Have you got any concluding statement or any further information you would like us to have? What we will do, of course, is initially receive evidence and then we may come back to you if we need more information. Is there anything else you would like to tell us?

Ms Blazow—I have just noticed something in our submission that I think I need to

check for you and it relates to Mrs West's question about the health benefits card and the Health Care Card being collapsed. I noticed in our attachment we actually do not show hearing services being an eligible entitlement for one of those cards, the Health Care Card. I am not sure which one is being collapsed into the other, although the submission says that people eligible for all the cards are at attachment A. So I am confused about that issue and I think I need to get back to you to clarify that, because you asked me whether or not people would lose a hearing service entitlement and I need to check that for you as a result of the collapsing.

CHAIRMAN—And if there are any other matters which witnesses are going to provide addition information to us on, you could direct that through the secretary and he will circulate that information to members of the committee. Thank you very much for coming here today. I appreciate your taking the time to do so.

[2.16 p.m.]

BLACK, Mr Robert, Policy Officer, Australian Council for Rehabilitation of the Disabled, PO Box 60, Curtin, Australian Capital Territory 2605

TAYLOR, Mrs Sue, Deputy Executive Director, Australian Council for Rehabilitation of the Disabled, PO Box 60, Curtin, Australian Capital Territory 2605

CHAIRMAN—I now call witnesses from the Australian Council for Rehabilitation of the Disabled to be sworn in. I welcome the witnesses from ACROD. We have received your submission. We have published it, and we have read it. We have distributed it to the members and they in turn have digested it. To help focus questions, there might be some elements of your submission that you might like to emphasise or highlight, or perhaps even change.

Mrs Taylor—Certainly. We would like to take the opportunity of thanking the committee for allowing us to participate in the hearings because the concession cards are particularly important for many people with disabilities. I thought as background I would just give a very brief overview of what ACROD is in case there are some that are not aware. With the National Industry Association for Disability Services, we have some 570 members Australia-wide ranging from very small self-help groups that sometimes might even meet around the kitchen table to the larger service-providing organisations, so we go right across the spectrum. We also have some 250 to 300 individual members.

Many Australians with disabilities and their families are faced with significant extra costs in daily living stemming directly from their disabilities. This fact has been accepted by governments and has been an important fact in the extension of eligibility for many concession cards to people with disabilities. ACROD believes that income aspects for eligibility for concession should recognise this and, for people with disabilities and, where appropriate, for their families, these should be based on net disposable income. When we say that, we mean discounting for the extra costs associated with disability.

We believe it is important that it is recognised that extra costs resulting directly from disability actually can increase when people enter the work force. An example of this is people with severe disabilities not able to access transport may need to access public transport, may need to access taxis to and from work at a much greater expense. As we mentioned in our submission, there are schemes to offset some of this cost but they certainly do not cover daily travel, and use of it on a daily basis to and from work also severely restricts those individuals in their travel outside of work, that being recreation or going into the community.

The Department of Social Security undertook a major study of the cost of disability in the late 1980s and the early 1990s. We have got available today for the committee the copy of an executive summary of a follow-up study undertaken by one of our members, the Australian quadriplegic association, amongst their membership, which sought to

quantify the actual cash outlays made by people with severe physical disabilities on a regular basis based on their disability. These out-of-pocket expenses ranged from $108 a fortnight or $2,799 per annum, to $300 a fortnight or $7,500 per annum. That was just to give some idea of what we are talking about.

We have noted in our submission that concessions should be carefully designed and administered to not in themselves become poverty traps. We made particular mention of the retention of the pensioner concession cards for people with disabilities moving from the Disability Support Pension into employment. This has been particularly important in providing a Safety Net for people to take that risk of moving to employment, and ACROD certainly believes that such a Safety Net should be maintained. I think really that is all we wanted to bring out.

CHAIRMAN—ACROD is a peak body.

Mrs Taylor—Yes.

CHAIRMAN—Is it government funded at all?

Mrs Taylor—Partially government funded.

CHAIRMAN—In your submission you state that eligibility for concessions needs to recognise the extra costs incurred by people with disabilities and propose that income be discounted by disability related costs for the purpose of the concession card income test. What categories of disability related costs would you consider should be taken into consideration when accessing income eligibility for concession cards?

Mrs Taylor—Again it probably varies, and that probably does not help the process of trying to reduce administration. As I have mentioned, for people with severe physical disabilities, transport is one of their major costs. I have noted that you mentioned earlier the continence scheme; that is another cost for people with physical disabilities. For families with children it will often be a chronic illness, perhaps asthma or something that actually has a very high ongoing cost. Particularly if more than one child in the family has those extra costs it can really put the whole family into poverty, even if they are a middle income earning family. So it really depends on the individual.

Mr QUICK—I do not wish to sound flippant but in the recent games in Atlanta, everybody who participated was categorised quite simply. Everybody knew what category they were in. Why can't we have something similar on a piece of plastic card that says that Mr Quick is, whatever it is, S1 or SD1 or whatever, and is entitled to a subsequent concession? Is that too simple a system? They did it and everybody knew what they were in and they were quite happy with their categories, because, in most cases, they were permanent.

Mrs Taylor—I am not actually aware of the categories. But they are decided, I think, so that there is even competition. You may be able to link groups of those together for the extra costs of disability—

Mr QUICK—But for all the people who are MS sufferers and those with some other disabilities—the loss of limbs and the like—there are different costs associated as you are bringing up the child through their life. I agree with what you are saying: we do not realise the costs, especially when they leave school or go from a certain age group where everything is provided—they suddenly turn 16 or 18—to one where the family has to bear the cost, the state doesn't, because there is an assumption that they can find work.

Mrs Taylor—It is also very difficult because within disabilities there is a very big range and some people would not require any assistance. It is something that we have looked at and perhaps it should be looked at again.

Mr QUICK—As an organisation, what is your response to proposed state roles for disability services, with the Commonwealth handing aged care and disabilities over to the states? Do you worry about accessing concessions and services on a state by state basis so that there is equity right across the country irrespective of where you are if you are disabled.

Mrs Taylor—We worry about that. In fact, for disability services all services other than employment have been with the states for four years, I think it is now. I am not certain that the concessions that people with disabilities get through the concession cards actually relate to the services that are moving because I think they all hang off social security benefits. They are a concession for an individual in addition to any support service they might get from an organisation. I do not think that that move will affect them.

The greatest difficulty for people with disabilities is that they will get at Commonwealth level a concession card and then each state interprets who they are going to give concessions to. There was the old program of aid for disabled people. That was actually a Commonwealth scheme for people who did not have any concessions. It was handed to the states and they all immediately limited it to concession cardholders. That program virtually lost its focus the minute it went to states. So the different interpretations around the states would be a concern, but I do not think that is going to result from the COAG process; that, perhaps, is there already.

Mr QUICK—Train and bus are the two concessions that most pensioners get. It varies enormously within states. If you are in Tasmania, you do not get any because there are no suburban trains. But what happens if you go and visit and there is no reciprocity across the states? With what is currently provided, is there a great difference between states for services for people with disabilities?

Mrs Taylor—There are. The ones that I am more aware of are perhaps the parking

schemes and the taxi schemes, where we have tried for many years to get some sort of level playing field across Australia. Really, all we have ever been successful in getting is each state recognising the eligibility of an individual in their home state, but they then have to abide by whatever the rules are in the different states.

Mr QUICK—You know we have a little thing you can put in your windscreen to say to you get an additional two hours parking. In New Jersey they have that disabled wheelchair type logo on their car number plate and you have to meet strict criteria to get it and that is on there permanently. If the husband or the spouse has got some entitlement, it is there and you do not have to worry about mucking around with stickers and doing all that sort of thing.

Mrs Taylor—The advantage of the stickers, if I can say so, is the fact that it does not actually label people quite so obviously and that is a concern to many people with disabilities. The other thing is that some states have a little plastic thing that sticks on the car and you actually can move the card from car to car so it goes with the individual rather than necessarily with the car, which I think is very important for some families where they might perhaps all be providing support for an individual.

CHAIRMAN—Most of the assistance received by members of your constituent organisations would be at state level, I imagine.

Mrs Taylor—All except, at the moment, employment support and some print disability and advocacy that is limited.

Mr FORREST—I would like to comment on that. There is a real equity issue that I am aware of where all these travel concessions are available but for country people there is no public transport, so they are not able to access them. But the Mobility Allowance provides the disabled people an opportunity for some cash to compensate for that, but the eligibility criteria is that if they are capable of travelling on public transport they do not get it. That leaves a lot of disabled country people with nowhere to go. They are able enough to travel on public transport, but there is no public transport.

Mrs Taylor—It is a major issue and it is one that we are trying to address. A lot of our members have raised the fact that the actual lack of any public transport even for those who can use it—

Mr FORREST—Have you any suggestion to make to the committee?

Mrs Taylor—One of the suggestions that we have made is that where there is no public transport, people with disabilities—where it can clearly be identified that they have a disability and perhaps they are unable to drive a car—should be eligible for a Mobility Allowance. But often we can suggest these things; it is not as easy for governments to implement them.

CHAIRMAN—I have questions from Mrs Elson, Ms Ellis and Mrs West, in that order, please.

Mrs ELSON—I have worked with people with disabilities for the past 15 years prior to this job. I have found that governments stuck them in categories and said, 'You've got an arm missing, you've got this, so you sit in that category,' and they have made rules for that. There are so many people out there with children with certain disabilities and they cannot get support for them. It is causing financial ruin in a lot of households. If someone has got a severely handicapped person, the Mobility Allowance is needed if they are going out looking for employment or getting them to some place where they utilise themselves that day.

I know someone who has just lost their house only last Friday because their son is severely handicapped and has to get to a place to get therapy. They will supply the transport to get to that place, but when he gets there, they have to pay for the therapy. It is costing them about $89 a week extra for this child to survive, because if he does not get the therapy his lungs will congest and he will pass on. That is a big sacrifice and if they could get that Mobility Allowance that would help pay for that. I have seen that over the past 15 years that we are putting people into categories rather than treating every disabled person as a different category and being able to provide services for them.

Mrs Taylor—That is a major concern of ACROD and I think that if you went back through our budget submissions for probably the last 10 years you would find that we have been lobbying. We mentioned it in our submission particularly for families with young children under 16 or for families where the provider at home—the carer at home—may in fact have a disability, yet they have got to keep their family going.

Mrs ELSON—And the older the children get the more difficult it is.

Mrs Taylor—We see one of the concerns with that is with the Commonwealth now that the Commonwealth's role is in employment. So, really, any concession they are looking at they are very narrowly looking at the—

Mrs ELSON—That is why I believe it should be handed back to the states to keep a closer eye on it.

Mrs Taylor—Yes, but my concern then would be that you would not have a national—

Mrs ELSON—Body—

Mrs Taylor—No, not a national body—you would not have national standards. I was listening earlier on to the references to the continence aids scheme. We are pushing very hard for children to be included in that. And, as well, when a person reaches 65—I

am not quite sure what the age is for women at the moment for the age pension because it is in flux now, moving up to 65—that suddenly you don't have the disability, you don't have the need for the scheme; and it just does not change. In fact, we are doing a lot of work on ageing and disability because now is really the first time that people with disabilities in Australia have started to age because of medical developments. That generation is only starting to age and it is a major problem.

Ms ELLIS—I have a range of questions on the transport issue. It is an issue that concerns me terribly. First of all, could you tell me what the amount of the Mobility Allowance is at the moment?

Mrs ELSON—It is $64 a fortnight.

Ms ELLIS—Thank you. Even though I am a proponent of it, what earthly use would that be in a country town where there is not a bus system or maybe even a taxi system? In other words, how else can we work out a way to compensate? That is an open-ended question really. I am not saying, 'Don't pay it.' But I am saying that in some instances it would be useless, as anything other than cash in the pocket, to allow the service to be accessed by the individual. I think that is a difficulty.

Mrs Taylor—One of the benefits of the Mobility Allowance is that, after Social Security did their cost of disability and they increased the Mobility Allowance quite significantly and broadened the eligibility significantly, people can take that allowance as a six-month thing to put towards some extra aid they might need. The other benefit is that, in lieu of Mobility Allowance, people can actually get sales tax exemption on buying a car. We would like it to go further, obviously, but I think we have to recognise that Social Security have actually tried to make it more flexible.

Mr Black—Perhaps I could add to that. The problem with Mobility Allowance is that it is not actually officially targeted at people who incur high costs because of disability.

Ms ELLIS—I think that is what I might be getting at.

Mr Black—That is what needs to happen. There needs to be, if you like, a higher level or some recognition of people who incur quite significant costs, either because of going to work or because of the nature of their disability.

Mrs ELSON—Flexibility—

Mrs Taylor—But it is more flexible than most concessions.

Ms ELLIS—The next question I had in relation to that was that I noticed in your submission you make a point of saying that many people with a disability who are eligible

for transport concessions are unable to use them because they do not have access to it. I find that whole situation quite ludicrous—that there may be a budgeted allowance somewhere within this big system that someone could call on if they could only access it. Would it not be better if we identified at the source that person A, with this disability, cannot use public transport, so let's not waste the time making a concession available to them, let's give it to them in another form? In other words, a more direct form that they could make more use of.

That leads me to the question of taxis. Can you give me an idea of the variety of access that people with a disability have across the country in relation to taxis? For example, how easy is it in Victoria; how difficult is it in New South Wales; is it better in Queensland? There is a variety of accessibility, isn't there?

Mrs Taylor—I cannot give it to you, but we could certainly be able to get you that, because one of the things that we have been lobbying on is to have, I suppose, a flat playing field across Australia. But it has virtually been impossible.

Ms ELLIS—I know. I know it is not necessarily a subject of COAG right now because, as you have said, that is already the case. But do you believe there would be a good argument for it being put on the COAG agenda to remedy that very situation, for it to be part of the discussion, so that it does not matter where you live as to whether or not you get fair and equitable access to taxis if you are disabled? Could it become part of that discussion process?

Mrs Taylor—The only thing that I think would be a difficulty is that my understanding is that social security concessions are not part of those discussions and the Mobility Allowance is very linked to social security. But I think it should be something that is raised.

Mr Black—I think there are probably two aspects to the access to taxis you were talking about. One is the access to physical taxis—and in fact the supply of taxis themselves is a problem from state to state. There are different types of taxi vehicles being used and there are limitations on licences and the like. The other thing is the supplementation of the cost of taxi travel. Were you referring to the supply?

Ms ELLIS—Either or both, I do not mind, because they are both relevant. I have a brother who can only come home at the time of the day that we can get a taxi that can fit him. By the same token, you have got people who want to get to work who need to have access to a normal taxi, who need to be able to financially afford that, and that is the other element. I think there are two sides to it.

Mrs Taylor—We have an access policy officer who I am sure can provide some detail across Australia.

Mrs WEST—Do you feel that cashing out the concessions and abolishing cards could be more equitable to those groups, in those situations where they have the availability of concession cards but cannot use them because of transport problems? If you cashed out, could they then pool their resources and apply for community transport? I know local governments provide community transport submissions to the departments and they often get a bus or a special vehicle provided so that they can use special facilities to go within the local area.

It is not extending very far, but in regional areas it might be an idea, I would have thought, if they cashed in their allowance and pooled their resources and worked within the local framework, the local community. We have just started a STAR committee, which is a transportation committee for disabled people, and their main aim is to get a bus to go and help those people in their own local community. Do you think that is a possibility?

Mrs Taylor—It has certainly been ACROD policy since the early 1980s that there should be a cash Disability Allowance for people with disabilities to recognise the extra cost of disability. I think succeeding governments have been frightened by the amount of money. If such a thing were brought in, it would need to be rights based. But that has certainly been our goal, I suppose, that was worked towards. A lot of these changes are working towards that, but they have not quite got there.

CHAIRMAN—The Mobility Allowance would be a form of that, would it not?

Mrs Taylor—The Mobility Allowance certainly, and certainly the changes that came in in the early 1990s we saw as a real move by government towards that, but it did not ever quite get there and, again, it limited it to a certain group of people between 18 and 64, and did not recognise the needs of families and the needs of older people.

On pooling their resources, that would allow that, but I think we also have to be aware that many people with disabilities do not want to be lumped together. They do not want to be in a bus with community transport written on it—although some do—but that has to be taken into account. I am not certain that those sorts of services actually recognise that for a lot of people with disabilities, they perhaps provide services between 10 and three. There are many, many people with disabilities in the work force who are working normal working hours—nine to five or seven to seven or whatever—and it would be very hard for a service like that to provide that flexibility.

Mr Black—Can I just add one point in relation to cashing out. I think ACROD would be very concerned if cashing out was on the basis of averages—an average $1,100 per person—because in fact many people with disabilities are high users of those concessions and the cashing out would need to accurately represent their level of usage, rather than be an average.

Mr QUICK—I am interested in the area of concessions. I note here on the last

page of your submission that legally blind people have a postal concession. I did not know that that was the case and I am wondering when that was brought in and who instigated it and how relevant it is in this day and age. I understand that free air travel for companions makes sense because a lot of people are more mobile. You are citing examples of hearing impaired people assistance with cost of interpreters especially for private health or legal appointments, and the cost in Victoria you quote is $65 for a para-professional interpreter, and the need for concessional admission to courses intended to assist hearing impaired people and their independent living capacity. Whose role is it to suddenly say, 'Look, we need to revamp and revisit potential concessions for people,' considering we are about to embark on the 21st century and some of these might have been decided 10, 20 or 30 years ago? Is it the Department of Health and Family Services? Is it the Department of Social Security's job? Veterans' Affairs? Attorney-General's? You people?

CHAIRMAN—Everybody's or nobody's.

Mr QUICK—Yes. Who actually says, 'Look, postal concessions for legally blind people are totally irrelevant in this day and age because everyone has got access to a phone,' or is it relevant? Who decides what is added and what is deleted?

Mrs Taylor—My understanding of those postal concessions—I will need to check, I may be wrong—is that they are not actually concessions for individuals, it is more a service provider that may be providing a talking book library service, they can actually post out their books or they can post out an audio tape. That is my understanding of those postal concessions. It is not for individuals, I think.

Mr Black—The postal concession I think arises from the Florence agreement of about 1954 or something like that which relates to transmission of cultural and other materials. The way it has been applied is that the providers of audio and braille—if anyone has every seen a braille book they know how big they are—when they are transmitted through the post, because of the enormous cost otherwise of sending them out to users of libraries for the blind and print disability people, that there is a concessional rate struck for those, and for the transmission similarly of audio cassettes and the like through the post. I think it is still a relevant concession.

Mr QUICK—Back to my point. Who is setting what you delete, what you add, as we move into new technology?

Mrs Taylor—It is probably a lobbying thing. I think that ACROD has to take some credit. There has always been some sort of support for travel for people who are blind. That came in a long time ago, I understand, and in the last 15 years the airlines have actually in some cases moved that to include people with physical disabilities who require to have someone travel with them. So we will often lobby government on these issues if they are brought to our attention.

Mr QUICK—If you are travelling on a tram in Melbourne or train in Sydney, does the companion get free access?

Mrs Taylor—Not as far as I am aware, because someone requiring that sort of free air travel would not be able to get onto a tram.

Mr QUICK—If your only transport is on the tram out to X or the train to Y, why have you not got similar sorts of things? That is the sort of thing I am saying. The concessions seem to be very static. They have been set in place for a long period of time and the mobility of our nation is changing, and perhaps you ought to look at adding some concessions.

Mrs Taylor—I think actually a lot of concessions have been added in the last 15 years as people have become more aware. I suppose groups have become more aware of lobbying and governments have become more aware of the rights of different groups of people, and I suppose it is just for the community to keep pressuring governments.

CHAIRMAN—It would always be competent on us as a committee as one of our recommendations to suggest that we ought to look at the concessions that are available and decide which should go and perhaps which should be added, if any.

Mrs Taylor—If I can put in a plug there, this is why we would like a Disability Allowance because then it leaves it up to the individual to use it as they wish.

Mrs VALE—Following on from Mr Quick, have you ever considered giving concession cards to carers? As you know, the disability population is growing and so is the phenomenon of people that dedicate their lives to their families as carers. Often if it comes to having to use public transport it does seem, as Mr Quick was saying, horrendously prejudicial if the carer does not get any kind of concession at all. Have any carer groups ever approached your organisation in this regard?

Mrs Taylor—In our work, particularly with families with children, that has been our argument. Whoever is the carer should get a concession. However, not all people with disabilities that require concessions have a need for a carer. A lot of the people whom we are talking about are totally independent.

Mrs VALE—I understand that.

Mrs Taylor—But there has been a lot of pressure put on.

Mrs VALE—It is becoming quite a phenomenon. In my own constituency, I have two women: one who actually cares for three members of the family—they are intellectually disabled young people—and another who has a child who is 19 who has cerebral palsy and a husband who recently developed early onset dementia. I do not know

how these people cope. I really do not. They cannot work because they are carers. They are on carers pensions and on carers benefits. I am just wondering—do some of these concession cards follow through to people who are recognised as carers?

Mrs Taylor—I am not certain.

CHAIRMAN—Can you check on that?

Mrs Taylor—Yes, we can check on that.

Mr Black—Essentially, the concession cards are driven by pension status. Part of the problem, as pointed out in our submission, is that if that pension status is unduly restricted or narrowed in some way that carries onto the concession that is attached to it.

CHAIRMAN—Does ACROD have any views about the complexity of the current system of concession cards being issued by various authorities and the level of coordination in administering the system? Do you think that perhaps one department should be responsible, rather than a number? do you have suggestions on how the current arrangements in relation to the issuing of cards could be improved? Do you think that we really need one card instead of three or four?

Mrs Taylor—I am not certain because I have not been involved in the admin. I do not know that we have had terribly many people bringing us concerns about applying for cards. We have been far more interested in trying to extend eligibility and linking it to other assessment processes, I suppose.

One of the major developments was actually linking the Health Care Card to the Mobility Allowance and to the Child Disability Allowance. That happened sometime in the last ten years, I cannot remember when, and was a major thing for people with disabilities. I suspect that the people in administration do not have to worry about people with disabilities, because their main worry is to get on to whatever the initial eligibility is. I do not think that we could comment on improving the administration.

Ms ELLIS—I want to take the Chairman's discussion a bit further. You made a comment a moment ago, Sue, about ACROD's desire for a Disability Allowance. I take it, from the way you were speaking, that that would replace all of these different eligibility things.

Mrs Taylor—Yes.

Ms ELLIS—With that in mind, can you give us an idea of the range of disabilities that ACROD has in mind when you say that, in terms of the lightest to the heaviest? I know that is a big ask. What extreme to what extreme does that cover? Would you imagine that there would be a sliding scale of Disability Allowance? How would it be

averaged out? I use the word 'averaged' carefully.

Mrs Taylor—We believe that it certainly would have to be a sliding scale. There would have to be some assessment brought in, because it should be linked. Taking it to its full extent, you would not even have any accommodation support, employment support or anything; you would take all those things into account.

Ms ELLIS—So they would be all factors.

Mrs Taylor—They would all be factors that would need to be taken into account. It would be a lot of work but it probably would not be impossible. But it would be a significant move. The current support for people with disabilities, in most instances, is not an entitlement.

Ms ELLIS—What would be the major benefits of that sort of scheme?

Mrs Taylor—I suppose it allows people the flexibility to decide what is important for them and what is not important for them, rather than having governments decide what is important for them and what is not.

Mrs WEST—How do you envisage family circumstances being taken into account when assessing eligibility for concessions, as proposed in your submission?

Mrs Taylor—I suppose, again, that would be the cost of disability. If it were a child with a disability, if we had a Disability Allowance you would not have to worry about anything else because the Disability Allowance would cover it. But it would again be what we term net disposable income after you have taken out the cost of disability.There is quite a lot of evidence available now on the cost of disability that was not available 15 years ago.

Mrs VALE—Submissions to this inquiry have proposed that Disability Support Pensioners should retain their concession cards irrespective of their partners' income or that families with a child with disabilities should be eligible for concession cards irrespective of income, to help offset the additional disability related costs, which follows on a little from what we were speaking about before. What is your view of those suggestions?

Mrs Taylor—My understanding is that, for families, with the Child Disability Allowance, there is no income test involved in that, so that is not taken into account. With regard to Disability Support Pensioners, we would support people being eligible for the pension but perhaps not getting it because of a spouse's income, but still being eligible for a concession card because of those extra costs of disability, particularly if they do not get any of the other concessions. Mobility Allowance is a very different concession from the other concession cards we are talking about because it does have no income test. It is

purely a functional test.

Mr ROSS CAMERON—How do you define disability? If you are talking about assessing the cost of disability, what are the parameters of disability?

Mrs Taylor—I think we almost touched on this before. It is very broad. It needs to come down to functional ability, the different types of tasks.

Mr ROSS CAMERON—So that would be physical and intellectual?

Mrs Taylor—Sensory, psychiatric, it could be anything. When I say functional, it is how that disability creates a barrier to your functioning in the community or in the workplace.

Mr ROSS CAMERON—What about, for example, geographical remoteness?

Mrs Taylor—That would have to be factored in.

Mr Black—That is not necessarily a disability.

Mrs Taylor—No, but that would be a factor. To make a level playing field, you would have to factor that in.

CHAIRMAN—We have discussed different approaches in various states and territories. I am just wondering in particular whether you have in mind any areas of state, territory or even local concessions which might need a more consistent national approach.

Mrs Taylor—Parking, probably. I have to admit that I started working on this in 1983. All we have ever been able to achieve is what we call reciprocity across states. It has been very, very difficult to get state governments to agree that they will have a national scheme across Australia.

I cannot think of many others but we probably could bring some together. Aids and appliances is a classic example. That actually was a state scheme—states' aids and appliances scheme. In different states they allowed different services, goods, equipment or whatever. I think the continence aids scheme was a classic example—the fact that it was not working. In some states you could get continence aids, in other states you could not.

One of the other major concerns was that there was a lot of cost shifting when it was made a state responsibility. Things that had been provided from hospitals suddenly came onto the aids and appliances scheme. Oxygen was a classic example. I understand in some states something like 60 or 70 per cent of the money is spent on providing oxygen. There is great variety. It would be very difficult.

Mr Black—I think it is very difficult to answer your question, partly because of a line in our submission—there is a lot of variety in the way governments respond to needs. Some things are very clearly concessions. You say, 'Yes, that is a concession scheme.' In other cases, we made reference to rental assistance of various kinds. In some cases it is a rental concession, in some cases it is a rental allowance, in some cases it is a rental rebate. So there are a variety of things which, if you were thinking of them in a concessional framework, could be provided in that way.

Therapy services are a major concern for families who have got kids with disabilities, in order to maximise their potential. They are provided by way of services generally but, in many cases, people have to pay for them. Access to therapy services on a concessional basis would be a major achievement for families with kids with disabilities.

Ms ELLIS—I endorse what you were saying then, because only a short number of years ago I was involved in an inquiry into early intervention services for children with disability, and I understand very well that that would be a huge inroad. To ask what may appear to be a silly question, does ACROD classify people with disability as people who would also meet the same guidelines for a disability pension or allowance through DSS? Is your category of people mirrored by that or do you have a category of people outside of that? I think their interpretation is 85 per cent or more categorised as disabled for employment purposes, is it not?

Mrs Taylor—Yes. It has changed. It is 20 per cent impairment. You asked whether ACROD classifies people. ACROD is well aware that there are people with disabilities across the spectrum. The majority of our members, in their support programs for people with disabilities, are funded by the Department of Health and Family Services for employment. Certainly, we have supported the department to limit those services to people on the Disability Support Pension, because they tend to be the people with the highest level of need. Our major concern is that, if that is taken away, they will be overrun and the people with the highest support needs—

Ms ELLIS—So it is a prioritisation.

Mrs Taylor—In that respect; but we certainly are not unaware of the concerns, and we are doing a lot more work with departments like DEETYA.

Ms ELLIS—And do you have some membership from bodies that may represent people from outside that?

Mrs Taylor—Certainly, yes.

CHAIRMAN—We will make time for two more questions.

Mr ROSS CAMERON—I have quite a lot of people in my electorate who are on

disability pensions. Obviously, with some of the cases that Danna and Kay were talking about today, you cannot help but feel a tremendous sense of empathy with what people are trying to cope with. Every now and again I come across cases where I feel that somebody may be on the margin of that 20 per cent disability, and there may be a range of things within the remaining 80 per cent that they could functionally do. I get concerned sometimes that qualifying for the pension acts as a kind of ceiling in their minds and provides a level of security that becomes a disincentive to explore the 80 per cent of their remaining ability. Is that of concern to you, at all?

Mrs Taylor—Are you talking about the individual or the person that is assessing them onto the pension?

Mr ROSS CAMERON—The individual.

Mrs Taylor—It is a great concern to some people with disabilities that they have to actually get eligibility for the Disability Support Pension to then get assistance into employment. But I suppose that somehow you have to make a line, otherwise the people with higher levels of disability will miss out. The area of people just below the 20 per cent impairment level is of major concern. Personally, I am even more concerned about them, because they are in an area that could miss out. Often, our members tell us that that group of people actually requires as much support as, if not more support than, some other people. I suppose that some people may want to get on the pension and stay there, but I think most people wish to become independent.

Mr ROSS CAMERON—I am not suggesting it is a massive problem. But, every now and again, I will have somebody come into my office. The other day a guy came in and said, 'Fifteen years ago I had a car accident and it left me with some disability in my back and so I have not worked since.' Then there was some other sort of constituent question which flowed from it. I guess I felt for him, in a way, that sometimes people get classified and told, 'You are disabled in this way' and it becomes very much a defining element of their self-image. Do you think there is any way we can address that from a policy standpoint, to give people the incentive and encouragement not to focus on their disability? Obviously, many people do not.

Mrs Taylor—I do not know that I can answer that. It is probably a dilemma that many of us face.

Mr Black—It partly relates back to injury compensation schemes and whether the emphasis is on people maximising their disability in order to secure compensation or whether, as in most accident compensation schemes nowadays, there is an emphasis on early rehabilitation and to minimise the disability. There is positive intervention on the part of insurance companies and others. I think that has changed. I do not think it is fully changed yet but there is a far greater emphasis on reducing the level of disability and achieving results.

Mr FORREST—Concerning the Mobility Allowance, I can give you some examples of wonderful community organisations, some of them even statutory organisations, in my electorate and many rural electorates that operate a transport service. It is not your community bus, it is very personalised, where they can coordinate the rotation on a roster basis for people who want access to their doctor if they are aged or to their therapy class if they are disabled or whatever. It is very efficient and it is funded through HACC and other means. What is wrong with that approach rather than the payment per diem directly to people?

It is socially enriching. You could find yourself on the way to your therapy with an aged person off to their doctor and that is done and it involves people who are socially motivated. I have talked to disabled people who participate and they say it is a welcome part of their day. It seems to be more efficient than people individually hopping in taxis using their Mobility Allowance. Is that an alternative that would be acceptable to your organisation and have you any suggestions to make?

Mrs Taylor—I do not know whether the point of whether it is accepted by our organisation is important. I think that is an important issue for people with disabilities themselves. I am not running down community services at all, I think they provide a very important role in society, but sometimes you have to book one, two or three days in advance and there are a lot of people with disabilities who would rather have the money to be able to do the same things as perhaps you or I might be able to do, that is, decide in five minutes time that we want to go and see someone or we want to go to the pictures or we want to do something and to be able to do that. It is not always possible for a community service to be able to respond in that way. There needs to be choice and I think there would be a lot of people who would be very concerned because it does put a certain level of dependence on someone else to be able to live your life.

Mrs ELSON—Is not the Mobility Allowance only there if you are going to a job or going to job training?

Mrs Taylor—No, it is much broader now. You used to have to be in work for 20 hours a week. It is now only eight hours a week and it can be community work. You do not need to be employed. You can be doing voluntary work for an organisation.

Mrs ELSON—So it is not there to get them to therapy or to get them back or anything like that. That is where there is cross-communication there. People think when they hear ‘mobility’ that it is to get severely handicapped people mobile to get them to their services, but it is not that.

Mrs Taylor—I do not think it is. It is to allow them to do what they want in the community.

Mrs ELSON—Yes, what they want but not to get access to the services they need.

That is where the big problem is with that Mobility Allowance. It is not taking people to get to therapy they need to give them a better quality of life, it is only there providing them with access to job training or a job or community work. Take this one particular case, and I have seen it over many years. A person may be totally disabled, cannot talk, cannot do a single thing for themselves, but they have to get to their services. If they could be taken out of the wheelchair and stood up for a second they can get Mobility Allowance but because they cannot get out of that wheelchair or move they cannot get the Mobility Allowance. When they get to the services there is no-one to lift them out of the wheelchair as far as putting them somewhere else for a while and then putting them back in their wheelchair to get Mobility Allowance.

Mrs Taylor—The services that you are talking about are day services that are considered not to be employment.

Mrs ELSON—The ones that are missing out in society are the severely handicapped people who are being looked after by parents. As the carers, they cannot get any of those services. It is too fine lined. There is no flexibility in that system. Some are misusing it. Organisations that I have worked closely with, like workshops and so forth, have people who are all being paid Mobility Allowances. They can get a bus to work and a bus home, yet they are getting the full Mobility Allowance. I find that that is totally unfair to the person who is—

Mrs Taylor—That would be an eligibility thing.

Mrs ELSON—No. I have worked with it now for 15 years. It is very easy to get the Mobility Allowance if you can speak, or move an arm or a leg yourself.

Mrs Taylor—It is supposed to be limited—

Mrs ELSON—It is not.

Mrs Taylor—It is supposed to be limited to not being able to use public transport.

Mrs ELSON—No. I can give you a list of about 70 names of people that use it on a daily basis. Those people get the Mobility Allowance but they are quite capable of—

Mrs Taylor—I think that that is a decision for DSS. That is not something we get involved in.

Mrs ELSON—And, yet, the people who really need the services cannot get them.

CHAIRMAN—Perhaps, Mrs Elson, you could pass that list on to Senator Newman.

Mrs ELSON—I will.

Mrs Taylor—We would like to see the Mobility Allowance available for everyone who cannot use public transport.

Mrs WEST—Are you aware of the concessions that might be available for changing your house or your workplace to accommodate disabled people? Is there any concession in building or maintenance, or something like that?

Mrs Taylor—They are not so much concessions, as programs. Under HACC, I think that there are some programs for modifying your house. I am not certain what has happened to employment programs since the budget, but certainly there was an amount of money there for readjustment of the workplace.

Mrs WEST—So that would be a type of concession that you would like to foster, as well as the aids and the Mobility Allowance and the Disability Allowance.

Mrs Taylor—Certainly. I suppose that we were not thinking of those in terms of concessions with a card because you do not get access to them through a card.

CHAIRMAN—I would like to thank Mrs Taylor and Mr Black for coming along today. Obviously, what you had to say was of great interest. I think that you are the only two witnesses where we have gone over time. We would like you, if you are getting back to us with some additional information—and I think that you are—to pass that on to the secretary and if we need to get any more information from you, we will also contact you. Thank you very much for being with us.

[3.23 p.m.]

BANKS, Mr Si, President, NSW Branch, National Council of The Pharmacy Guild of Australia, 14 Thesiger Court, Deakin, Australian Capital Territory 2600

GREENWOOD, Mr Stephen, Executive Director, The Pharmacy Guild of Australia, 14 Thesiger Court, Deakin, Australian Capital Territory 2600

TATCHELL, Dr Michael, Director Health Economics, The Pharmacy Guild of Australia, 14 Thesiger Court, Deakin, Australian Capital Territory 2600

CHAIRMAN—I now call witnesses from the Pharmacy Guild of Australia to be sworn in. Welcome. I invite you to make an opening statement. We have received the submission; we have published it; we have circulated it; and we have read it.

Mr Greenwood—On behalf of the Pharmacy Guild of Australia I would like to make a short statement to this committee which draws out the main aspects of our submission and adds to it in one important respect.

In our submission we make it clear that the guild's concerns with concession card availability and eligibility arise from the day to day contact between community pharmacists and entitled persons, that is, pensioners, concessional beneficiaries and veterans. Under the terms of the National Health Act, pharmacists are required to be satisfied that persons seeking to receive a prescription medication at the concessional rate are, in fact, eligible for the benefit. Pharmacists run the risk of not being paid by the Commonwealth for dispensing the medication if they inadvertently dispense the medication at the concessional rate to an ineligible person. To reduce this risk, pharmacists are required to record the person's pension, concession or entitlement number in their dispensary computer at the time of dispensing. Correct recording of such numbers will ensure that the pharmacist is paid by the Commonwealth for subsidised prescriptions.

In our submission we draw attention to the many practical problems facing the pharmacist which can complicate this process and can unfairly lead to rejection and non-payment of prescriptions by the Health Insurance Commission. We also suggest possible ways of simplifying the current arrangements aimed at achieving greater accuracy and eliminating possible sources of error. Bar coding of entitlement cards is one suggestion; another not mentioned in our submission could be the inclusion of basic entitlement information on a magnetic strip on the card. The third suggestion could be for the pharmacist to obtain information on the entitlement status of persons holding concession cards at the time of dispensing through an on-line interactive connection between the dispensary computer and the Health Insurance Commission's central computer. We believe such a gateway would only be acceptable to pharmacists if it were controlled by them.

These suggestions are consistent with the guild's efforts to reduce the considerable burden of clerical and administrative tasks required of pharmacists in their day to day

administration of the Pharmaceutical Benefits Scheme. This is reflected in the second agreement between the guild and the Commonwealth government. There is an important undertaking in the agreement that the guild and the Commonwealth will work together during the period of the agreement to substantially reduce pharmacists' clerical tasks. Streamlining the checking of entitlement cards would go a long way towards this objective and sits well with the government's central commitment, irrespective of the guild-government agreement to reduce the paper load on small business by 50 per cent.

The other matter I wish to raise concerns one of the government's recent budget measures for the Pharmaceutical Benefits Scheme. I refer to the decision to deny visitors to Australia access to PBS benefits. The intention is to align access to the PBS with Medicare so that visitors to Australia will no longer be eligible for PBS benefits except where Australia has a reciprocal health care agreement with another country. This decision will impact on community pharmacy. While the fine detail has yet to be resolved, the guild understands it will be up to the pharmacist to decide whether or not they ask an individual presenting with a prescription for their Medicare card.

The exact circumstances when this might occur are unclear. However, an obvious example would be a pharmacy located in a tourist resort where a significant number of overseas tourists are to be found. If the person does not produce the Medicare card at the request of the pharmacist, the prescription would not be dispensed as a pharmaceutical benefit but would be treated as a private prescription.

The guild understands that it will not be mandatory for the pharmacist to ask for a Medicare card; indeed we know of no legal requirement for them to do so. The pharmacist will be expected to ask for the card if they are not reasonably satisfied as to the patient's residency status. The guild supports this government initiative and recognises the importance of such measures in helping to contain the growing cost of the Pharmaceutical Benefits Scheme.

We are happy to encourage our members to ask for the Medicare card in those circumstances where they reasonably believe there to be some doubt as to the person's residency status. However, we would be concerned if this were ever to move from being voluntary to compulsory as this would add another administrative task to those already required of pharmacists at a time when the aim is to reduce such tasks to a minimum. The guild is looking forward to discussing with government in more detail the implementation of this budget measure.

CHAIRMAN—The PharmaNet Computer Network in British Columbia seems to be working very well. There seem to be real advantages there to the revenue, to the patient, and there is even an incentive for the pharmacist to highlight troubles because I think one gets a double dispensing fee when that occurs, and also the overall health of patients would benefit because the multiplicity of prescriptions being filled would not occur and people would not take home drugs at dangerous levels.

We have discussed this with other witnesses from various government departments and the Health Insurance Commission in particular said that it would be necessary for there to be changes in some laws, including privacy provisions. It just seems to me—and from the vibes I got around the table, it seemed as though other members agreed with me—that this PharmaNet computer network would be a pretty good way to go. Do you see it as being viable in the short term? How long do you think it would take to set up such an arrangement, or do you just see that it is going to get bogged down?

Mr Greenwood—If I could just partially answer the question. We certainly will address this in more detail tomorrow, but at this stage we think that it is well worth while having some sort of feasibility study into whether or not such a system would be appropriate in Australia. At this stage, the guild has an open mind on the system. Dr Tatchell has examined it and I will ask him to speak further on that, but certainly we believe that present claiming arrangements are somewhat outdated and that this may offer a more contemporary, user-friendly and cost-effective way of handling pharmaceutical benefits. At the same time, we would want to emphasise that, just as in British Columbia, the gateway should be controlled by the pharmacist. Certainly, that would be one of the major concerns that our members would have. Perhaps, with your leave, Dr Tatchell may wish to add further to what I have said.

Dr Tatchell—I did visit British Columbia in October last year, which was only a few weeks after the system had begun in fact. It began on 1 September 1995, so it was still very much in the early stages of development. There were some teething problems, particularly at the pharmacy level. We would certainly be concerned that those were not duplicated in any system that started up here.

The system has now been running a year. We are in contact with many groups over there that have been involved in the process and we are expecting an evaluation of that first year to be passed over to us within the next few weeks. When we get a copy of that document we will make sure that the committee gets hold of it.

CHAIRMAN—The second question I was going to ask related to the way in which, when some concession cards are borne into pharmacies by people, you cannot read the information on the cards. It makes it difficult for you to decide the eligibility and sometimes when the duplicate cards have been issued by the Department of Social Security wrong numbers have been put on those cards and so the pharmacist could be in the situation of dispensing an item at the concessional rate and then having his or her claim knocked back by the Health Insurance Commission.

Do you see that as a major problem, firstly? Secondly, it was interesting to note that one of the earlier witnesses mentioned that, if a pharmacist actually receives a claim which you think is dubious, you are apparently able to mark on the form that you are a bit worried about it, but you have dispensed it anyway. Apparently, in that case, you get paid. Are there major problems with the scheme as it currently operates? Do you get many of

your members being out of pocket as a result of what I suppose you could say were inadequate government forms, or actually inaccurate information given by government?

Mr Greenwood—It certainly has been a matter of major concern for us. It is perhaps of less concern now, but Mr Banks can comment on that from a practising pharmacist's point of view. It is a problem that we raised with the Department of Social Security, as far back as February 1994. As far as I am aware, we have had discussions with them every year about this particular problem, and some of the difficulties that we have had have not been addressed. But, certainly, pharmacists are able to mark the claim form card as sighted, which does get around some of the claiming problems that they had in the past.

Mr Banks—That is right. It is the ineligibility of the card, very often, that is a problem; and you have got to have a stab at what it really says. The degree of anxiety amongst members varies according to where they submit their claims. If you went across Australia, you would find different experiences from different major payment centres. You will get some of them that are more in keeping with commercial reality and they seem to have no trouble with it; but you will get other areas where it is a problem.

CHAIRMAN—While your member has been out of pocket, that has not been to the full extent of the cost of that item. Presumably, he is out of pocket for the difference between $17.40 and $2.70.

Mr Banks—If the item is an expensive item—say that it is $100 worth—he is substantially out of pocket.

CHAIRMAN—An earlier witness told us that, if a claim was knocked back, the pharmacist would most likely put that in a general batch and it would be processed by the Health Insurance Commission as though it were an access to the PBS by a member of the general community who was not in fact in receipt of some concession; which would mean that all that the pharmacist would be out of pocket for would be the difference between the concessional rate of $2.70 and what you or I would pay, which would be $17.40.

Mr Banks—Yes. Again, from my experience, it depends on the office. At times there have been substantial underpayments, but what was said there is correct: in a lot of situations you would just get the difference between the two numbers. I have had personal experience where the claim has been rejected for quite a substantial amount.

Mr QUICK—I am interested in the whole issue of privacy. I know quite a few pharmacists and, with their computer networks, they seem to be leading the world. The whole issue of privacy seems to be the biggest or the only stumbling block to putting an interactive, real live system on. Are things going to change all that much? Surely the pharmacists have signed a privacy code of conduct already, as have the people who operate the computers in their absence. How much more do we have to change? Is it a big

furphy that all this privacy stuff is stopping us doing this?

Mr Greenwood—Privacy is a major concern for the profession. They have a long track record of maintaining the privacy of patient data, and they are very proud of that. They are also held in the highest regard in community surveys of what people think of the health professions: we regularly top the list in that regard. We would not top the list, I believe, if we were to be treating privacy information in a cursory manner. Certainly the case is that pharmacists do not and they are very concerned that they protect the privacy of their patient data. So, in regard to the PharmaNet system, we think we have a good track record there already and we think that there is no reason why that track record would not be maintained under any such interactive system.

Mr QUICK—As soon as you mention a change, the first flag that comes up is, 'Oh, we have to make these massive changes to privacy rules and regulations.' Is it a big furphy? And linked to that is, I notice in your submission there was a trial of paperless claims. Why was that done? That seems to me to be a very minimal change to the current system. And why was the PharmaNet thing not trialled? I would be interested to know how much that trial cost. Obviously, from reading through your submission, it was virtually a waste of time and effort and money by all those involved and ended up with more work rather than less. Who institutes these trials: is it done at your suggestion or HIC's or the department's?

Dr Tatchell—Perhaps I could answer that one. In the guild-minister agreement that was signed in April last year, there was an undertaking on both sides to try and cut down on the administrative work that pharmacists have to do. One aspect of that was to try and introduce—or look towards introducing—a paperless claiming environment. It was agreed between us and the Health Insurance Commission that we would run a trial and we chose Victoria as being a suitable place to do that. We had about 15 pharmacies involved. Now, it is true to say that the protocol that was drawn up for that trial did not go as far as we were hoping it would. We were hoping we could move to something more in line with the PharmaNet approach in a trial, but it was not possible in that trial to do that. Now we are hoping, as you can see in our submission, that some sort of trial of a PharmaNet type approach could be tried in Australia. So that first trial was a very important stepping stone, I believe, to setting up another trial in that process.

CHAIRMAN—How close are we to such a trial?

Mr Greenwood—We would hope it would take place fairly quickly. I did not address the matter of a change to the privacy legislation, and we would obviously need to take advice on that from the Health Insurance Commission and Attorney-General's, but certainly we think that those privacy issues can be overcome and we cannot see why that cannot occur if it has already occurred in the Canadian situation. As far as our members are concerned, as I said before, they would want to control the gateway under any such system and they would want to do that not only because they would want to be able to

check the eligibility of claims themselves but they would also want to be able to maintain the privacy of patient data and not have that interactive system out of their control. It seems to work well in Canada but I think we have to bear in mind that it has only been up and running for about eight months now and there is no full evaluation of it. I would think that there would need to be some evaluation of that system prior to any trial taking place here.

Mr QUICK—This is my last question on this and I will keep quiet then. The Canadian system is the same as ours basically—provincial and federal—whereas it is state and federal here. Were there national privacy rules and regulations drawn up just for BC or did the BC state say, 'Look, we want to do this; we'll draw up our own provincial privacy laws and to heck with the rest of them'?

Dr Tatchell—The Canadian system is a little different in that every state can run its own health insurance arrangements and I think likewise the privacy laws are also separate from state to state. So British Columbia has its own unique—I think it is Pharmacare—system and the particular arrangements they have worked out for PharmaNet are also unique and I believe the privacy arrangements are also unique to that province.

CHAIRMAN—You talk about this trial; have you contacted the Department of Health and Family Services or the Health Insurance Commission? Is something imminent or is it just something that we are looking at on the never-never—it would be nice, but -

Mr Greenwood—I do not think it is something that we are looking at on the never-never; it is something that we have had discussions with the Health Insurance Commission about. Dr Tatchell has taken the opportunity to go and see the system as have officers of the Health Insurance Commission separately. At this stage there have not been detailed discussions as to how a trial might be implemented in this country so I think it is still early days in that sense.

CHAIRMAN—I suppose I was asking whether there are any log jams that we could break in our report.

Dr Tatchell—We have written to the Minister for Health and Family Services, Dr Wooldridge, urging him to get behind it and support a feasibility study that could be completed within 12 months. So, yes, if this committee can hurry that process along we would be very pleased.

Mrs WEST—On the losses that you are incurring presently with the system that is currently in practice, what kind of cost would there be?

Dr Tatchell—I think the costs are not so much to the pharmacist, they are more to the government and patients because as we understand it the British Columbian system will allow pharmacists to advise patients if they are inappropriately taking drugs that may

interact with one another. At the moment, unless the patient goes to a single pharmacy, the pharmacist is not able to track their medications. The British Columbian scheme allows them to track medications obtained elsewhere so there would be benefits to the patient, there would be benefits to government through reduced hospitalisations and from the pharmacist's point of view there would be a much more efficient administration and running of their business.

Mrs WEST—What would the costs be to set up such a system?

Dr Tatchell—I am afraid I cannot answer that. We can talk to the Health Insurance Commission.

Mrs WEST—Trial it and find out?

Dr Tatchell—I think it is something we need to look at more closely.

Mr Greenwood—Yes, that has not been identified. The main costs to pharmacy on your previous question would be in terms of time and just the administrative load that they have to carry that has a cost to it. In the past we have attempted to quantify those costs and we have undertaken a major study of those sorts of costs through ACIL Australia. We could provide the details of that to the committee.

Mrs ELSON—Most of the questions I was going to ask have been answered. I think it is of the utmost importance to get the PharmaNet set up fairly quickly because we have been hearing here—and as we have been members of parliament only for a short while we have been hearing it out there, too—that the system is being abused by people getting repeats when they should not be getting them at that rate. I think if the privacy side of it can well and truly be protected by your having your own password put on your first prescription—you choose your password and only you know it—and that gets used each time to get access to your files that could be the safeguard that we are looking for. Australia needs to set up a system where all pharmacies know what is going on instead of people running from one pharmacy to the other getting prescriptions filled and not doing the right things with their medicine.

Mrs WEST—Why do you want to control the system?

Mr Greenwood—I think that it is important that the membership, all of whom are individual small proprietors, have control over their patient data. Mr Banks might like to add to that.

Mr Banks—I certainly would. I think that the important relationship that the pharmacist has with his patient is historical. There are people who will go to a particular pharmacy because of their reliance on the confidentiality of the material that is in that database. I think that if we took the next step where we extend that into another database

that is there ostensibly for the benefit of all patients, the expectation would be that this is managed by pharmacists. From my members' point of view, that is important and I think that concern would be shared by the community at large.

Mrs WEST—Who guards the guards?

Mr Banks—Medications that have been had. Now it is all right for the Health Insurance Commission to have a series of numbers so that they can say patient X has had number 1013 25 times, and that is the information that they need. But, as far as your particular medication or my particular medication is concerned, I think that there has been an expectation at the moment that that is bound up within the confines—not in a network; it is in each pharmacist's own system, and that is where it lies at the moment. But if we extend it so that it is available to be accessed by pharmacists generally to aid in their dispensing, then I think it should be controlled by pharmacists. That aspect of it should be controlled by the pharmacist.

Mr ROSS CAMERON—One of the earlier people giving testimony said that a fairly substantial cause of hospitalisation was an adverse reaction to conflicting medication. I suppose that an electronic approach to this could probably help you in that regard. What measures do you have at hand at the moment to avoid that sort of situation?

Mr Banks—The individual pharmacist to whom that patient goes is the only one at the moment—plus their doctor, presuming they go to the same doctor—that has a reference to their history in terms of medication. The process is that the pharmacist before dispensing the next prescription has a look and scans the history and sees what other medications have been supplied, but of course that is only available if the person goes back to that particular pharmacy.

Mr FORREST—I am interested in the Canadian experience, and I am also aware of the need for an ongoing community debate about the confidence they will have in the privacy issue. What was it that drove the early part of the British Columbian need to have this system? Was it the concern about the proliferation of prescribed drugs, was it the concern that we have about fraud in the system or was it just the need to get administrative costs down? Dr Tatchell, you have been there and had a look at it. I also have another technical question, but could you just answer that one first? What was it that drove it?

Dr Tatchell—My understanding is that the same things drove the introduction of PharmaNet in British Colombia as are driving us now—just the things that you have mentioned: fraud and abuse, multiple doctor and pharmacy shopping, and also the aim to contain the growing cost of their scheme.

Mr FORREST—This is a technical question that you may not be able to answer, but was it an intranet system which is a secure system that only certain terminals have

access to? It was not a broad thing—in other words, it could be very secure?

Dr Tatchell—As I understand it, it is secure in the sense that it is only the pharmacist in the pharmacy dispensary through their computer that can access the central database from which they would get the information about the patient's entitlement and about their other medications. You cannot tap into it from any computer, any personal computer at home, for example. It is only the—

Mr FORREST—So those pharmacists that go to it would have had to have gone through some level of accreditation, security checks, that sort of thing beforehand? Has that happened?

Dr Tatchell—I believe so, yes.

Mr FORREST—Really we have got a lot to learn from what they have done over there.

Mr Greenwood—I think that is true, but the other part of the issue is that it gives pharmacists a much better range of data in order to prevent adverse drug reactions because they have access to the full medication profile, and that can only lead to better health outcomes and less hospitalisation. From that point of view alone it is of interest to us. The other thing that is of interest to us is that it would enable pharmacists to have their claims paid quicker than at present. Under the current guild administrative agreement we have an arrangement of payment times of 20 days, I think.

Dr Tatchell—That is 20 days after the lodgment of the claim. The claim is not lodged in most cases until the end of the month, which could be four weeks after the prescription was dispensed, and then the pharmacist has to wait another 20 days before they get paid.

Mr FORREST—Bankrolling the government.

Dr Tatchell—Yes. But, under the PharmaNet type system, there is no reason to say that they could not actually be paid at the time of dispensing.

Mr FORREST—So it is operating on real time. Does the British Columbian system allow any rebates to be paid directly to the pharmacists? That process is the next step, is it not? Or has that already happened in British Columbia?

Dr Tatchell—I do not believe there are any payments made to the patient. Is that what your question is?

Mr FORREST—Yes.

Dr Tatchell—No, I do not believe there are any payments made to the patient at the time of dispensing. They would still have to go through—

Mr FORREST—Sorry, I mean the compensation to the pharmacist from the equivalent to the—

Dr Tatchell—No. I believe what they have in British Columbia is a payment within 10 days. They allow the prescriptions in a 10-day period to build up and then they press a button at Treasury or Finance and an electronic payment gets put into the pharmacist's account. But there is no reason why it could not happen at the time it is dispensed.

Mr FORREST—Ten days is reasonable, and it is happening electronically which is—

Mr QUICK—Having been over to Vancouver and lived over there for a couple of years I understand the remoteness of the area; it is equivalent to some of the remoter areas of Australia. I am interested in the indigenous communities that proliferate in the extreme parts of BC. We heard evidence today of our indigenous people in Australia trying to access concessions and the difficulty in places like Kununurra and Broome and far-flung areas of Australia. PharmaNet obviously is looking after those concerns, is it—or are they just as difficult to address as they here in Australia?

Dr Tatchell—I do not know the answer to that question, but I imagine that those difficulties have been addressed. If you are asking how that might happen in Australia, I would think that because 99.9 per cent of all pharmacies have a dispensary computer, all of those pharmacies, you would think, could be linked on-line to a central agency. The connection would be just as quick in an outback area as it would be in a metropolitan area.

Mr QUICK—Would I be right in saying that your members in some of those far-flung areas have got a little bit more 'flexibility' to do a few things? I am not suggesting anything illegal, but having a bit more flexibility than, say, someone in Bankstown Square where you have got half a dozen pharmacies and everybody has got adequate access to whatever they need, and prescriptions that are difficult to get are not difficult to get in Bankstown compared to, say, Kununurra. HIC perhaps gives them a little bit more flexibility when it comes to privacy and the processing process and access and things. I should have asked them that question, but I will ask you.

Mr Banks—I would be guessing. I would think though that maybe, as I said earlier, we do experience different attitudes from different payment offices, and I think that could well exist in those remote situations. That is all I could comment.

Mr QUICK—But your members in those areas would appreciate something as

simple and constructive as this PharmaNet if it was replicated in Australia.

Mr Banks—I think they would, if it solves that problem. This is a matter that has been discussed year after year after year, and it is a well-recognised fact that there is a multiplicity of names, the same person having the same name, all sorts of difficulties. I think in a large number of cases that those difficulties are resolved. I am not aware of the fact that people are actually being refused medication. I think that our members are usually fairly astute in terms of the relationship with a local doctor who would check to see if Bill Stanton is Bill Stanton, for example, if he has been there, and if he has been seen before and so forth. In most of those situations I think a supply of medication takes place without there being a major disadvantage. The person who generally loses in that bout is the pharmacist because of the time loss and so forth.

Mr QUICK—The Royal Flying Doctor Service covers huge areas of Australia; are they a pharmacy in their own right so that they can dispense bits and pieces or do they have to come back to Broken Hill or Port Augusta or Tennant Creek or wherever? How does their system work? I am interested in the regional and rural aspect of it.

Mr Banks—I think we all agree that they have what is commonly called the doctor's bag supply. So, for the immediacy of medication, they have it with them. That is fairly easy to cater for in probably 80 per cent of the cases. It might be a different percentage but the doctor can usually have the stuff there that he needs for urgent requirements and probably the rest of it comes a few days later.

Mr QUICK—Thanks for that.

Mrs WEST—How many scripts per pharmacy would you be processing per week, on average?

Dr Tatchell—I have a figure for the year. If we divide that by 52 it is about 701 on average, per pharmacy.

Mrs WEST—Do you think there might be a problem translating the British Columbia component to an Australia wide component, in size?

Dr Tatchell—It certainly is a leap in size but it is our understanding, from our preliminary discussions with the HIC, that it should not be a problem.

Mrs WEST—You would not compartmentalise it state by state or something like that?

Dr Tatchell—Yes, I guess that is one way it could be done. We would be concerned if there was significant delay in the dispensing process to get the information on-line. Even a five or a 10 second wait for a pharmacist can really interrupt the flow.

Mrs WEST—It would create a huge demand on the processing terminals. If that information is being relayed, it would also have to be improved at the other end. You could implement the system in the state but what happens to the body you feed it into; does it have to keep up to speed with the technology? Will it be advanced as quickly as the process in the field?

Mr Greenwood—I think it would have to be state-of-the-art. That is why, at this stage, the guild would only be interested in undertaking a feasibility study to see whether it is possible for such a system to operate in an on-line, real-time way. If we are talking on-line, real-time, that is what we mean. There have been systems proposed in the past that have been interactive with the HIC which the profession has roundly rejected. But this one has a number of other advantages and also offers the sorts of protections that the profession might need. At this stage the guild would only take the view that a proper feasibility study should be funded by the Commonwealth to see whether it can operate in our environment.

Mrs WEST—Would that feasibility study be a pilot, such as a working operational model, or would you do all the homework first?

Mr Greenwood—I think it would have to be a major pilot.

Mrs WEST—Practical application.

Mr Greenwood—It would have to involve many of the members.

Mrs WEST—With that, you would have to link in with the Health Insurance Commission's database in order to verify eligibility. The proposal raises issues of privacy and the protection of confidential and identifiable data. What legislative framework does the guild consider would be needed to address these issues before the pilot?

Mr Greenwood—I imagine there would have to be discussions with the Privacy Commissioner as to whether or not there were concerns. Once again we would be taking advice from the government officers in that regard and we would be asking them to seek advice from Attorney-General's but there would have to be discussions with the Privacy Commissioner and with the consumer movement, I would think, in terms of the sort of regime that could be put in place which protects not only the integrity of our members' data but the individual patient data and also proscribes the way in which any of that data could be used by government.

Mrs WEST—So you see the need of the Privacy Act 1988 to be extended to cover pharmacists and their staff in order to—

Mr Greenwood—That is not for me to say. I do think that those negotiations with all of the stakeholders need to take place and there needs to be some agreement as to what

protections need to be put in place.

Ms ELLIS—In your submission, I think it is actually 2.3.4 where you talk about PharmaNet—and I have to confess that I am not as au fait with the British Columbia system as others in the room. But you say here:

Each prescription dispensed by the pharmacist is adjudicated by the central agency at the time of dispensing.

Could I play devil's advocate for a moment and ask what does that mean and what room is there, if any, for an embarrassing situation to arise within a pharmacy where someone is on the spot refused a prescription and then it is found that they should have got it?

Dr Tatchell—I will kick off if you like. What we mean by adjudication is you would get information back on-line as to the patient's eligibility, whether they were in fact a concessional patient, if that is what they claim to be, and you would be told that through, I suppose, a message on the screen. There could well be some embarrassing scenarios in pharmacy as a result of that. Mr Banks might like to comment on that.

Mr Banks—You hit it on the head. That is where the real problem does arise and it is embarrassing. It is embarrassing for all parties: the pharmacist, the staff and the patient. I really do not know how you get around that. I was asking the question today of how up to date is the database at any one time and apparently that is updated on a daily basis; that is, from the Department of Social Security to the Health Insurance Commission. Really, you would have to say that has got to be on-line. In other words, it would have to be on-line as from the moment it was processed by the Department of Social Security because otherwise there would be problems—maybe a small percentage, but you do not need big percentages in that arena to be rather discomforting. So, yes, that is a problem.

The other aspect of it, I think, that should be carried through is the fact that people do not always carry their cards with them, whether the Medicare card or others. It is very often at home, on top of the fridge—people are afraid to lose it. So it is registered at the doctor's surgery and that is it. They do not carry that with them at this point in time—maybe in a few years they will. I think when we go across to talking about cards generally the concept of reducing the number of cards is certainly the one thing that we must look at with all seriousness.

Ms ELLIS—May I suggest then that with any planning for a feasibility or pilot study this should be one of the primary concerns in formulating that pilot or feasibility.

Mr Greenwood—We would certainly support that. Obviously there has to be a major element of discretion that is worked into any feasibility study for those specific reasons. It is not only that people leave their cards at home, they are often very elderly, they often arrange for an agent to pick up a script on their behalf. Often the agent can be

a child and there does need to be an element of discretion that the pharmacist is able to exercise in a professional way, not only to meet his professional obligations but also to meet any professional liability concerns that might exist.

Mrs ELSON—Your submission states that there is scope for streamlining the current array of concessions available to people on low incomes. Does this statement apply to the overall range of concession cards or to the specific concessions attached to those cards? Could you expand upon this view?

Dr Tatchell—We are really making reference to the number of cards, more than anything else, and I will let Si pick that up in a moment. We list all those cards in our submission. We heard evidence earlier today about the fact that some of them are issued annually and sometimes there are temporary cards. We need to add to that that there are also entitlement cards that the patient and family can receive if they reach the Safety Net limit. They are generated by the pharmacist. There may now also be a requirement for the Medicare card to be used. So there is a plethora of cards out there that the pharmacist has to be knowledgeable about and aware of, which can cause the pharmacist problems. Si might like to pick up from there.

Mr Banks—Yes. The number of cards is a problem. I guess with the problem comes identification. When the cards were specific, they were certainly specific. So if someone was watching that basket for some particular reason it gave them the information that they needed. However, with the advance of technology, I think we would all have to agree that the advances in card technology that we are seeing would make it possible for the one physical card to have all sorts of different information on it. I think we have to pursue that with great determination. Maybe it is a matter of waiting another 12 months for that technology to come to its peak, but there is no reason that we should not start the game now.

CHAIRMAN—So you would be happy if, for instance, the government decided that instead of having a multiplicity of cards it would be best to have one card.

Mr Greenwood—We would not be concerned about having one card as long as all of the relevant information was on it. That can be done with smart card technology.

CHAIRMAN—It has also been suggested that, instead of having concession cards, the government could cash out the average cost of concessions. For instance, a pension might go up by approximately $1,100, which has been estimated to be the average cost of the use of a card. If that were the case, it would remove from the pharmacy area altogether the problem of determining eligibility, because all people coming in would be dealing with the PBS on the basis that they were part of the general community rather than a concessional community.

Mr Greenwood—That would be a political decision, but it certainly is something

that we would look at very seriously. The main objection that I would have to any such system is that it would not necessarily be able to accommodate people over 65. As people get older they use more medication. So if you were working out some sort of average arrangement whereby the pension was to be increased to take that into account, there would be a lot of very elderly people who might be over that average. I think that would have to be taken into account.

CHAIRMAN—We still could have a Safety Net arrangement whereby all of us, if we spent over a certain figure on pharmaceuticals, would get the benefit of that Safety Net. That obviously would still be an entitlement.

Mr Greenwood—That is true. Our other concern would be that, if money were paid to people up front and they were able to cash out in that way, they would not spend the money on pharmaceuticals. They could get themselves into financial trouble. I have not really thought this through, but the only way that you could actually counter that would be to use smart card store and send technology to actually load the card with the additional moneys so that it could only be used for pharmaceuticals. Perhaps it could be topped up in some way. But I think you would need to have some method of making sure that people did not waste the money that the government was providing on purchases other than pharmaceuticals and then find themselves in situations wherein they cannot afford to get the medication that they need.

CHAIRMAN—Your submission states that, in the interests of patient privacy, PharmaNet allows individuals to protect their patient files with a password. This password is then disclosed to pharmacists in order to gain access to the patient's files for prescribing purposes. The submission reports that within seven weeks of the introduction of PharmaNet, some 810 people had chosen to protect their files with a password. I wonder how many did not. Do you have any more up-to-date information on the numbers of people currently choosing to protect their patient files with a password? I imagine this information will be in this review of the 12 months of operation, which you will receive shortly and pass on to us?

Dr Tatchell—We sought that information before coming here, but we were told that that will be made available at the time of this evaluation report.

CHAIRMAN—Is there anything further that you would like to add?

Mr Greenwood—There is nothing further that we would like to add, but we will send you that information about the administrative costs involved.

CHAIRMAN—We would appreciate it if you could pass any information on to Bjarne Nordin, the secretary, and he will circulate it to committee members. Thank you very much for attending this afternoon.

[4.18 p.m.]

MARKHAM, Ms Carmel Annette, Coordination ACT Community Care, ACT Department of Health and Community Care, GPO Box 825, Canberra, Australian Capital Territory 2601

PURCELL, Mr Jim, Executive Director, Council on the Ageing (ACT), PO Box 66, Hughes, Australian Capital Territory 2605

CHAIRMAN—I now call witnesses from the ACT Council on the Ageing and the ACT Department of Health and Community Care to be sworn in. Welcome. Would you like to, briefly, give us an opening statement. We have got your submission. It has been circulated and published and we have all read it. There might be some aspects of it that you would like to highlight. I noticed upon reading it that it appeared to concentrate on a fairly specific area.

Ms Markham—Yes, it does. The reciprocal arrangements have been the most specific area which we have had to deal with. I shall just give you a little bit of background. The area in which I work took responsibility for the seniors card when the new government was elected in the Australian Capital Territory last year. There had been earlier discussions. Rosemary Follett had previously had discussions with Mr Fahey and Mr Greiner as to reciprocal state rail arrangements which seem to be the biggest issue.

The biggest barrier has probably been that the criteria for having a seniors card in the ACT are different from those in other states and, as you would know, they are different in all states. In the ACT the only requirements are that you are 60 years of age and that you are an ACT resident. You could be working or be a millionaire and still have a seniors card. That seems to have been one of the barriers to negotiations about reciprocal arrangements.

CHAIRMAN—What is the ACT government's view on the current diversity of concession cards being issued at Commonwealth level and the complexity of the administrative system which currently exists which involves a number of departments and the Health Insurance Commission?

Ms Markham—I cannot answer that question for you, because I did not actually prepare this submission. I have just come here to answer for you anything I can about the seniors card.

CHAIRMAN—Okay.

Ms ELLIS—Jim Purcell, now that you have got the contracted carriage of the seniors card, to ensure the appropriate delivery of that service has the council been given additional resources?

Mr Purcell—Yes, it has.

Ms ELLIS—To what degree?

Mr Purcell—The contract was worth $40,000.

Ms ELLIS—Over and above your current funding level?

Mr Purcell—That is right. That will allow us to purchase the necessary hardware for the database and to hire an additional part-time staff member.

Ms ELLIS—So you are not taking over a current system that was operating within the bureaucracy prior to that?

Mr Purcell—Yes, we are. But there are some necessary changes to that system which are taking place at the present time. The database has yet to be handed over to us. The ACT government is currently working on that database to ensure compatibility with the systems that we operate, and there are some privacy provisions which need to be complied with before the database is handed over.

Ms ELLIS—The other questions I have got might be a bit awkward, given that Carmel has just said that you are primarily here to handle the seniors card questions.

Ms Markham—I am.

Ms ELLIS—Between the two of you, I am not sure whether I am going to go out of your brief.

Mr Purcell—I will answer questions for the ACT government. I do not mind.

CHAIRMAN—It might not like it.

Ms ELLIS—It is an interesting thing to have on record.

Mr Purcell—It is.

Ms ELLIS—As it operates in the ACT, the seniors card is a concession system outside of a more formal one. I know that a lot of the concessions that are available on there are at the behest of people offering them rather than their being a formal governmental system of concession.

Mr Purcell—That is correct.

Ms ELLIS—Do you see any problems in the formal government concession

system as it operates in the ACT, given that we are surrounded by New South Wales, geographically, and we have a desperate need for reciprocity on that basis?

Mr Purcell—Yes, I do. The problem from a consumer perspective at the present time is that if you are an ACT resident you can access a range of services and retail opportunities and those sorts of things. The problem that most people face is that, if they try to get some sort of concession in New South Wales, it depends basically on the person that might be providing the concession. Any number of people have advised us that, if they go to the railway station and show their seniors card, some individuals will recognise it but others will not. It is the same sort of thing in Sydney. Some bus drivers will recognise it but other people—for example, some ferry operators—will not.

Ms ELLIS—Where are we up to in addressing that?

Mr Purcell—As far as I am aware, the ACT government has had a number of discussions with New South Wales on that particular issue but I do not believe it has been advanced terribly far at this stage. I understand that the New South Wales government has done some sort of costing of the problem but I have not seen any figures in relation to what it does cost.

It seems to me, though, that from a consumer perspective the ACT draws an awful lot of New South Wales seniors, particularly at this time of the year with Floriade and so on, and there would not be any major financial drain on New South Wales if it offered the same sorts of concessions to ACT seniors as it does to its own seniors.

Ms ELLIS—Now that the council has the implementation and the carriage of the seniors card, who is going to be the negotiating body in the ACT on behalf of pensioners here with the New South Wales and other governments? Is it going to be the ACT government, or is it going to be the council?

Mr Purcell—It will be the Council on the Ageing.

Ms ELLIS—So you are really being put into a fairly political position, in that sense, in negotiating with other governments?

Mr Purcell—Yes. That is correct.

Ms ELLIS—Let me also turn to the submission from the ACT government. There is an attachment which has been referred to as the ACT concessions program for 1994-95. Was that also the program for 1995-96, which is the year we have just finished?

Ms Markham—I cannot answer that.

Ms ELLIS—If you could find that out, I would be grateful. I notice that on that

program—in the letter to which it is attached, it says it is for 1994-95—one thing is glaringly missing from that, and that is a dental concession. We heard evidence earlier today that there is a supposition drawn by most of us that, although there was the controversial withdrawal of the Commonwealth dental process of assistance, states and territories did, in fact, have their own. Is there an ACT government administered dental system and, if so, when did it come into implementation given that it does not appear in 1994-95? What is the current position affecting Health Care Card holders or seniors card holders in the ACT of the age category requiring dental assistance?

Mrs WEST—That may be addressed in their budget in September.

Ms ELLIS—There is a year missing, as well.

CHAIRMAN—We realise that you cannot answer some of the questions that Ms Ellis is asking.

Ms ELLIS—Yes, I acknowledge that.

CHAIRMAN—And, to be honest, the ACT government has not sent the people from the ACT Treasury who we understood were going to come along. They would have been in the position to answer those questions. All we ask you is that you go back to the ACT government and tell them the matters that we would like answers on, and get to the secretary, Mr Bjarne Nordin, a further submission from the ACT government answering these questions. That would assist the committee in its deliberations.

Ms ELLIS—In relation to what I understand to be the 1994-95 program of concessions, could we have a confirmed program for the year that has just finalised and for the program that is currently in place? That would be useful as well.

Ms Markham—You want it confirmed for 1995-96.

Ms ELLIS—This is referred to as 1994-95 only. Was it exactly the same for 1995-96 and, if not, what was it and what is the current one?

Ms Markham—Fine.

Mrs WEST—They are in budget mode in the ACT. You could possibly put it into the system now; I do not know whether they have worked out what they are going to do on 24 September. But, with your concern about the travel concessions, what would your group like to recommend to the New South Wales government?

Mr Purcell—The issue is a little more complex than that. Carmel Markham mentioned, in her opening statement, the eligibility criteria for seniors cards; they are different across all the states and territories. The ACT's eligibility criteria are perhaps the

easiest criteria in that the only criteria are that you be 60 and live in the ACT. All other states and territories have more stringent eligibility criteria. I believe that that is one of the stumbling blocks in relation to why they do not provide reciprocity with the ACT. If the ACT were to introduce different eligibility criteria, then I suspect that the New South Wales government might be a little more ready to talk about reciprocity.

What we would simply need to do is change the eligibility criteria to remove the simple fact that you need to be 60. It should be 60 and not in a full-time job or not working more than 10 hours a week or something like that. That would satisfy the New South Wales government to some extent, but I still believe that the New South Wales government sees some financial disadvantage in recognising ACT seniors.

Mrs VALE—If a national transport concession card could be developed that would address this problem with reciprocity, would you endorse such an initiative?

Mr Purcell—Yes, I would, but I do not really see the advantage of a national transport card in addition to a seniors card. The concessions provided for transport are usually government concessions. Most of the other concessions that people get are commercial concessions provided by private organisations. It would be a better option if we could get the transport concessions accepted as part of the seniors card.

Mr ROSS CAMERON—In terms of the generosity of the benefit, you actually wind up with very little in the end, or you lose a big chunk of the possible benefit, if you cannot get agreement with New South Wales. My questions are: firstly, what is the logic of giving 60-year-old Rupert Murdoch a travel concession—

Mr Purcell—There is no logic.

Mr ROSS CAMERON—Secondly, what are the prospects politically?

CHAIRMAN—He is a resident here, is he?

Mr ROSS CAMERON—It sounds as though he would not have to be, to qualify.

Mr Purcell—No. If he were resident here, he could get a card: you are quite right.

Mr ROSS CAMERON—Okay. What are the prospects of the ACT government reviewing it to come up with a deal which the New South Wales government is going to be happy with?

Mr Purcell—It would be my view that the organisation that I work for, the Council on the Ageing, would consider putting a recommendation to the ACT government to alter the eligibility criteria.

Mr ROSS CAMERON—They ought to do it, shouldn't they? It is in the interests of their constituency.

Mr Purcell—They ought to do it. I believe so. It will be a political decision that the ACT government will make, but that decision can be based on the fact that we can provide them with information to show that ACT seniors might get a better deal if the eligibility criteria are altered slightly.

CHAIRMAN—When is this all going to happen?

Mr Purcell—As soon as possible. We have signed the contract within the last few weeks, so we have not had any opportunity to put any recommendations to government yet. When we do put a recommendation to government, it will be up to government to consider that, so I cannot give you a time frame.

Mrs ELSON—Mr Purcell, did the suggestions on the eligibility for the Pensioner Health Benefit Card in 1993—it was later renamed the pensioner concession card—have any impact on the level of demand for concessions provided by the ACT government?

Mr Purcell—I cannot answer that. Ms Markham might be able to answer.

Ms Markham—I cannot answer that.

Mrs ELSON—That is okay. If you could get back to us on that one, I would appreciate it.

Ms ELLIS—Mr Purcell, with the contract for the operation by the council of the card, does the $40,000 include the production and the sending out of the cards, and the whole kit and caboodle?

Mr Purcell—It does indeed.

Ms ELLIS—Could you quickly outline for us the formal government concessions that come with the seniors card, as against the generosity of the commercial sector wishing to attach themselves to it?

Mr Purcell—I believe the government concessions are restricted to travel on ACTION buses. I do not believe there are other government concessions.

Ms Markham—And I think there is admission to swimming pools and some theatres. I actually have it here, somewhere.

Mr Purcell—Theatres are not government owned.

Ms Markham—No.

Ms ELLIS—All of the rates concessions and all of those other things are attached to all of the other concession cards that come through the Commonwealth, are they?

Mr Purcell—To all of the other concession cards. There are no other government concessions attached to the seniors card—other than, I believe, ACTION buses.

Ms ELLIS—You may need to take this question on notice. We had a discussion with ACROD earlier today about the access to taxi concessions for disabled people in our community. Given the location of Queanbeyan in relation to the ACT, can you give us some indication of whether there is any reciprocity at all between Queanbeyan—and, therefore, New South Wales—and the ACT in the use of transport and taxi concessions for the disabled? If so, how does it work? If not, what are the problems that emerge as a result of that lack of two-way concessionality?

CHAIRMAN—Will you take that on notice?

Ms ELLIS—Yes, I am happy for that.

CHAIRMAN—I have two other questions, and I suspect that you might have to take those on notice as well and get back to us. Firstly, a number of submissions have proposed that a national transport concession card be introduced to overcome the problem of the lack of reciprocity across states and territories. Would you see merit in such a proposal? Secondly, are there any issues relating to Commonwealth-state coordination of concessional entitlements which you would like to raise with the committee, either now or perhaps in a written further submission?

Mr Purcell—On the first one, Mr Chairman, Mrs Vale asked a similar question about the benefit of a transport concession card. Whilst I would accept that there are significant benefits to be had, if we are able to negotiate a transport concession card for older people aged 60, 65 or whatever, I believe that it ought to operate in conjunction with the seniors card, whether that be a national seniors card or a state operated seniors card. Another card, a transport concession card, would simply add to the range of concession cards that are already in existence, and I do not know that it would be beneficial to anybody to have another card and another set of administrative arrangements in place to look after that particular card. It could be added quite successfully to the seniors cards in all of the states and territories.

Mrs WEST—What kind of budget are you looking for for the card? Is it unlimited travel for a concession card?

Mr Purcell—At the present time in most of the states and territories people have unlimited travel at concession rates. In the ACT, seniors card holders can get unlimited

concessional travel at certain times outside peak hours.

CHAIRMAN—Is there anything else you would like to tell the inquiry at this time? Thank you very much for appearing before us. As I said, we were disappointed that the ACT Treasury officials did not arrive as originally planned, but we thank you in any event for being here this afternoon.

Resolved (on motion by Mrs West, seconded by Ms Ellis):

That, pursuant to the power conferred by section 2(2) of the Parliamentary Papers Act 1908, this committee authorises publication of the evidence given before it at public hearing this day.

Committee adjourned at 4.35 p.m.