COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON ECONOMICS, FINANCE AND PUBLIC ADMINISTRATION

Reference: Tax file number inquiry

THURSDAY, 9 MARCH 2000

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON ECONOMICS, FINANCE AND PUBLIC ADMINISTRATION

Thursday, 9 March 2000Thursday, 9 March 2000

Members: Mr Hawker *(Chair)*, Mr Albanese, Ms Burke, Ms Gambaro, Mrs Hull, Mr Latham, Mr Pyne, Mr Somlyay, Dr Southcott and Mr Wilton

Members in attendance: Ms Burke, Ms Gambaro, Mr Hawker, Mrs Hull, Mr Pyne, Mr Somlyay, Dr Southcott and Mr Wilton

Terms of reference for the inquiry:

The House of Representatives Standing Committee on Economics, Finance and Public Administration will investigate administrative, policy and client service issues of TFN management, as recently reported by the Australian National Audit Office in audit report no. 37 1998/99. The committee will also inquire into other aspects of the TFN system in Australia.

The committee will pursue its investigation under House Standing Order (324b), which states that the reports of the Auditor-General stand referred to the relevant committee for any inquiry the committee may wish to make.

WITNESSES

COMMITTEE MET AT 10.07 A.M.

BALDOCK, Mrs Leonie Jann, Manager, Information Policy and Access Branch, Information Management Division, Health Insurance Commission

GRAYSON, Mr Graham Malcolm, Manager, Health Programs Branch, Health Insurance Commission

PROBYN, Mr Geoffrey James, Manager, Investigations Coordination Section, Compliance Branch, Professional Review Division, Health Insurance Commission

RICHARDS, Dr Brian Howard, General Manager, Information Management Division, Health Insurance Commission

TRABINGER, Mr John, Manager, Health Informatics, Information Management Division, Health Insurance Commission

CHAIR—I declare open this public hearing of the House of Representatives Economics, Finance and Public Administration Committee as part of our inquiry into tax file numbers. Today we will hear from the Health Insurance Commission.

THE WORK OF THE HEALTH INSURANCE COMMISSION AND THEIR LARGE CLIENT BASE MEANS THAT THEY ARE IN A POSITION TO COMMENT ON DATA QUALITY AND SYSTEMS MANAGEMENT. THESE ISSUES HAVE IMPLICATIONS ACROSS THE WHOLE OF GOVERNMENT AND PROVIDE A GOOD COMPARISON WITH THE OPERATION OF THE AUSTRALIAN TAXATION OFFICE. WE WERE GOING TO HAVE THE AUSTRALIAN FEDERAL POLICE APPEAR, BUT, GIVEN THAT THERE IS SOME PRESSURE FOR ANOTHER MEETING AT 11, THE COMMITTEE MIGHT HAVE TO DEFER THE SECOND PART OF THE HEARINGS TODAY.

I WELCOME THE REPRESENTATIVES FROM THE HEALTH INSURANCE COMMISSION. I REMIND YOU THAT THE EVIDENCE THAT YOU GIVE AT THIS PUBLIC HEARING IS CONSIDERED TO BE PART OF THE PROCEEDINGS OF PARLIAMENT AND I THEREFORE REMIND YOU THAT ANY ATTEMPT TO MISLEAD THE COMMITTEE IS A VERY SERIOUS MATTER AND COULD AMOUNT TO A CONTEMPT OF THE PARLIAMENT. YOU HAVE NOT MADE A FORMAL SUBMISSION TO THE INQUIRY. DR RICHARDS, WOULD YOU LIKE TO MAKE AN OPENING STATEMENT BEFORE WE PROCEED TO QUESTIONS?

Dr Richards—Thank you. The Health Insurance Commission is responsible for administering a range of government health programs. They include Medicare and the Pharmaceutical Benefits Scheme, but there is a range of other programs we also administer. We are thus uniquely placed to have registered almost all Australians on our database and we have had 25 years experience of administering these programs. We are pleased to be able to assist the committee with its work.

CHAIR—One of the points that the Audit Office reported on—tax file numbers and so on—was on the question of data matching. Could you explain in what way, at the moment, the ATO could or does do data matching with some of your records?

Dr Richards—I might ask Mrs Baldock to answer that question.

Mrs Baldock—There is no ongoing data matching arrangements between the Health Insurance Commission and the Australian Taxation Office. There was a particular exercise that was conducted approximately two years ago and that was as a result of the Auditor-General's power to require agencies to match data for particular purposes. But, to the best of my knowledge, that is the only data linkage exercise that has gone on. That report was tabled in parliament as a result of that particular exercise.

CHAIR—Could you expand on that a bit more; what did it actually do?

Mrs Baldock—The intention, I understand, was to examine the accuracy or effectiveness of the tax file number scheme. The Audit Office decided to engage several agencies—firstly, in discussion to find out what information the agencies held with a view to a data matching exercise to achieve certain outcomes that the Audit Office wanted to achieve with regard to validating the accuracy of tax file information. As part of that examination, the Health Insurance Commission was chosen as one of the agencies with which data would be linked. There was a strict privacy protocol that followed on from that which required destruction of linked records and so forth to ensure privacy and confidentiality were maintained but, at the same time, it allowed the Auditor-General to draw certain conclusions about the tax file number system.

CHAIR—Did you see any weaknesses in the tax file number system from this work?

Mrs Baldock—There was a formal report that was prepared as a result. That was sent to the Treasurer and tabled in parliament. It was not submitted to our agency for comment, but it does report the findings of the audit.

CHAIR—One of the questions I am interested in is the growth of fraud. We read reports in the paper and so on that there has been growth in fraud. Are you experiencing that with the HIC? Do you find that a problem? What sorts of numbers are we talking about?

Mr Probyn—There was no significant growth that we could see through our systems and strategies that we have employed. We have what we call sourced based audits, purpose based audits and random audit process that tells us that there is no significant growth in services provided. But, from the point of view of putting a percentage on it, like all fraud, it is very difficult to assess that. All I can say is that, from our strategies, we believe that we do not have a significant fraud problem.

CHAIR—Do you have any difficulties with proof of identity?

Mr Probyn—I would have to pass that to Mr Grayson.

Mr Grayson—Before we move on to proof of identity—just to clarify in the context of ongoing matching—like Leonie mentioned, there was a one-off exercise as requested by ANAO. Under the 30 per cent rebate scheme, which is a specific program, data is exchanged annually with the ATO. It used to be for the then private health insurance incentive scheme. But that is all contained for those that come under the umbrella of that program. Remember, they can either get the rebate through their private health fund or claim it back through the tax system.

CHAIR—Can you explain what information you provided to the tax office and how you provided it?

Mr Grayson—I am not across the detail but we keep records of those that have claimed the rebate through their private health fund. That is then checked off with the tax office with those who have claimed through the tax system in their tax returns. People are not allowed to double dip.

CHAIR—Do you have any experience of people actually trying to double dip?

Mr Grayson—I do not have the figures on that. There is a separate audit on that program. The findings are out and people are working through those findings.

CHAIR—What did the audit actually say?

Mr Grayson—I am not across that.

CHAIR—Would you be able to send us a copy of that?

Mr Grayson—Certainly.

Ms GAMBARO—Can I continue on with Medicare fraud, particularly with general practitioners. HIC has a system in place where you visit general practitioners to ascertain the level of procedures—Pap smear tests, et cetera—that are being carried out. What methodology do you use to determine if a general practitioner in an area is overprescribing and how are your methods of detecting fraud validated there?

Mr Probyn—We have a neural net. I would refer that to Mr Trabinger to explain the neural network. It assesses doctors against their peer group average and the provision of medical services. If there is some anomaly in the servicing arrangements, that would stand out with the neural network reports. There are other ways that those anomalies can be detected. That can be through the review and analysis process; it can be through the spot audits, source based audits. The source based audit is a random audit affair. From that can come a purpose based audit. If it homes in on a particular area where there is high servicing with a particular item number or something like that, we would then look at each of the practitioners that are providing those services on an individual basis.

Ms GAMBARO—I do not know whether this is a question for you or for John Trabinger: do you look at demographic factors of an area—if there are, for example, a high number of older women living in a particular area—or do you just compare it to your standard models? How do demographic factors come into it?

Mr Trabinger—The methodology is looking at pattern recognition. The HIC does not define what inappropriate practice is. It is a peer review system. What we look at is abnormal profiles or atypical profiles. Once we establish what an atypical profile is, it goes through a system of external peer review, if necessary, to establish whether it is inappropriate practice or, at the other end of the scale, fraud. The pattern recognition systems would look at situations where there are demographic age and sex issues and factor those in for normalisation.

Ms GAMBARO—There are increasing cases of Medicare fraud. What about provider numbers? Are there cases of provider numbers being abused now that the government has tightened up the provider number legislation or have you had no cases reported of provider number abuse?

Mr Grayson—On the fraud side, we leave that to the fraud people. In terms of the access to provider numbers, that is a very tightly controlled process. They have to go through the medical boards and then the recognition committees. We provide a secretariat for the recognition committees. Once they have been through that process, we are notified of the outcome and then we will issue a provider number and put them up on a provider file.

Ms GAMBARO—So it is pretty tightly administered and audited? There is no chance of abuse on that front?

Mr Probyn—We do not find abuse. Normally, it is administrative error where a provider number has been used in error by staff at a particular location.

Ms GAMBARO—If a doctor dies—I know I am harping on medical practices—have you got a good system in place? What happens to that provider number if there is a death? Do you just take it away from the doctor? Does it get reallocated?

Mr Grayson—We would get advice through the medical boards because there could be other factors that would impact on providers' eligibility for Medicare benefits. We would get advice from medical boards through to us and then we would act on that advice.

Ms GAMBARO—I have a question on non-residents being given Medicare numbers in the past. What is your procedure and how have you tightened that up?

Mr Grayson—The current process—it was launched late last year, the first phase thereof—is that when people, visitors or immigrants, come into the country, the Department of Immigration and Multicultural Affairs send us an electronic file with the names. When people come into the country we ask them to wait probably for a week, come into one of our offices and provide some form of identity, usually passport papers, and then we will issue the Medicare card.

Ms GAMBARO—So you have a good relationship in terms of data with the Department of Immigration and Multicultural Affairs?

Mr Grayson—Yes, it has certainly improved over time. That process makes it administratively easy for somebody coming into the country; they do not have to move between two agencies verifying documentation. As mentioned, we get the data up front, so when they come into our office they do not have to fill out a form, they provide their identity, we generate a receipt which they are required to sign, then we will issue the Medicare card. It is a much simpler process.

Ms GAMBARO—So there is good cooperation and there is good flow-through?

Mr Grayson—And that will then go on. People may have, say, eligibility for three months, and that was very much a paper type process. Now, we will be getting that data electronically from DIMA as well.

Ms GAMBARO—With DIMA and the ATO that cooperation does not seem to exist. We have spoken to them as well. It is good that you are able to operate very smoothly with that.

CHAIR—On that point, there is anecdotal evidence that non-residents coming to Australia have been getting hold of stolen or false Medicare cards. What level of fraud is there?

Mr Probyn—I cannot give you an accurate figure on that, but there have been frauds committed in that way and there is a market for stolen Medicare cards. I could possibly supply those numbers, but I would have to do that at a later date. They are not significant—I can say that.

CHAIR—It has been suggested, anecdotally anyway, that there are something like 23 million Medicare cards on issue. Is that correct?

Mr Probyn—I am not sure of that.

Mr Grayson—I do not think there are. I will have to check that.

CHAIR—When someone dies, what do you do to withdraw the Medicare card?

Mr Grayson—We may or may not. We might have to reissue the card because if there are multiple people on the card it will need to get reissued. We are now getting data from birth and deaths registrars and we are just starting to apply that, and by applying that automatically we will then go through and turn off Medicare benefits.

CHAIR—So at the moment you have probably got a lot of cards out there. When someone dies, probably not the first thing that the next of kin are going to do is to hand back a Medicare card, is it?

Mr Grayson—People do advise us.

CHAIR—But if you were that way inclined you would not. You are saying you are just starting to get the list of deaths to check?

Mr Grayson—And applying that to our enrolment files.

CHAIR—So, until now, there has been no systematic check when people die as to what happens to their Medicare card?

Mr Grayson—There has not been a systematic check on our part. We have relied on those families coming forward and providing the information.

CHAIR—And you are confident that—

Mr Grayson—I understand the majority do.

CHAIR—I am sure the majority do, but there is always a risk, isn't there, that quite a few of those cards are going to reappear with some other person?

Mr Grayson—There is a risk that some could, but remember that a lot of cards are family cards with multiple people on the card.

Mr PYNE—So you are working on the 'honesty is the best policy' policy—is that right?

Mr Grayson—No. We have just gone down a path of actually purchasing the data.

Mr PYNE—What about in the past?

Mr Grayson—In the past we have relied predominantly on people coming forward and saying that somebody in the family has passed away and we then turn off the entitlement.

Mr PYNE—That is noble but don't you think that it is slightly unwise to do that?

Mr Grayson—Hence we have gone down the path of getting the data from the births and deaths registrar and applying that to our files. We will be getting that every year and applying it.

CHAIR—Presumably that is only the current and prospective data. You are not going back 10 years and rechecking deaths, are you?

Mr Grayson—The first batch of data that we have got goes back several years.

CHAIR—How far have you got in applying it?

Mr Grayson—We have just commenced applying it.

CHAIR—So you do not have any figures as to how many surprises you are turning up.

Mr Grayson—Not at the moment.

CHAIR—You have not got there yet.

Mr Grayson—It depends on what we mean by surprises. It is possible that we will find people who have passed away and we do not have their entitlements switched off. There then becomes a second question about whether there has been any claim against that particular person since they died. We certainly will be undertaking that analysis.

Mr PYNE—Pardon my ignorance because I have not opened a bank account since I was at school, but is a Medicare card a tool for getting 100 points to open a bank account? Is that one of the things that you can show at a bank to make your 100 points?

Mrs HULL—No.

Mr PYNE—You cannot use a Medicare card.

Mrs HULL—Sorry, yes, to make up the 100 points.

Mr PYNE—Yes, obviously to make up 100 points you cannot use just one item. So you can use a Medicare card to get to 100 points at the bank?

Mr Probyn—Yes. The banks do accept it.

Mr PYNE—Isn't it dangerous to have a whole lot of Medicare cards out there that people can be using for setting up bank accounts and so on with other identification potentially so they can get tax file numbers? Is that right?

Mrs Baldock—It is our view that the Medicare card is simply to establish an individual's eligibility for Medicare. If the banks have chosen to exercise a discretion to accept that in some other way, that is not something that has been done without imprimatur. We simply say, 'It is proof of your entitlement for Medicare.'

CHAIR—One of the things the Audit Office found in a sample when looking at the tax file numbers was that 62 per cent of deceased clients were not recorded as deceased in a sample match against fact of death records—62 per cent had not been picked up. Wouldn't that be some cause for concern if people want to use that Medicare card for something else or sell it?

Mr Grayson—Hence we are getting that data and applying it. We will be doing follow-up analysis. As I mentioned, there are two components. We want to actually get the records complete and accurate, then check

out the assumption that there may or may not have been some fraud committed. We would want to undertake that analysis first.

Mr SOMLYAY—You may have answered this before I got here: if you have a Medicare card with five names on it and one person dies and it is reported, do you reissue that card in four names?

Mr Grayson—Yes, we would reissue the card. In our procedures the card actually gets a different number.

Mr SOMLYAY—Do you retrieve the other one?

Mr Grayson—We ask them to destroy or hand the card in. With each card issued there is an issue number so the previous card becomes invalidated and benefits get turned off.

CHAIR—According to the Audit Office there are over 400,000 Medicare records that could not be matched to an existing tax record. Do you not think there are an awful lot of grey areas here?

Mr Grayson—It is possible. I am not in a position to comment about fraud, et cetera.

Mrs Baldock—I guess we do not know what their matching methodology was either. It may well be that a mismatch is not because there is no record; it is simply because the information you are matching is not held in some—

CHAIR—Who has the problem? Is it the Health Insurance Commission or the tax office in this case?

Dr Richards—There could be circumstances in which people hold Medicare cards who are not taxpayers.

CHAIR—Most people would have a tax record with the ATO, wouldn't they?

Dr Richards—If a child were living away from home, for example, in a boarding school, and both parents consented to that child having their own Medicare card, the child could have their own card.

CHAIR—But that would not be 400,000.

Dr Richards—I do not know the characteristics of the 400,000.

CHAIR—Just to clarify, that audit excluded anyone under 18 and the elderly. It was a narrower focus on the people who would be likely to have both, and there were still 400,000 they could not match.

Dr Richards—Mr Trabinger might care to comment on data matching accuracy and the issues that relate to the ability to get 100 per cent matching. Four hundred thousand in 20 million Australians is not a high percentage, but Mr Trabinger may like to comment on that.

Mr Trabinger—With most data matching processes that take place between external databases of other organisations, matching software available at the moment and algorithms, you are looking at anywhere between a 75 and 85 per cent success rate of getting good matches. There will always be that redundant information that you will not be able to get a confident match on, and that might help you with some of that 400,000. I would not suggest that it was all the 400,000, though.

CHAIR—Can you explain that a bit further: the best you can achieve is 75 to 80 per cent?

Mr Trabinger—Seventy-five to 85 per cent in matching because you are trying to match a record from one disparate database to another, and you are looking for some common links that you can match. Sometimes they are very hard to find. For example, people will store addresses differently on different databases, so it is hard to get a good match; people might go by different names on different databases, using first and second names. There is a lot of tuning to try to get those types of matches. That is why you cannot always get a very confident match.

CHAIR—So, if you were that way inclined, you could very easily muck the system up and never get matched just by changing your name slightly?

Mr Trabinger—Yes.

CHAIR—So it is fairly limited value, all this data matching—is that what you are saying?

Mr Trabinger—No, I am not suggesting that either.

CHAIR—Could we assume that?

Mr Trabinger—It is possible to assume that.

Mr WILTON—Would you say that data matching was your primary means of control over the way the HIC deals with either duplicate or false Medicare cards on issue?

Mr Trabinger—I am not sure I understand the question.

Mr WILTON—I am not sure that I understand it myself!

Mrs HULL—He has had a hard couple of days.

Mr WILTON—Could you summarise the procedures that you have in place to keep a check on inactive or false Medicare cards on issue? Obviously you see it as your role to do that and your procedures are regarded as being pretty decent. What are those procedures?

Mr Grayson—At the front end, with enrolment, most children get enrolled at birth, the majority of them. I have mentioned about people coming into the country: we pick those up, and these days that is electronic. For others that enrol, they need to come along and provide documentary evidence. For most, we expect some form of photographic evidence as well. There are some elements of the community where that is not possible, for example Aboriginal communities and the homeless, and we have some special circumstances there. Then people can come and claim benefits. We have just gone down the path with Births, Deaths and Marriages to pick up that data regularly and run that against their files. And we have a rolling program of replacing cards. Remember, the majority of Medicare claims are for direct bill: a person goes to the doctor, assigns their right of benefit to the doctor and the doctor then claims on us. Then there are purpose based audits, source based audits and the heavier compliance programs that are all part of a continuum.

IF YOU THEN LOOK AT PHARMACEUTICAL BENEFITS, IT IS THE SAME ELIGIBILITY CRITERIA FOR ACCESSING MEDICARE AND PBS. FOR THOSE WHO GET A CONCESSIONAL ENTITLEMENT, WE DAILY RECEIVE DATA FROM CENTRELINK THAT WE APPLY TO OUR PHARMACEUTICAL BENEFITS ENTITLEMENT FILE. IF THOSE PEOPLE GO INTO A PHARMACY TO CLAIM CONCESSIONAL STATUS ON PBS THEY PROVIDE THEIR CONCESSION CARD.

Mr WILTON—Following on from that, does the HIC see it as its role at all to monitor prescription medicine abuse through the excess number of cards or false cards on issue? Is there any evidence of such prescription medicine abuse through the use of more than one card by an individual?

Mr Probyn—Not so much through the card itself. We have programs like the doctor shopping program that we are looking at—the misuse of drugs or overuse of drugs—where we identify people that are taking them for a number of reasons or moving them on, selling them on the black market overseas. That comes into our prescription drug smuggling program. In the course of investigation, there may have been occasions when we have found that there has not been a proper entitlement to it. I cannot give you figures for the number of those cases that have come to our attention. All I can say is that it is not significant. I would say most of the things are related to doctor shopping—people who have a legitimate claim through eligibility. It is mainly for the drug side of the problem. That is where the misuse of drugs comes in.

Mrs HULL—Bearing in mind that the discussion involving the last two questions led to the linking that you have with various other organisations, do you see it as a benefit to have a client service number that should be used by all government agencies? Would you see that as having a benefit? In answer to Mr Wilton's question you say that you verify this or you go with that and you look at pharmaceuticals, et cetera. If you had one client service number, would it be of benefit to you?

Mr Grayson—I guess we have not really looked in a policy sense at that issue. As Leonie mentioned earlier, our role is the administration of Medicare PBS. We get access to part of the data from some organisations to help administer those programs—for example, the information from Centrelink that provides concessional access to PBS. We get information from DIMA on people coming into the country so that we can provide them with access to Medicare. In terms of looking at a broader number, if we were asked, that is something that could be examined. That may well have policy implications in the health sector. An important agency there would be the department of health, having policy responsibility.

Mrs HULL—When you were talking about all the different areas that you are involved in, it would seem to me to be less time consuming and perhaps more expedient and more able to be targeted if you did have a client service number.

Dr Richards—This would be a government policy issue. As Graham explained, we administer government health programs as they are legislated. Currently, our legislation enables us to administer the Medicare and pharmaceutical and other schemes. Our legislation allows us to exchange some information with specific agencies, as Graham has mentioned. It does not allow us to exchange information with any others.

CHAIR—If you issue a Medicare card to a temporary resident coming into Australia, what happens to that card when they leave?

Mr Grayson—The cards have expiry dates on them when they are issued. We ask them to hand them back in or destroy them, or we will turn benefits off.

CHAIR—Do you archive inactive records?

Mr Grayson—We would comply. While I do not have that detail, we certainly comply with whatever the Archive Act requirements are.

CHAIR—No, I mean if you have a Medicare card and it has been used for some years and suddenly it is no longer being used, do you then flag it on your records as being inactive, or do you archive it? What happens to it?

Mr Trabinger—Medicare cards get re-issued every five years through that process.

Mrs HULL—So it is not like having a birth certificate where it goes forever? A Medicare card gets re-issued every five years. If you came into the country and you were able to qualify for a Medicare card for a period of time, it would have that and their date of departure expiry date on it. So it is going to be inactive anyhow because you cannot re-issue that number again. Is that right, you never duplicate a number?

Mrs Baldock—That is my understanding. By end dating a card, the record does not vanish. We still maintain computer records. We can still trace an individual. Even though the card has been end dated some years ago, they remain on the database.

Ms BURKE—With me recently having had a child, I put myself and my husband and my child on the one card, getting rid of my husband's card number. We have all got different names, of course, in this lovely new area. So his card technically now should be gone. He should not be able to use it because he has now been transferred onto my card with my number. So where is his card?

Mrs Baldock—Not necessarily, because a person can be active on two Medicare cards.

Ms BURKE—So he can actually continue to keep that old one?

Mrs Baldock—If you did not ask for it to be end dated, it is quite legitimate for us to have put his name onto a new card, recognising that he is an eligible person. But he now wants to be recognised as eligible within a different family group, so unless you had specifically asked for his card to be end dated, I would anticipate it is still current.

Ms BURKE—So that number could be accessed. If someone got hold of that card, and because there is no identifying factor except a name and a number, that somebody could actually use that card? It is currently still active then?

Mrs Baldock—That would be my expectation, yes.

Ms BURKE—So there is a fairly easy explanation of how there are lots of cards out there.

Mrs Baldock—It might be useful for me to say that, even though you can be on more than one Medicare card, you are still only identified as a single individual if you drill down into our database. So we would not say that that is two different identities. We still have a unique number sitting behind the Medicare number that says, even though you have got two numbers, I know you as one individual. Does that make sense?

Ms BURKE—Yes, because he would have two numbers on the cards, but you are saying in your system he is identified as one.

Mrs Baldock—Exactly.

Mr Grayson—So your first card that you had, that would be end dated and that card could not be used again. When people misplace or lose their cards, they tend to contact us. If they do, we will re-issue a card and the previous card would be end dated.

CHAIR—If they found the old card and inadvertently used it, what would happen?

Mr Grayson—They would not get a benefit. The benefit would be turned off.

Dr Richards—In summary, a Medicare card simply is an entitlement to a Medicare benefit and if a card is no longer valid, a benefit is not paid.

Ms BURKE—Except, of course, if you are using it for an up-front service. If you see a doctor and present your card, then we cannot do anything. If you go to a Medicare-provider-only doctor and you say, 'I'm here, take the card,' you are getting the benefit straight away.

Dr Richards—No, the doctor is not paid the benefit if the card is end dated.

Ms BURKE—That is the doctor, not the individual carrying the card. Therefore, the fraud is committed against the doctor.

Dr Richards—Yes, that is correct. It is usually by error.

Ms BURKE—Is there any checking mechanisms for the doctor in that instance?

Dr Richards—Yes.

Ms BURKE—Is it like a stolen credit card list? I have never had a doctor check against my card, I am just curious. Technically, should they be going through a matching system when they are presented with a card?

Mr SOMLYAY—They swipe it, don't they?

Dr Richards—If the card has been reported as stolen, the benefit is not paid from that card, the card is end dated.

Ms BURKE—Suppose I present at the doctor. I present the card and the doctor swipes it. Has the doctor got any mechanism of checking at that point, and should they be?

Mr Grayson—It is up to them. We offer a service, and if they want to ring up and do a check, that can happen.

Ms BURKE—Do people do that?

Mr Grayson—Yes, they do.

Mr SOMLYAY—When he swipes the card, and if the card is invalid it will be rejected there and then, will it not?

Mr Grayson—That is in the doctor's system. That system is not connected to our system.

Dr Richards—Doctors usually send in batches of claims.

Mrs HULL—The only time it will come up as 'invalid' is when you are making your claim at a Medicare office.

Ms GAMBARO—I will go back to Medicare numbers, seeing that we are on a bit of a roll here. In my case, I have got two children, so my name and my two children's names are on my Medicare number. Is there a record in your system of the two children, be it an informal record, and is there a subnumber issued to those people in your system so you can track the usage of all the people on the Medicare card?

Mr Grayson—Absolutely.

Dr Richards—Every Australian who is registered with Medicare has an individual identification number within our database that is different from the number on the card. So every individual is checked against a card, or more than one card if they are on a family card and one of their own.

Ms GAMBARO—For every individual, how accurate would that be, when you say that every individual in Australia would have some sort of identification?

Dr Richards—Every individual who is registered with Medicare would have a personal identification number in our database.

Ms GAMBARO—So your record of people would be a hell of a lot better than the ATO's, which we have heard about, if you are able to assign a number to each person accurately within the confines of the system?

Dr Richards—I cannot comment on the ATO system.

CHAIR—That is assuming that you are using your card and not someone else's.

Ms GAMBARO—Anna has had a baby recently, which is great. But, what about a family where there is a separation? You mentioned the case of a 14-year-old boy at boarding school having his own card. Let us say there is a separation, is it possible to have a duplicate card? How does that work and how do you track it? For example, you might have one parent with the names of the two children and the other parent is issued with a Medicare card with the two children on it. How do you keep track of that?

Mrs Baldock—Because it is linked back to the PIN, the personal identification number, when we issue the card, although we are issuing a new Medicare number in respect of the children, each of those numbers links them back to the unique PIN. So we can tell what card the business has been transacted on by the number that is quoted, but the service will be attributed against the PIN record which is common across the two cards.

Ms GAMBARO—That works great in a separation situation. What if the partner then goes and enters into a de facto relationship or gets married? Is it possible to have another card with the second relationship, and is that all taken into account as well?

Mrs Baldock—At the moment—and Graham can correct me if I am wrong—my understanding is that our system only has the capacity to hold an individual on two cards. So generally in those situations, when we indicate that, we say to the family, 'You probably need to make a decision about which adult the child is most likely to be with if a service is required.' Then we move the child off one of the cards. That can sometimes cause problems. Or we say, 'We can issue the child with its own card' with the consent of the appropriate parties and then that card can be handed around and used—

Ms GAMBARO—Depending on the amount of access by either parent.

Mrs Baldock—That is right.

Ms GAMBARO—It is quite complex.

CHAIR—To add another factor into that scenario, if one of the two partners then happens to lend their card to an illegal migrant, how would you know?

Mrs Baldock—We would not. The only way we might pick up an anomaly would be through our assessing rules. For example, if a service were attributed to a young female child and it was a service that would only be rendered to an elderly male adult—and I am making up the scenario—then our assessing rules would say, 'This is not a service that we can process for this individual.' So that might cause some alarm bells to ring and some inquiry might indicate an anomaly. But there are not a lot of services—

CHAIR—If it was a routine visit, you would not pick it?

Mrs Baldock—No.

Mr Grayson—It is a possibility. Remember, in the process, the practitioner is involved as well. They might actually take some action.

CHAIR—They may, or they may not.

Mr Grayson—They may or may not, but they are part of the process. We would be working on the basis that the majority of practitioners out there are quite honest.

Ms GAMBARO—But if they do not know—

Mr Grayson—If they do not know, that is possible, yes.

Ms GAMBARO—Say that I come to you as a general practitioner for the first time. You do not know that the person on the Medicare card and the person who I claim I am are the same people.

Mr Grayson—Yes.

Ms GAMBARO—There is nothing in the system that would pick that up, is there?

Mr Grayson—It is a possibility, but it might depend also on what other information that particular practice might ask for. If somebody presents at a practice, they are asked for some information to start off their health record there. Different practices may have different procedures. I am just making the point that part of the process may actually assist pick up if there is anything untoward going on. But certainly it is possible that they may miss stuff, yes.

Ms GAMBARO—Thank you.

Mr Grayson—There was a point made earlier about the cards. There is a layer of controls around the cards and then in underneath each and every individual is uniquely identified. As Leonie mentioned, there are rules around the services explaining the Medicare Benefit Schedule. At the compliance end there are audits, and part of those audits includes checking with the actual individual. There is a range of controls that are in place.

CHAIR—Have you thought of adding more to the card itself, for example, a signature or photograph so that the person using the card is seen to be that person?

Mr Grayson—We are always considering options that will enhance administration of the programs.

Dr Richards—When there are five people on a card—a card can hold up to five names—it starts to challenge the—

Ms GAMBARO—A group photo! It gets a bit messy with all these families.

CHAIR—To come back to this question of records, when you identify someone who has died, does that file still stay active on your database or is it archived?

Mr Grayson—We always maintain the record, but that particular record would be end dated.

Mrs Baldock—At any time we could access the record and simply see that it is no longer an active record. It would still be available on the system.

Mr Grayson—Yes, it is not as if would disappear off on to an archive tape. The record is there and the record is end dated. Hence, if somebody came along and tried to claim a service against that particular individual, we would not pay benefit.

CHAIR—Why would you keep it on your active records?

Dr Richards—For that purpose—to make sure we do not pay benefits to people who do not have an entitlement.

CHAIR—That is one way of doing it.

Dr Richards—Every five years when the cards are reissued, it obviously cleans up the database.

CHAIR—Are the files of that person still sitting there on your database?

Mr Grayson—I cannot remember the detail of when it is taken off, but over time information is taken off and put away. So we can go back and get it as per the Archives Act.

Ms BURKE—Is there any benefit in extending the tax file number in any way, shape, size or form to the information that you already use? Would that be seen as any benefit to the current system to crack down on fraud?

Dr Richards—That is a policy issue that you would probably best take up with the department.

Ms BURKE—That is right. Thank you.

CHAIR—Thank you very much for coming before the committee today.

RESOLVED (ON MOTION BY MR PYNE**):**

That this committee authorises publication, including publication on the parliamentary database, of the proof transcript of the evidence given before it at public hearing this day.

Committee adjourned at 10:54 a.m.