COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health funding

FRIDAY, 7 APRIL 2006

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON HEALTH AND AGEING

Friday, 7 April 2006

Members: Mr Somlyay *(Chair)*, Ms Hall *(Deputy Chair)*, Mr Cadman, Mrs Elliot, Mrs Elson, Mr Entsch, Mr Georganas, Mr Johnson, Ms King, and Mr Vasta

Members in attendance: Mr Entsch, Ms Hall, Mr Georganas, Mr Somlyay

Terms of reference for the inquiry:

The Committee shall inquire into and report on how the Commonwealth government can take a leading role in improving the efficient and effective delivery of highest-quality health care to all Australians.

The Committee shall have reference to the unique characteristics of the Australian health system, particularly its strong mix of public and private funding and service delivery.

The Committee shall give particular consideration to:

a. examining the roles and responsibilities of the different levels of government (including local government) for health and related services;

b. simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;

c. considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;

d. how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and

e. while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior’s Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

WITNESSES

DOWLING, Mr John, President, Tasmanian Branch of the Pharmacy Guild and Chairman, Health Economics Committee, The Pharmacy Guild of Australia 45

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ROFF, Mr Michael, Executive Director, Australian Private Hospitals Association 62

ROSS, Mr David Henry, Director, Healthcare Access, Medical Industry Association of Australia 37

TATCHELL, Dr Michael, Director, Health Economics, The Pharmacy Guild of Australia 45

VALE, Mr Brian, Chief Executive Officer, Medical Industry Association of Australia 37

Committee met at 9.34 am

CHAIR (Mr Somlyay)—I declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing inquiry into health funding. We are examining how the Australian government can take a leading role in improving the efficiency and quality of the health care system. Although Australia has one of the best health care systems in the world—though we have had evidence to the contrary—members of parliament are only too aware of the need for improvements. We all receive a steady stream of complaints from our constituents concerning the health system—often about private health insurance premiums, gap payments and, of course, public hospital waiting lists. The suppliers of medical goods and services are an important part of the health system. The change in the quality and cost of these goods and services impacts directly on the cost of the health system and the ability of health professionals to provide appropriate care for patients. At today's public hearing, the committee will hear from the Australian Association of Pathology Practices, the Medical Industry Association of Australia, the Pharmacy Guild of Australia, the Australian Nursing Federation and the Australian Private Hospitals Association. This hearing is open to the public and a transcript of what is said will be made available on the committee's website. If you would like any further details about the inquiry, or transcripts, please ask any of the committee staff present today.

[9.36 am]

GILMORE, Ms Victoria, Federal Liaison Officer, Australian Nursing Federation

ILIFFE, Ms Jill, Federal Secretary, Australian Nursing Federation

CHAIR—Welcome. Before we start, I want to acknowledge that the Australian Nursing Federation represents probably the most important group of people in the health care system. Although the committee does not require you to speak under oath, you should understand that these proceedings are formal proceedings of the parliament and that the giving of false or misleading information is a serious matter and may be regarded as a contempt of the parliament. I invite you to make an introductory statement before we proceed to questions.

Ms Iliffe—First of all, I want to thank you for the opportunity to give evidence to the committee. The Australian Nursing Federation, the ANF, represents 150,000 registered nurses, enrolled nurses, midwives, assistants in nursing and personal care assistants across the country. This group is 50 per cent of the frontline workers wherever health care is provided. In large teaching hospitals, small rural facilities, remote clinics, general medical practices, nursing homes, homes, schools and factories—wherever health-care is provided and wherever people need care—you will find nurses. Nurses know the health system very well but there are lots of things about it that we do not understand. We do not understand why we have to treat people on trolleys in emergency departments. We do not understand why people have to wait for months or years for much-needed surgery that might improve their lives and perhaps even get them back into the workforce. We do not understand why our workloads are so high and why we struggle to provide basic care to ever-sicker people in shorter amount of time. We do not understand why people cannot see a general practitioner outside business hours to prevent a minor illness from becoming a major one. We do not understand why there is no-one to help people with illness and disability to negotiate the complexities of the health care system. We do not understand why there does not seem to be enough money, even though there are large amounts of money going into the health sector, to provide the high quality health care service that we feel Australian people deserve.

Nurses strongly support a health care system that allows people to get health care when they need it, not just when they can afford it. We want our health care system to be safe for nurses, for the other people who work in it and for patients. We want to be able to give patients high quality nursing care whenever and wherever it is needed. So we are calling for reforms that close the gaps by linking primary care, community care, aged care and hospital care, eliminates cost-shifting and introduces greater equity and accountability.

We think that everybody needs to agree—non-politically—on the ground rules to build a system that delivers the health care services that are needed: what we want, how we measure what is achieved, how much it is going to cost and what we need to do to make it work. We need to build a system that provides incentives, rather than the disincentives that we have now, to work efficiently and effectively. Take cost shifting. We do not want to, but we could give you lots of examples of where cost shifting is so inefficient.

We have puzzled over what is the right approach, and we do not know that we have the answer. We think that one option might be the Australian government taking responsibility for being the funder and setting national policy, with the states and territories being funded on a needs based formula as the provider of primary, secondary and tertiary care as well as age care and community programs. We need a coordinated system. We need priorities that are set at a national level with community consultation as one of the key elements, and I recognise that is not always easy to obtain. The states and territories would be measured against performance criteria established by the national government. The ANF is recommending that a health care reform commission be established, for a defined period of time, with a mandate to explore the options, to consult with the public and to trial if necessary a new way of doing things.

Health care funding must include educating enough health care professionals to be there for the future. That is a really serious concern for us. The Productivity Commission has recently completed a major inquiry into Australia's health workforce. The ANF is strongly supporting the implementation of those recommendations. We are concerned that nearly 50 per cent of the nursing workforce is over the age of 45 years. In real numbers that is about 109,000 nurses. It has been estimated that we need to be exiting around 10,000 registered nurses each year. We are struggling to exit 5,000—half that number. It is not because there are not enough people who want to do nursing. Almost two-thirds of the people who apply for nursing courses are unable to get in because there are not enough places, so we seriously need to look at those figures. Although, as I said, nursing is the largest component of the health workforce, being 50 per cent of the health workforce, the same situation applies to allied health professionals and medical practitioners.

We are supporting the implementation of the Productivity Commission recommendations. They look at innovation as well as at numbers, new ways of working, new ways of paying for primary health care and new ways of teaching health care. I would commend its report to you in your deliberations on your final recommendations. In conclusion, health funding must be reviewed, with the goal being high-quality and safe health care for Australians when they need it and for the workers who provide that health care. We are happy to take questions, including questions on our submission.

CHAIR—Are you aware that there is a COAG process under way?

Ms Iliffe—Yes.

CHAIR—You would be aware that there was a report prepared at the federal level called the Podger review that went to federal cabinet and nobody else. That formed the basis of the Commonwealth submission to the states during the COAG process. When we adopted the terms of reference that this committee has, we tried to run very much in parallel with what COAG is doing in trying to get many more organisations to have a say. Considering that your organisation represents 50 per cent of the health workforce, did you have any input into the COAG process?

Ms Iliffe—We have input to the COAG process in two ways. We make representations at a state and territory level to the premiers who make up COAG and we lobby the health ministers so that they can instruct the premiers—

CHAIR—The COAG process was a committee of officials that reported to COAG?

Ms Iliffe—Yes. We certainly made a submission to the Podger inquiry along similar lines to our submission. Although the submission is nearly 12 months old, rereading it I think it is just as relevant. There is nothing in that submission I would change. Maybe I would add a bit to it, recognising some of the things that have been done, particularly the announcement about mental health funding.

CHAIR—You obviously had input to the Productivity Commission report?

Ms Iliffe—Yes, we did. We had quite significant input to the Productivity Commission report. Commissioner Woods met with us several times in the lead-up to his initial report, to which we made a submission. He also met with us before his final report, to which we also made a submission. We had a very good hearing from the Productivity Commission.

Ms Gilmore—Through our membership of the Health Care Reform Alliance we had an opportunity to engage through the COAG process—in a limited way, obviously, because, as you would be aware, when officials get together they think they have all the good ideas and they perhaps limit the amount of input. But we have certainly taken an interest all the way along. We have not had as much success as we would like in getting our message across to officials at COAG. I think the Productivity Commission's inquiry into the health workforce was a much more engaging process and was seeking answers to the questions that were being put to it. We certainly felt very happy with the way that went. Even though there were some challenges and risks to our profession tied up in those recommendations, it was a great step forward. If COAG had had the opportunity to the same sort of process, we would be a little further along.

CHAIR—The issue that comes up in every forum we speak at is the health workforce. It is hard to understand why Australia has such a shortage in its health workforce. It is really a worldwide phenomenon. In some areas it is quite well-paid, yet it is still very difficult to get people to train.

Ms HALL—Chair, when you have finished, I would like to pick up on what you are saying.

CHAIR—Yes, sure. It has been put to us that a country like Australia should be an exporter of people with health qualifications.

Ms Iliffe—We certainly should not have to rely on importing—that is for sure.

CHAIR—It is not only the shortage of workers; it is the age distribution. Doctors are getting older and, in the private sector, they want to work four days a week instead of six days a week. They want to maintain their income, so their fees go up. With the pressure on the private sector now, with premiums rising every year and the gap in doctors fees increasing every year, something has to give, particularly in the provision of workforce, both nursing and professional.

Ms Iliffe—I will hand over to Victoria in a moment—she obviously has a contribution to make—but, from my perspective, there are two things. Firstly, for whatever reason, we have not—and I think it is unproductive to blame anybody, because we have to move on and find solutions—been educating enough people to maintain our workforce into the future. I am going to say there are three reasons now.

Secondly, again for whatever reason—and I am not going to lay any blame—health facilities, to meet their bottom line, have cut workforce numbers. The remaining workers are faced with increasing acuity because the way health care is delivered has changed. We have more people being cared for in the community. Sick people are being admitted to acute care facilities and are there for shorter stays. So, if you are in an acute hospital, you do not have any downtime; with acutely ill people, it is go-go-go all the time. Because the nursing budget is the largest, it is always the first to be attacked. Nursing numbers—others as well, but nurses in particular—are down to the bone.

Thirdly, unless you can provide an environment where people can do the job they were trained to do, they are not going to want to do it. This is particularly relevant for nurses. You become a nurse because you care about people, and, if you cannot care for people the way you want to care for them, you do not want to be there. If you have to walk past somebody who is in pain and you cannot respond to them quickly enough, if you cannot spend time to just sit with someone who is scared, there is no satisfaction. If you cannot respond to somebody's call bell or if you cannot sit and counsel a family, there is no joy in nursing anymore and people just do not want to work there. Because staffing levels have been cut so much, nurses do not want to work in a system where they cannot provide quality care or safe care. Some nurses are really concerned about their registration. They are concerned that, because they are so busy, there will be an adverse outcome—that they will inadvertently make a mistake and cause harm. For someone who is there because they care about people and want to do good, the thought of doing harm is horrendous. I know that doctors feel the same way as well.

Ms Gilmore—I am going to do a bit of blaming because I have been in the job for six years and I am a sort of 'bad cop, good cop'. We have been calling for additional nursing numbers in the higher education sector for the whole six years I have been working for the ANF.

Ms HALL—How many do you think the government should make available in the next year?

Ms Gilmore—The best number is 4,000 additional places. So, with the recent 400 places announced by the Prime Minister, we only have 3,600 to go! We think between 3,000 and 3,500 places would be filled every year because of the number who are applying for university and are eligible to get in but find there is not a place for them. We are not so optimistic that we think we could get 4,000 people in every year, but we need to have the flexibility of being able to bring people in. Some of the work on those figures was done two or three years ago, so every year that we do not have those numbers the problem gets worse and worse. So I am going to do a bit of blaming and say that we do need additional places and that we have been calling for them for six years. It is also the states' responsibility to increase the number of enrolled nurse places as well. Some of them have done that, though it has been a bit patchy. Victoria, for example, doubled its numbers a couple of years ago and Queensland has increased its number of enrolled nurses. It is the mix of nursing places that needs to be increased.

On the issue of workload, we have seen a steady decline in the number of hours that nurses are working, and most of that is due to workload. They have to balance their personal lives with their working lives. They do that by reducing the number of hours they work and by doing more night duty and weekends to be able to get, with shifts penalties, the same income they might get if they were working full time. The decline in the number of hours that nurses are choosing to work has only just plateaued out in the last couple of years. I think that something like two-thirds

of nurses work part time because they are not interested in working full time; it is not good for the health. The increased casualisation in nursing has taken away the opportunity to have that downtime. You have a bit less than the number of nurses you need whenever you go to work. The nurses are often the ones who are looking for additional people. Because of the devolution of management responsibilities, they are the ones phoning around to see if they can get someone to come in and do a double shift or an extra shift as well as providing care to people. So I support the comments Jill has made.

Mr GEORGANAS—You said the 3½ thousand to 4,000 new nurses going into tertiary places per year should solve the problem. Do you think all of those 4,000 nurses per year should come through the tertiary system? Is there perhaps some other system through which we could bring people into nursing, as we used to do many years ago?

Ms Gilmore—We have two levels of nurse: the registered nurse and the enrolled nurse. The registered nurse has a three-year bachelor level degree, which in our view is critical for sustaining the nursing workforce for the future and providing that safe and high-quality care. So that is the number we are looking at in making sure that we have enough nurses to come through the system. Enrolled nursing—that is obviously the second-level nurse—is also a critical element. One of the things that we keep pushing with enrolled nursing is that about a third of enrolled nurses will always go on to become registered nurses, so that recruitment pathway is very important, as well as getting the right mix of staff, both registered and enrolled nurses, available for work.

CHAIR—What are their relative numbers?

Ms Iliffe—At the moment, about a quarter of the nursing workforce are enrolled nurses. The nursing workforce nationally is about 235,000, and a quarter of those are enrolled nurses. They are educated in the vocational education sector. They are a really critical level.

CHAIR—What different duties do they carry out?

Ms Iliffe—Over probably the last five to seven years, enrolled nurses have taken on an extended role, just as registered nurses have taken on an extended role, in doing lots of things that they did not do in the past. They work broadly under the supervision of registered nurses, so they are working as a team in the overall care plan. That supervision is generally fairly indirect supervision. The enrolled nurse carries a case load. Just recently, enrolled nurses have received additional education to be able to give out medications, if they have done the education endorsed by the board, so their role has certainly been extended to being a really critical, effective and valuable member of the health care team, which takes some of the load off the registered nurses.

Ms HALL—Of course there are also the AINs, and that is the third level of the nursing workforce, isn't it?

Ms Iliffe—That is the third level, yes. Assistants in nursing mainly work in the aged care sector. The aged care sector would not survive without them.

Ms HALL—That is right.

Ms Iliffe—We see them as part of the nursing team. They are eligible to be members of our organisation, and we are involved in their education and in their scope of practice. In fact, the ANF are a registered training organisation as well, and we provide education at the assistant in nursing and the enrolled nurse levels, making sure that we have some coming through for the future, doing our bit. But the assistant in nursing does predominantly work in the aged care sector. Their education level is a certificate III level, and their career path is generally into nursing, so we have articulation pathways for those who want to move into enrolled nursing or into registered nursing.

Ms Gilmore—We have been calling for that group to be licensed as well, like nurses are—

Ms Iliffe—Yes, that is a good point.

Ms Gilmore—just because of the sort of vulnerable clientele that they are providing care to. We think that would be an additional safety measure, and we have been talking to Senator Santoro about that.

Mr GEORGANAS—Certainly in the light of what has been happening.

Ms Gilmore—Yes, some of the elder abuse. Obviously in the staffing teams the skills mix, whether it is in the acute sector or in aged care, is very important. The number we have used is that about a third of the nursing workforce could be enrolled nurses, with two-thirds registered nurses, but in aged care it might be more enrolled nurses. Perhaps in an intensive care unit it might be only one or two enrolled nurses, and perhaps in some of the groups in between there might be a mix where it could be one-third to two-thirds. But every sort of health setting might be a little different. Having an enrolled nurse, for example, working on their own in some of the remote areas of North Queensland is probably not the best option, but if there is a team of registered nurses and enrolled nurses in perhaps a bigger facility it might be a perfect mix of a health care team.

Ms Iliffe—We do not think that enrolled nurses have been used as effectively as they could be, and that is why we did a lot of work on their scope of practice and extending the scope of practice, supported by education. I just want to reinforce Victoria’s point about licensing. Registered nurses and enrolled nurses are of course licensed professionals, and we are quite accustomed to being licensed. We value that licence. We need to protect it by providing safe care. We understand that the whole purpose of licensing is to protect the public. If we forget, the nurses boards tell us quite frequently that they are not there to look after us; they are there to protect the public.

Our view—and it is a really strong one—is that any health professional who has direct contact with a vulnerable group of people should be licensed. This is particularly so for aged care staff. Our reasons for saying that are that there have been calls for mandatory reporting—which of course occurs after the event—and police checks—and we have to undergo a police check; that does not bother us. But police checks only give you convictions. They do not tell you about the person’s history or about investigations or complaints. A licensing system would mean that information would be available: your history, complaints against you, investigations and outcomes would all be there for a prospective employer. We think that would provide much greater protection. That system would not bother us; we do not mind being accountable. We

would not mind that information being known, because that is really what is going to protect the people that we care for.

CHAIR—In relation to that, it is unfortunately the case that no matter how much you do in the way of background checks and licensing of carers it still does not deal with the major source of abuse of these elderly people—family members.

Ms Iliffe—Yes, that is true.

CHAIR—The reality is that there are no background checks on them, yet when you look at all these abuse cases you see a lot of those are actually perpetrated by family members and friends.

Ms Gilmore—We would strongly support the right staffing and skills mix, because that is another way of addressing it. That is as well as being able to have the time to get to know families, to be around, to be involved and to be much more responsive. It is a mixture of licensing and making sure the right professional team is there providing the care in residential aged care facilities

Ms Iliffe—And in community care too. That is another concern, because it is hidden in the community to a great extent.

CHAIR—You can tie in disability care and mental health care with aged care. In those areas it is predominantly women who are involved in embarking on those careers. One of the problems they have, particularly in relation to workplace health and safety, is having to lift patients and do things like that. A lot of the mechanical devices that are designed for that cause a great amount of discomfort to the patient, and a lot of people feel uncomfortable in using them. It is hard to get around that and you have got to use these devices in some cases.

Ms Iliffe—I worked as a community nurse for 10 years. In the community you do not have occupational health and safety aids. It is an entirely different thing. You have to work in the environment in which you find yourself. As we said earlier, we think having one level of government setting policy and being the funder and having the other level of government being the provider means that there will be better coordination. The level of government that is the provider is responsible for disability, responsible for home and community care, responsible for aged care and responsible for the provision of mental health services under the policy direction that has been established at an Australian government level while having to meet the criteria and performance indicators that have been established at a national government level. A lot of the stuff, particularly in disability, mental health and community care, is all so fragmented and so hidden that it is impossible to get a handle on it. About five years ago, my organisation did a research project on home and community care to try to work it out. The number of different small organisations that were funded, with none of them coordinated and all offering services, was unbelievable.

CHAIR—With no checks and balances.

Ms Iliffe—Yes, there were no checks and balances. It was really hopeless.

Mr GEORGANAS—I recall comments about the complexity of the health system with no-one being there to negotiate with the consumer. I suppose all of this ties into that, so it is not just about hospital stays.

Ms Iliffe—That is exactly right. If you had one level of government being the provider, you could employ coordinators. The aged care sector put forward, through the National Aged Care Alliance, a proposal for aged care some years ago which was not taken up. That was to have a coordinator attached to a geographic area, employed by either the aged care facility or by the community health centre, coordinating aged care with community care and acute care. You could have a similar proposal if you had one level of government, a coordinator who could coordinate care right across the sectors.

Mr ENTSCH—You mean a standard national benchmark right across the whole system.

Ms Iliffe—That is right.

Ms HALL—In New South Wales they have patient support officers who link in if something goes wrong, but the kind of model you would like is to have somebody up front driving it rather than mopping up the mess at the end. Is that the type of thing you had in mind?

Ms Iliffe—Yes.

Ms Gilmore—I think there are a couple of good examples around. In cancer care there is a big push to get nurse coordinators involved in helping patients negotiate the maze of when they have to turn up for radiotherapy, when their chemotherapy appointments are and when their follow-up appointments are. There have certainly been a lot of advances. It is always patchy—I guess that is the problem—and there is no real evaluation of whether it is making a difference. Yet people are saying that in their experience it is making a huge difference and it is worth the investment.

Ms Iliffe—With those mental health announcements, a similar model is the increased use of mental health nurses to coordinate mental health care.

Ms Gilmore—Even if you go back to the coordinated care trials that I think were done in the late nineties, one of the best outcomes of that process, which was mainly about putting all the money together and distributing it at a local level, was the message that care coordination was the critical element. Many of the pilots or trials employed a nurse coordinator in the main to manage the patients who were in the general-practice environment and get them through the process. It was one of the most overwhelmingly positive things about that trial. The money stuff seemed a bit dodgy, but making things better for how people negotiated that maze of health care really made a big difference. That was contained in the reports that went to the government in, I think, 2000 or 2001.

Mr ENTSCH—Earlier you mentioned the age of the workforce. You said that about 10,000 should be exiting each year and you only have about 4,000.

Ms Gilmore—Five thousand.

Mr ENTSCH—So it is 50 per cent. You called for an additional 3,500 or 4,000 places a year. If suddenly we were able to achieve the 10,000 exit rate that you suggest we should, then we are still going to be understaffed to blazes in relation to recruitment. That is one observation. Also, we were talking about the initiatives in mental health. How is that going to impact on the public sector? A little while ago there was an initiative to provide incentives for registered nurses to go into general practice surgeries. That would have taken a lot of highly qualified registered nurses out of the public sector, I would have assumed.

Ms Iliffe—It is quite interesting in that it did not have as much of an impact as you would have supposed, though it certainly did have an impact. When you offer different employment opportunities for nurses, those nurses who have left the acute system and are not working in any system find another employment opportunity more attractive. The figure of 10,000 we quoted was put forward by the Australian Health Workforce Advisory Committee in a report released last August. Their suggestion was that we needed between 10,000 and 12,000. We think that, if we could start by recruiting and retaining those people that we recruit and then improving the working conditions for those people still in the system, that will also contribute to maintaining our numbers.

Mr ENTSCH—So broader opportunities like those we are talking about in the mental health sector and in general practice in fact start to bring people back into the workforce who may have been disillusioned with the way they had to deal with the public sector. You are bringing more people back in.

Ms Gilmore—I think that is what we are seeing. People have really hit the wall and the exit rates will increase. Mental health is a great example. Mental health nurses, who are probably a little bit different as a group to the ones who were picked up in the other general practice incentive approach, are really looking for a way of providing mental health care services in the way they know it should be done, which is in the community setting with the right resources. I think the mental health nurses are well prepared to be moving into the community setting and to be providing that slightly different model of care than they are perhaps providing at the moment. Rather than crisis management of every single person who is in the mental health care system, it will be a much more preventative, health-promoting approach of assisting people to deal with their daily lives. Some additional money for upskilling with a graduate certificate in mental health nursing, even for some of the nurses who are already working in general practice, would also be of benefit to nurses.

Ms Iliffe—It would be much more rewarding than what happens now with mental health care.

Mr ENTSCH—If government can focus on those sorts of initiatives, that is going to—

Ms Iliffe—So long as they are coordinated with everything else. We see good ideas, but they are spasmodic—here, here and here—and it adds to the fragmentation. So coordination is critical.

Mr ENTSCH—It would also help with the difficulty in building the numbers that you need. The numbers you need are really to focus more on the chronic illnesses. So you would agree that there needs to be a greater and continued focus on allied health professionals for preventative

areas? You would not be getting as many ill people coming to you because you will be looking at more preventative initiatives.

Ms Iliffe—We would really like to see more community primary health care teams and teamwork.

Mr ENTSCH—Particularly for Indigenous people.

Ms Iliffe—We need a team of health professionals—including doctors, allied health nurses, social workers and psychologists—who can provide that essential care in the community before people require acute care. That would be in looking after chronic illnesses and looking after healthier lifestyles.

CHAIR—To take pressure off the emergency departments.

Mr ENTSCH—Diabetes is a good example of an area where illness is totally avoidable in most cases.

Ms Iliffe—Absolutely. There are lots of good examples, but that is a good one.

Ms Gilmore—Why our numbers perhaps do not add up is that we are looking for an increase in the number of enrolled nurses as well. We have had to balance the number of people who might be interested in coming into nursing at a higher educational level so we bring in about the right number of people. We do not want empty spots in universities that are being paid for but not filled. Looking at the data from the last few years, it looks like we could get about 3½ thousand, maybe a few more, into nursing. But we want to increase the number who are coming through the enrolled nursing pathway, who are coming into nursing in Cairns, doing their enrolled nursing course, loving it—

Mr ENTSCH—Going to TI and getting qualified.

Ms Gilmore—TI, a great program—and doing a distance education program through James Cook University and becoming a registered nurse. One of the barriers is in the number of places James Cook University, for example, has in the second year. We have to make sure there are enough so that an enrolled nurse who has recognition of prior learning has a spot in the second year of the program if no-one drops out during first year, which obviously does not happen, as with any university course. We would like some quarantining of spots in the second and third year of higher education for enrolled nurses who are coming through that pathway. It is that kind of balance that we are looking for—the mix of enrolled and registered nurses. We want to encourage people to follow that pathway of nursing.

CHAIR—Have you pursued that?

Ms Gilmore—Yes. Obviously, we are pushing really hard with the Productivity Commission's recommendations. We have gone through the Department of the Prime Minister and Cabinet and also through the Department of Health and Ageing.

Ms Iliffe—And the Department of Education, Science and Training.

CHAIR—Have you had a response?

Ms Gilmore—Until we see things in writing and in budget announcements, I would say it has been positive, but we have heard positive things before and nothing has happened. So people are listening, but whether they are doing anything I do not know. I am hopeful. I was talking to the department of health recently about that critical issue of having enough places, and Jill has emphasised coordination. Trying to get Health and Education to come together over health workforce planning is impossible, or it has been. That was picked up in the Productivity Commission report. I am sure Health wants to do something; I am just not sure Education thinks they can do anything. Everything seems to fall down in that hole between the two critical areas.

Ms HALL—In paragraph 3.5 of your submission, and also in your presentation, you talked about the different levels of funding and the different areas of the health system. To link that to what you said about the need for a health reform commission, could you give us a little bit of background on the model that you would like to see for the health reform commission? Could you expand on what you were saying about the different levels of government and the funding? I know you have touched on that to some extent, but I want to know how they all link up.

Ms Iliffe—It is probably not unlike one of the Productivity Commission recommendations, which suggested the establishment of a national body that looks at innovation and the health workforce. We do not see a health reform commission as being a body that exists in perpetuity; we see it as a short-term body that can look at the whole of health in an objective way. We do not see it as being a political body. I know I am not telling you anything that you do not already know, but all too often we have decisions made about health that are political decisions and they are not made totally in the interests of the best way of using the money or the best way of providing care. We would like to see a body that is established to look beyond the political and do what is best for Australia as far as health care is concerned. We see it as having consumers on it as well as clinicians, who deliver the care, and economists, who can have a look at all that is happening and suggest or trial a way forward. We think it has to be taken out of the political process, that we are not going to get done what we need to do unless it is taken out of the political process.

We see a lot of unnecessary inefficiencies because of the way that health is provided and funded in this country. Aged care is provided as a federal government responsibility, home and community care is a state government responsibility and who knows who is responsible for mental health? We would really like to see it made clear. Our view—and we are not fixed in this view, I have to tell you, and we are not economists, though we are certainly involved in policy—and the conclusion we have come to is that the federal government is best placed to provide leadership, policy direction and funding, and the state and territory governments are best placed to provide the services under that direction. They would have to be accountable, with performance measures that are established by the funder—

Mr ENTSCH—That makes more sense.

Ms Iliffe—which is what happens with any funding. Performance criteria are established.

CHAIR—You would like to see a national agenda in health run by the Commonwealth government.

Ms Iliffe—Yes, and delivered by the states and territories.

CHAIR—So the Commonwealth would fund the states to that national agenda.

Ms Iliffe—That is right, yes.

CHAIR—That used to be the case, 20 years ago. But the health department has effectively become a post-office box between Treasury and the state health departments. The role of setting the national agenda has gone by the board.

Ms Iliffe—Yes, and that is what we are missing. They set the agenda in some respects. Mental health is a really good example. They have tried to take some leadership in mental health, but it is not a policy that the states and territories have to comply with. They set the policy in particular areas, but there are huge gaps because they are not responsible for the whole. Some really good things have been done for mental health, but there are great gaps in the announcements. Before I forget, I would really like to talk about better use of private hospitals as well.

Mr GEORGANAS—That is my question!

Ms HALL—A question I was going to ask you refers to 7.3 and 7.4 of your submission.

Ms Gilmore—May I just add something to the last bit?

Ms HALL—Yes.

Ms Gilmore—We have been pushing for a national health policy because, as Jill said, the block system we have is such that if you are a national priority area, you do get some coordination, but if you look at something like dementia care, which has recently become part of that national priority approach, you cannot really look at it as separate from a lot of other things. It is almost a competition now for the best disease group to get considered and have their national priority established. That is not the best way to do it, and it does not coordinate the person with asthma who gets cancer and has a musculoskeletal illness. There is no coordination across that sort of realm.

Ms Iliffe—And who is also old!

Ms Gilmore—Yes, that is right. It is about having a national health policy and really getting the key points clearly articulated that we want to achieve for anyone who has ill health or a disability. Sorry, Jill did not have a chance to ask her question because I jumped in.

Ms HALL—It was just about 7.3 and 7.4 of your submission that I mentioned a moment ago about a review of the private health insurance rebate and looking at the funding of private hospitals. I think Alex is interested in that as well.

Ms Iliffe—We certainly think that there can be better utilisation between private and public hospitals. They should be complementary, not competitive. Public patients should be able to be treated in private hospitals if there are spare beds, to reduce the waiting lists, in the same way that private patients, if they need the care that is provided in public hospitals, should be able to

access public hospitals. Again, it relates to coordination and complementarity—that is really what it is all about—and not competition between two levels. What concerns me is that some of our procedures are now almost exclusively being provided in private hospitals, which disadvantages people who do not have private health insurance. We cannot let that situation happen.

CHAIR—What happens in future training for clinicians in those disciplines where the training happens in the public hospitals and the procedure is only carried out in private hospitals?

Ms Iliffe—Yes. There also needs to be a sharing of the training. When we are talking about additional places for nurses—and the same applies for doctors—one of the things is that getting clinical experience is critically important because we are clinically based disciplines. It is quite difficult to get quality clinical places or even a clinical place. Better use of the community sector and the private sector is really important. The private sector has to take some share of the responsibility for training.

Ms HALL—That is happening more though, isn't it?

Ms Iliffe—It is happening more, but it is not happening enough. We are going to have to make it happen enough if we are going to be educating the sorts of numbers—

CHAIR—Is that the training of nurses you are talking about?

Ms Iliffe—Yes, contributing to the training of nurses—the clinical placement of nurses. We are going to have to use the community sector and private sector much more if we are talking about educating the numbers that we need in the future.

Ms HALL—I would like you to touch on the review of the private health insurance rebate too.

Ms Iliffe—It is a really complex issue. The federation has looked at the amount of money going into the private health insurance rebate. Of course, each time the rebates go up, more money goes in. Then we look at the sort of money that we need in community care, mental health and acute care and we have to ask ourselves whether this is the best way of funding private care. As I said before, we are not economists, so we are not saying, 'Ditch the health insurance rebate.' We are saying that there needs to be a review done. We read of economists who say, 'Yes, you've got to have it', and we read of economists who say, 'No, that's not the way to do it.' We think that at some stage, with the huge amount of money that is going into the private health insurance rebate, you have to ask yourself, 'Is this the most effective way?' Maybe the answer will be yes, but maybe the answer will be no. I think that review has to be done. Any amount of money that is so large, or any service really, has to be reviewed and you have to ask yourself, 'Is this the best way?' We do not know whether or not it is, but we suspect that there might be some better ways of achieving the outcomes that you want.

Mr GEORGANAS—Just touching on another area that you spoke about earlier about the pressures on your members, the nursing staff et cetera, you made a comment about having been

cut right down to the bone, which in turn puts enormous pressure on the staff as they are not able to deliver the care that they really want to as professional nurses.

I know we spoke about the shortfall in tertiary places, and that we need 3,500 to 4,000 per year to fix that particular issue, but to me it seems that it is fairly dangerous when you are in a situation where there is enormous pressure on the staff and they cannot provide the care that is really needed therefore resulting in a whole range of other effects that do not deliver quality care. I do not want to use the term 'immediate fix' because we know there is not one because of the shortfall of places, but what, in your view, is something that could be put in place as a short-term fix until these places, if ever, come to fruition?

Ms Iliffe—Certainly increasing staffing levels—that applies to doctors but particularly to nurses—and looking at the staff mix to make sure that you are using your registered and enrolled nurses most effectively and, if it is in slow stream area where it is appropriate, using your assistants in nursing most effectively.

Mr GEORGANAS—Are you saying that they are not currently being used effectively in a lot of places?

Ms Iliffe—Yes, I think it is true that they are not being used effectively, because they have not got access to the staff that they need. Quite often they just take whatever they can get. They might not even be trained for that particular area that they are being asked to work in. No, they are not being used effectively. You cannot use people effectively if you have not got enough of them. We have called for mandated staffing levels, and in some of our enterprise agreements we have specifically included workload measures because it is the only way.

Mr ENTSCH—They do it in child care.

Ms Gilmore—That is exactly right.

Ms Iliffe—We have provided an industrial response because it is the only way we have been able to make sure that there are enough nurses (1) to provide safe care, (2) to make sure they are safe and (3) to make sure that they do not leave. We have mandated staffing levels through industrial agreements, but we should not have to do that. An employer should want to employ the right numbers.

CHAIR—What sort of attrition rate is there in nursing, because of the burnout factor from the late/early hours they are all expected to work?

Ms Gilmore—A lot of it you see in that decline in the numbers of hours that people are working. They are putting their financial position on the line because they cannot keep working 40 hours a week or 40 hours plus their unpaid overtime. Often people will do a paid overtime shift plus they are obviously working half an hour or an hour after shifts to do the paperwork. That is where we are really seeing the exodus—in hours that people are working. An example is that of Victoria, which did bring in the mandated staffing ratios of one to four.

Ms Iliffe—That is a good case study because Victoria got an additional 5,000 nurses back into their system—nurses that people said were not around—just by mandating the staffing levels

and doing some recruitment. Having the staff to provide the care they got 5,000 nurses back into their system and the hours that nurses worked increased. Not only did they benefit from the fact that they had more bodies but, because nurses had that support and were able to provide that care, they increased their hours in the workplace.

Ms Gilmore—My argument has always been that if every nurse worked an extra eight or even four hours a week, we would not have a shortage. It is the same as in medicine. If you do not create an environment where people want to work full-time, you will get people working two different jobs. They will say, ‘I’ll do part-time nursing, but I’ll work in the florist shop or a child-care agency or whatever as well.’ I think the mandating of workloads, even just the announcement that we are doing something about it, would be a really big step forward. A lot of people are feeling like no-one cares and no-one is doing anything about it.

CHAIR—Are we still losing a lot of young nurses overseas?

Ms Gilmore—Nurses have always travelled; I think it is a great thing.

Ms Iliffe—Not any more than we normally do.

CHAIR—They come back eventually, don’t they?

Ms Gilmore—Yes.

Ms Iliffe—There is a balance. We get more nurses coming into Australia for—

Ms Gilmore—Twelve months.

Ms Iliffe—Yes, twelve months—a good period of time—as we have nurses leaving. We actually have a positive balance. Over 10 years or so it has barely changed. It is a really good thing, because we get experienced nurses from overseas who bring different ideas. Our nurses go over and have different experiences and bring that back. We are not like a lot of other countries.

Mr GEORGANAS—You touched on something which we quickly skimmed over. The unpaid overtime you spoke about seems to be common. A lot of nurses that I talk to tell me about having to finish their shift at three but hanging around for another hour or two.

Ms Gilmore—Or coming on earlier.

Mr GEORGANAS—Is that common?

Ms Iliffe—Very much so

Ms Gilmore—Yes. The thing that is keeping the health care system going is that additional work. It happens in aged care, it happens in health—nurses will always focus on providing care that is needed. My most recent clinical experience was in a paediatric oncology unit and the only thing I did was give chemotherapy. I did not have a chance to counsel people or the other things; all I did was give chemotherapy all day.

CHAIR—Who did the counselling?

Ms Gilmore—It was often left to parents or it was done at three in the morning when there might be someone who was able to help in that.

Ms Iliffe—Or it just did not get done.

Ms Gilmore—Yes, unfortunately, a lot of the time it did not happen. Or you were doing it behind a mask and gloves and things like that, which is not the best way to do it. On unpaid overtime, some of our branches have looked into it and done some reports on it. People are working a really significant amount of time. They are preferring to work part-time, but they know they are almost working full-time with their unpaid overtime on top of that. It is not a very satisfying way to work.

Mr ENTSCH—Have you found in recent times that the number of administrative staff is growing in relation to your clinical staff?

Ms Iliffe—No, not really in nursing. We have a classification structure where you have a nursing unit manager level that has management capacity at the workplace. Probably the nursing managers are having to pick up a bit more clinical than they used to. Generally speaking, no, it is a fairly flat management structure in nursing.

Ms Gilmore—We went into a very flat structure during the 80s that really eliminated that. Some of that has been quite detrimental. We lost people like clinical nurse educators and we lost a lot of the next layer up who were almost the flexible response people—when things were going bad in emergency departments, they could come down and help out and things like that. We lost a lot of that and it really is not coming back. The ones that are coming back slowly in some of the states are the clinical nurse educators, because someone has realised that you actually need those people and they are critical for keeping people in the system.

Mr ENTSCH—I have one last question and it goes back to the first sentence in your opening statement about cost shifting. You said you had examples if you were asked. I would be interested just generally in that.

Ms Iliffe—Probably the classic example that most people are aware of is in outpatients and emergency departments, where you have to refer people away to another practitioner and you cannot act to provide the care there or you cannot bring that practitioner in to provide the care. So you do not have that teamwork with a general practitioner or a specialist being able to work in an environment where people go for care, and emergency departments and outpatients departments are classic examples of that. Some of the cost shifting for nursing is starting to be addressed. As I said earlier, I worked as a clinical nurse consultant in women's health. I used to run women's health clinics and antenatal and postnatal clinics. I was not able to do routine things I was well qualified to do because the legislation did not allow it. I had to refer them off. Say for instance—a classic example—you are doing an internal examination and you notice that somebody has a vaginal infection. You are not able to treat that. You have to send the person off—the woman has to go through another invasive procedure—to do something that you really know, taking the swabs, is a simple thing to do.

CHAIR—In the hospital?

Ms Iliffe—No, this was in the community. I worked in community health.

Ms HALL—Basically that happens because of the restrictions placed on nurses?

Ms Iliffe—That is right. That is starting to be addressed. A lot of that could be addressed much more quickly. We have had political responses—with nurses in general practice and people being able to receive a rebate if they see the nurse directly. I provided women's health clinics for doctors and even then, with a doctor on site, they had to come in and see the person before they could order a test or write a script. It is silly. That is the sort of inefficiency that we should be dealing with.

Ms HALL—An emergency department is probably a good department when you are looking at cost shifting. It is cost shifting in a number of ways. You have people turning up in emergency departments because they cannot see their doctors locally. That is cost shifting.

Ms Iliffe—Because they do not do after hours care

CHAIR—It is cost shifting from the Commonwealth to the state.

Ms HALL—Yes. But then you have it back the other way from the state to the Commonwealth.

Ms Iliffe—The same thing applies in aged care.

Ms Gilmore—The interface between community care is the classic example—hospital in the home versus HAC type funding and the limitations on that.

Ms HALL—Yes, that is right.

Ms Iliffe—If you had one level responsible for policy and funding and one level of government responsible for the provision of care, that would all go.

CHAIR—Could I go back to the private sector for a second. We had evidence in Queensland from a private hospital. They were concerned about the new pay rises for nurses in the public sector that the Queensland government is providing. They believe that is going to have a major impact on the flow of staff from one to the other. If they have to match the increases, that will affect the costs of the provider. Can you tell us how much mobility there is between private hospitals and different fields of nursing?

Ms Iliffe—There is not as much as you would expect. People tend to work either in the public sector or in the private sector. However, there is sufficient to make it important for private hospital operators—and certainly they see it as such—to always match public rates so that they are not disadvantaged, particularly with the quality of staff. It has been a tradition in nursing for nurses in the private sector to have the private sector match the rates in the public sector. The public sector has always been the benchmark and the private sector has matched that. Sometimes they have even done better, with conditions like maternity leave. So there is a bit of mobility.

You are right: certainly private operators see it as important to match the rates. But it is important so you have a standard level of care. That is one of the reasons why in nursing we have tried to match rates so that you do not have a second tier, with all of your quality staff being in one place and then less qualified staff being in another place. That is why we have tried to match rates in aged care so they will attract quality staff.

Ms Gilmore—We have not been very successful.

Ms Iliffe—Unfortunately, we have not been very successful. We have been successful in having government respond with putting money into aged care for wages, but they have not gone the other step to make sure that that money goes into wages. That is the missing bit.

Ms Gilmore—A billion dollars has gone into what the previous Minister for Ageing said was to reduce the wages disparity for nurses between the public and aged care. Unfortunately—

Ms Iliffe—The gap has widened.

Ms Gilmore—the gap has widened. Unfortunately there was not any way to require providers who got that conditional incentive payment to actually use the money to address wage disparity issues.

CHAIR—In Queensland there will be mobility because of the increased pay rises. But how does that affect other states. Peter Beattie is trying to recruit health workers in other states to come to Queensland. Is there much of that happening?

Ms Iliffe—Nurses are a mobile population, but they are not as mobile as people tend to think. They have families. They have partners and partners have jobs. There will always be an element of nursing that moves, but it is not the big issue that people think it is. One state, certainly, that has a pay rise might influence another states, but you have to argue your pay rises everywhere you go and you have to have a legitimate case.

When they look at nurses' wages compared to other people's wages, I do not think anyone would say that they are overpaid. I do not think anyone could say that. The difficulty for nurses, and the reason we always have to argue so strongly and it is always so difficult, is that there are so many of us. So, if we get a pay rise, it amounts to a significant amount of money. That is why they always attack our budgets first: there are so many of us. That should not disadvantage us, but it does.

Ms Gilmore—Being a critical part of the workforce, you have to have people out there on the ground working and the numbers are critical for us. Certainly some of the Queensland pay rises are long overdue.

CHAIR—Yes, they were behind and had to catch up.

Ms Gilmore—Our branch in Queensland has fought very hard under difficult circumstances to get people on par. Working at Royal Brisbane is no different to working at Prince Alfred in Sydney. A lot of the things are still the same. The issue we raise is that, if you are a nurse in aged care now, it is not actually all that different—you need some really good skills and knowledge. It

is not like the old days when you sat and did paperwork, although unfortunately that is still a big part of the work; it is about providing specialistherontic nursing skills to the most frail, aged and vulnerable people in our community.

CHAIR—We have run out of time, but other things will come up in evidence where we may need to get more information from you.

Ms Iliffe—We would love come back, or you could come and visit us—we are only at Kingston.

CHAIR—Okay, and if need be we will ask you to respond in writing or appear again.

Ms Iliffe—Yes. Thank you very much for your time. We really appreciate it.

[10.44 am]

GUERIN, Dr Michael D, President, Australian Association of Pathology Practices

KINDON, Mr David A, Chief Executive Officer, Australian Association of Pathology Practices

CHAIR—Welcome. Do you have any comments on the capacity in which you appear?

Dr Guerin—I am the chief pathologist with Symbion Health, but I am here as President of the Australian Association of Pathology Practices.

CHAIR—I am required to say this, but it does not reflect on you. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Do you wish to make a brief introductory statement before we proceed?

Mr Kindon—If we may.

CHAIR—Please proceed.

Mr Kindon—You have had our submission. We have now distributed some handouts which summarise more succinctly some of the points we made in our submission. We really welcome the opportunity to be here. I would like to start off by reiterating that we are the invisible medical specialists. Like a lot of invisible things, we are actually the foundation of medicine. You do not see foundations, but they hold the whole thing up, and that is what pathology is. It is the science of medicine. One hundred per cent of all cancer diagnoses are made by pathologists. Because patients do not actually see the pathologist—only a little bit of the patient sees the pathologist—pathologists are not well known or they do not have a high profile in the community, but pathology is an important medical specialty.

The AAPP have a history of cooperating with the government. There is a brief fact sheet there on the AAPP. I will not go through that. We represent the private pathology providers of Australia, from the very large, like Symbion Health, Sonic Healthcare and Healthscope, down to the very small individual practices, so we do cover all the private pathology areas.

Ms HALL—Could you give us an idea of how a pathology lab is staffed? Obviously there is the doctor who is the pathologist, but underneath there would be a number of levels of disciplines that are employed there.

Mr Kindon—Perhaps Michael would be better to answer that because he is at the coalface. I am not a pathologist.

CHAIR—I will let you finish your opening statement.

Mr Kindon—I guess what I would like to say is that we have been reform ridden for 21 years since 1985, when the Public Accounts Committee report on medifraud and overservicing came out. It was report No. 236, which is etched into our memory! In the handouts you have there is something I call 'a stack of reforms'. Just on one sheet, that demonstrates a rather higgledy-piggledy stack of things that have happened over that 20-year period. Just about every year, some pathology reform has taken place. I supplement that by saying that most of those reforms have been put in or proposed by us, implemented by us and delivered by us. You will see there that the stack is higgledy-piggledy, but each reform is built on the previous one, and it does stand up. We are a little bit concerned that, if people start pulling out bits in the middle, it might topple over. So that is one point we would make: we have had this stack of reforms and all of those reforms have been proposed by us and delivered by us, including more recently the memorandums of understanding.

The main reason for these reforms over the years has been the government's need to rein in pathology expenditure in some way. We have taken the approach that it is better to be alongside the government, trying to deliver the government's fiscal objectives whilst maintaining as little damage to ourselves as we can. That is why we have been cooperative in that process.

But I refer you to the next page in there, that little blue chart. One of the issues that pathologists have, unfortunately, is that we are not in control of our own future. There is a drivers of demand study being undertaken by the department—this was our own chew over of it recently. The main three drivers of demand in pathology are the government, through its own programs; requesters or GPs—doctors; and patients. In recent times, you will have seen the Private Health Insurance Incentive Scheme. Because we are under capped funding, if a government policy over here impacts on pathology under the cap then we have to measure that and take it into account, because it is a flow-on effect of that successful government policy. In the case of the private health insurance incentive, we were able to demonstrate to the government that, whilst that had been successful, it had pushed a lot of people into private hospitals and raised the level of pathology ordering, and we were able to negotiate an adjustment to our cap to take that into account. Michael will talk briefly about the current reforms that have been impacting on our agreement more recently.

We only do the tests that doctors order; we do not order our own tests. We cannot self-refer. So the referrer-induced demand is very significant. That is the impact of preventive medicine; medicolegal issues, to make sure they have covered off on all possibilities in case they are taken under the medical indemnity insurance laws; and the computerisation of general practice, which has made it easier for them to order large batches of tests just by clicking a button rather than writing them all out. There are all these sorts of requests from induced drivers of demand. We know they are there. We think they should be measured, and the government in the Department of Health and Ageing is now undertaking a study to do that shortly.

Of course, patient-driven demand is equally important. There are people like me, now, who are the baby boomers who are older and hopefully a bit wiser. We are internet intelligent. We know what we want, and we are demanding about it. Therefore we put pressure on our own doctors to order things for us. I can remember that I was getting close to the safety net, the other year, and there is a definite desire to get into that net when you are near it. You can see it, and you want to get into it. Once you are in it, the whole family is there with you, and you try and get everything done before the end of the year when it clicks back to zero again. So there is a

lessening of inhibition in patients and more demand in patients that flows through to the GPs and into extra pathology being ordered.

CHAIR—Is that mainly the people with chronic conditions, or the general public?

Mr Kindon—Getting into the safety net?

CHAIR—Yes.

Mr Kindon—I do not know—probably chronic!

CHAIR—I do not think most people would even think of it until they get crook.

Mr Kindon—When you get close to it, you can see it out of the corner of your eye, and it is a good place to be if you can. Of course, once you are in it, you get the varicose veins and everything else done before the end of the year.

Over that whole period of 21 years, the next chart in there shows that, if you reduce pathology tests to a unit of one and track the fee increases and fee decreases over that subsequent period, that unit of one is now less by 0.4 of a per cent than it was in 1985. So, in 21 years, a unit of pathology testing in terms of cost is remunerated less than it was in 1985, over which period average weekly earnings went up by 175 per cent and the CPI up by 125 per cent.

Having said that, pathology has had all those costs, in that—particularly now—with the workforce shortages in pathology, it is a sellers market for labour, both for pathologists and for scientists. So our rate would be higher than AWE, I would anticipate. Similarly, with the fuel costs and the fleets of courier vehicles that take tests around the countryside, the CPI would certainly be up there in pathology. Therefore, that bottom line of the unit of one, down by 0.4 of a per cent over that period, represents efficiency dividends, I guess, to the government over that period. Do you want to expand on that?

Dr Guerin—There are really three things that have happened. The pathology industry, a bit like the radiology industry, is different from other areas of medicine because we are in fact heavily corporatised. Over those 20 years, three things have happened. One is the fact that there has been significant technological change. I started in laboratories as a laboratory assistant. If I was called in to do what was called a febrile screen on a baby, that would take me 3½ hours of technical time back in 1980. When I came back five years later, having completed a medical degree, that whole thing was done in eight minutes. So the technology change has occurred. But people believe that technological change has occurred in all departments, and that is not true. It has occurred in the biochemistry department. It has occurred in the haematology department. But you still require an anatomical pathologist to spend their time looking down a microscope to see what has actually happened to the tissue and what the diagnosis is, and in fact their workload has increased.

As for the second thing—and I was pleased to hear the ladies from the ANF on this—we have been involved in competency standards and the ability to slipstream people into various areas. I made the point earlier that I was a laboratory assistant. What is happening in both the public and private sectors of the pathology industry is that we are utilising different people to do different

things. We still require pathologists to do the things that are really significant. We get scientists to do the modification of tissue—cutting it up and things like that. We get laboratory assistants to load all the automated equipment where we can; we do not use scientists to do that. So we have actually upskilled, de-skilled, down-skilled and side-skilled to get through the process with the number of staff that we have currently got—and I will come back to that.

The final thing is economies of scale where you have got an organisation the size of Sonic, which has a market capitalisation of $4 billion, or you have got a company like Symbion, which has a market capitalisation of over $2 billion. Consider the economies of scale that they bring to the pathology industry compared to what was nominally a cottage industry back in the eighties. Where that industry may have had 50 or 60 staff, we have got 5½ thousand staff in pathology alone. You get massive savings from that. If you look at the second graph, you see that since the year 2000 the pathology cost index, which is an average of the AWE and the CPI and is actually in the memorandum of understanding with the federal government, has gone up by 28 per cent, whereas pathology has been incremented by seven per cent.

Two things come out of this. One is that that cap in pathology, as it does in radiology, actually works. The other is that the Australian public have benefited to the tune of $1.2 billion in that period of time because of cost control. That is actually 20 per cent of the total funding that has been spent. I need to make the point that when you are dealing with pathology we believe—the numbers are not clear but we do believe this—that in the public environment there is about three-quarters of a billion dollars being spent on pathology and that the federal government is spending currently just over $1.4 billion, of which $1.3 billion is being done in the private environment.

I will take you to the second-last page. One has to give credit to the Howard government. Consider the fact that there was a nadir in April 2004 when it comes to the number of general practice visits that were occurring—and it was a hot election issue. The federal government stimulated that. We come to our statistical take from Medicare data, but we have also had this validated by Access Economics, because we have a claim in front of the federal government. In the next year there was an increase of 4½ million in general practice visits and this year it is heading towards 5½ million extra general practice visits. The expectation is that you go to the general practitioner as the gatekeeper, so there will be a flow-on—and there was. There was an extra 440,000 specialist visits created by those 4½ million GP visits. By the way, of every 100 GP visits, 19 of them will result in pathology. If they go to a specialist, about 36 of them will result in pathology because of the high utilisation of pathology services by specialists. So there was a natural flow-on. The effect of that is that currently we have in front of the federal government, as a result of what we regard as being purely changes to government policy, a claim for $45 million to come under the cap of the preceding year. It is $65 million this year and at this point in time it is still escalating. So the issue that we see as facing all of us concerns the fact that we are under a capped funding environment and that we need to ensure, where there are necessary changes to government policy, that they are in fact implemented under the cap.

But we need other things, and I would like to back the Australian Nursing Federation as to the fact that we also are understaffed. We are not understaffed just as to pathologists, who would be the cream. We are understaffed as to scientists as well. In the past we would actually take pathologists from places like South Africa and New Zealand.

Ms HALL—This is why I wanted to get the mix before, so that later I could ask this question. You can answer my question as you go.

Dr Guerin—The issue is that we used to steal staff from South Africa, Rhodesia and places like that. The difficulty now is that it is becoming an ethical issue to take pathologists and any highly trained individuals from underdeveloped countries.

Ms HALL—Give us an idea of the mix in an average practice.

Dr Guerin—Let us take Dorevitch Pathology in Melbourne as an example.

Mr Kindon—It is part of the Symbion empire.

Dr Guerin—It has revenue of around $160 million, 46 pathologists and an administrative staff of around 50 people. I will not go into great retail, but 80 per cent of that revenue comes from the federal government and the rest of it comes from various other sources. There are about 1,600 staff. About 50 people are in administration. There are 50-odd pathologists who have done their 14 years of training. Underneath them, are in the order of 500 scientific and technical staff, of which the mix is fifty-fifty. Under them—and I am going through the organisational structure rather than talking about importance—are the courier drivers. This company has, as I recall, the fourth biggest courier fleet in Victoria. It has to transport the specimens to a central facility. There are a lot of courier staff and at least 80 cars in that business unit. As well as that, there are 120-odd collection centres that need to be staffed, as you heard from the previous speakers, by either registered nurses or enrolled nurses, of which there are 400 or 500 to provide rotation. That is pretty much how it works.

CHAIR—Tell me how it works in the public sector.

Dr Guerin—It is pretty much the same except that they do not have the couriers and, to a lesser degree, the collectors. A lot of the public laboratories have outreach services and collection centres, but they do not necessarily have the courier fleet that we have.

CHAIR—Does each hospital have a pathology unit?

Dr Guerin—The answer is yes. There are smaller places that do not. In most states, public hospitals provide their own pathology services. They may be aggregated. In New South Wales there was, I think, 17 and they have come down to 11—and they are talking about four pathology groups.

CHAIR—Area health services.

Ms HALL—That is right. I was going to say that in New South Wales not every hospital has it; rather, it is every area health service.

Dr Guerin—They still have a local pathology service, though.

Ms HALL—Yes, they do.

Dr Guerin—Most of them do.

Ms HALL—Yes.

CHAIR—What about mobility between public and private?

Dr Guerin—In half the private hospitals in Victoria the service is provided by private providers. That was the Kennett era, so privatisation of pathology services occurred, particularly in country areas.

Mr Kindon—In Sydney, public providers are allowed into the community to compete with the private labs. They can have their own collection centres and claim against Medicare. In fact, eight per cent of Medicare pathology is claimed by public sector laboratories. The reverse is not true, unfortunately; we are not allowed onto their patch. This has been a big issue in New South Wales, which specifically prohibits private pathologists from providing services to private patients in public hospitals. We took this to the competition tribunal—

Mr GEORGANAS—Providing a service to a public patient?

Mr Kindon—Providing a service to a private patient in a public hospital. But it is charged out to them.

CHAIR—How is it charged for private patients?

Mr Kindon—It is charged against Medicare. But the private sector is not allowed to compete for that work. It is not the same in every state.

Ms HALL—Now that you have given us an overview of the staffing in an average pathology service, could you give the committee an idea of where the shortages are and how long-term that will impact on the delivery of pathology services throughout Australia?

Dr Guerin—We can get the couriers and, as the ANF individuals indicated, there are previously trained nurses and enrolled nurses in the community who are not working in the hospital environment whom we can use in our collection centres. They are not an issue for us. They key areas are the pathologists and the scientists. AMWAC has already indicated that we are anywhere between 120 and 180 training positions behind where we ought to be.

Mr Kindon—It is 100 per year, isn't it?

Dr Guerin—No, at this point it is 120; it will expand to 200 in two years time. In New South Wales, 20 per cent of the pathologists currently working are over the age of 65. The second issue is that, to deal with that, the average training for a pathologist involves a five-year or six-year medical degree, a year or two of intern residency and then five years of training in pathology specifically—and that is if they are quick. Most of them now take six years. You are looking at about 10 to 14 years to complete pathology. They then come out as a junior. I make the point that, as a chief pathologist, I would never put an individual first-year-out on their own. They have to work in a collegiate environment where they can get the skills, and that takes another three to five years. So you are looking at 15 years before you can say to a pathologist, 'I need

you to go and work in the country to provide services.' A big concern to us is that we are withdrawing services from the country by attrition because we do not have the staff.

Ms HALL—How do you answer the problem?

Dr Guerin—The answer to the problem is to train more. We cannot steal them from overseas anymore. In fact, they are stealing ours.

CHAIR—Where are they trained—in public hospitals?

Dr Guerin—Public and private. There are three areas in medicine where you can currently train medicos in the private environment, and that includes general practice and dermatology—and I think there are two positions. But I give credit to the federal government; when we did the last memorandum there was an agreement that the federal government would fund directly 10 pathology registrar positions and they are training in private. I have to say that this is the best outcome because, when you look at the training of pathology registrars, roughly 40 per cent of them will end up in the public environment and 60 per cent will end up in the private environment. More and more we are seeing cross-fertilisation of the training between public and private.

Mr GEORGANAS—You mentioned earlier that you are losing more to overseas than previously. Why is this?

Mr Kindon—There is a worldwide shortage of pathologists. They become an international commodity. Some of the rates they are offering in the UK—

Mr GEORGANAS—The rates are far higher.

Mr Kindon—Yes, £250,000 for a pathologist, which is $600,000-odd.

Dr Guerin—The same applies with scientists, and they are just as critical.

Ms HALL—And technicians too. They are trained through the TAFE system and are employed—

Dr Guerin—There are a number of them, so we are not short of numbers, but when we are dealing with scientists the issue becomes their skill sets. People have a fixed idea that pathology laboratories are just big halls of automation. That is not the case. They are there—I do not deny that—and anybody who wants to see $1.5 million worth of front-end automation sending specimens everywhere is more than welcome to do so. But we still have scientists who have responsibilities to do the haematology morphology. It is those individuals who, at 10 o'clock at night, find out that you have leukaemia. You have the cytology scientists who do all the screening; the pathologists merely look at a subset. Finally, you have the microbiology scientists who actually look at the plates and determine that there is AIDS infection, there is a bacteria there, and ask: 'What is it? What is the antibiotic that will fix it?'

Ms HALL—Alex has just made a suggestion that we should visit one. You would be able to organise that for us?

Dr Guerin—We would be delighted to do so. You can choose which one you visit—if I get the opportunity I will show you both—but one is a stat laboratory working closely, for example, with an intensive care unit to provide the turnaround that it requires. If you have somebody on a ventilator you can change their blood gas, their oxygen status, in 30 seconds. We have all done it inadvertently by standing on a tube. If you are the intensivist you need to be able to know what their blood gas is, so the equipment is right next door. We call that point of care testing. If I take you to some of the big places you will see the courier systems bringing 12,000 or 13,000 episodes into one site. What you are really seeing is a huge, highly complex scientific factory.

Ms HALL—The message for us is that more scientists need to be trained and more positions need to be made available for training—doctors per se and then—

Mr Kindon—We have a submission before the government. Because pathology training was 100 short, we thought, 'The states should look after half of that but let's try and get 50 trained in the private sector.' We got 10 through our MOU. We had a submission in to build up to another 40 by the third year of the MOU. Unfortunately, it was signed off by the minister and when the writs were issued at 4.59 pm on 31 August ours was in the pile that did not get signed—otherwise, we would have had funding. It is only $5 million a year to fund another 40 registrars in the private sector. Having said 'private', they spend three years doing it in the private system and two years in the public system. There is an interchange—the person goes between the two systems. It is working very well.

Dr Guerin—I want to pick up on a point that our colleagues from the ANF made—that is, there are some activities in the pathology industry which occur almost exclusively in the private system and some activities which occur almost exclusively in the public system. That is why we believe that the best trainees are those that see both sides of the fence.

Ms HALL—That is a very good point.

CHAIR—Do you have any examples of what goes to the private and not to the public system?

Dr Guerin—Yes. The easiest one to recall is cytology. Almost all gynaecological pap smears are performed in the private industry. The majority of the more complex pharmacogenetic testing is performed in the public industry. There is a huge swell in the middle.

CHAIR—Why is that? Cost?

Dr Guerin—No, it is because of specific interests. I have to say that as well as being a kind and gentle doctor I also have to be a hard-hearted businessman. The issue is how I get around this. The private industry is starting to aggregate these things with very low turnover and highly costly tests which we will bring to one environment, like the Symbion institute or the Sonic institute. In the public system a lot of it is based on the interests of the individuals, such as whether they want to develop their technical, clinical or academic expertise. They will offer these specific subsets so they become expert in those areas. That is of excellent value to the Australian public.

Mr Kindon—Also, the frequency is not enough to spread clumps together where there are little centres of excellence.

Mr ENTSCH—You are making frequent reference to the nurses representation report. What is your view in relation to their position on the national policy or performance benchmark? Is the federal government taking a greater role in setting standards, if you like?

Mr Kindon—In pathology?

Mr ENTSCH—Yes.

Mr Kindon—Pathology is probably the most regulated and standardised branch of the health sector. We have a National Pathology Accreditation Advisory Council. All laboratories are inspected regularly. We have quality assurance externally and internally. We are very highly regulated under Medicare and the Health Insurance Act.

Mr ENTSCH—That is all done through the federal government already?

Mr Kindon—Yes.

CHAIR—But you are regulated by state and federal—

Mr Kindon—Yes. The state funding for pathology is a bit of a dark area for me. No-one really knows how much is done because it is all hidden in the Commonwealth-state grants. Everyone has a stab at how much pathology costs in the states, and nobody really knows.

Ms HALL—So is a review needed so that we can find this out?

Mr Kindon—I think so, yes. The answer to the question: 'Do MOUs work after a certain time or are we running dry?' is probably, 'Yes, we are running dry.' But what happens after this agreement? We are starting to look at future funding alternatives for pathology. One of those obviously is the global funding issue. But, as you say, the first thing that has to be done in that context is to work out what the global fund is. We know what ours is; it is transparent under Medicare. Nobody knows what the fund is in the state public sector of pathology. That has to be done first.

CHAIR—Part of our terms of reference is obviously cost shifting both ways. Is there potential for cost shifting to be going on between state—

Mr Kindon—It has already happened, I think.

Dr Guerin—In pathology, certainly.

CHAIR—Can you explain how it works?

Mr Kindon—In the old days, you went into hospital, you had tests done, you were admitted and you had some post-treatment. They have contracted that area now so that when you go to hospital the pre-hospital admission stuff and the post-hospital discharge are all done in the

private system. That is all going onto Medicare. There is just that bit in the middle now at hospital.

Mr ENTSCH—We had evidence in Brisbane of people going to a public hospital and basically the first thing staff do is stamp the Medicare card and get people to sign the blank card.

Dr Guerin—I could easily put the boot in there but I will not. The simple reason is that the funding of the public hospital laboratories is also under severe duress. They need to get funding from whatever source they can and, to their credit, they decided that they needed to get the funding from an alternative source and they have gone for Medicare. I have to say, as a taxpayer, that I am absolutely surprised that the federal government hands over a whole bundle of money and has no idea how much is meant to be or is spent on training. When I come along and say, 'Here's the big issue that we have in training: we need funding', nobody can tell me in the federal grants these days how much funding is involved for training. Nobody knows. Dare I be reticent and say that my pathologist colleagues, who all lurk in dark rooms, do not have the aura that the bow-tie wearing cardiologist or orthopaedic surgeon has got. When it comes to local hospitals or area health funding for training in pathology, it is often overlooked in favour of the squeaky door.

Mr Kindon—The first task with global funding is finding out what the amount is. For the second task, if we are presumably talking about competition between the whole sectors, the old hoary question of the level playing field comes into view. That also has to be determined before competition commences. I think that is an interesting process to go through. It has to be done in the right sequence and very carefully.

CHAIR—As an old footballer, the only person who wants a level playing field is the bloke who is running uphill!

Mr Kindon—Everyone's level playing field tilts in the opposite direction, I have discovered.

Ms HALL—It does!

Mr GEORGANAS—You gave an example earlier of Symbion and what the staff break-up is. Are there still any smaller units left around the place with a couple of hundred people?

Dr Guerin—Yes, there are.

Mr GEORGANAS—What are their issues?

Dr Guerin—The Australian Association of Pathology Practices represents almost 95 per cent of the private pathology industry. It is composed of three main players: Sonic, Symbion and Healthscope. They represent 70 per cent of that 95 per cent. There are boutique pathology practices that are specifically interested only in histopathology. I did not break pathology down into its various disciplines. Their expertise is purely with lumps and bumps, so to speak. They will have a turnover of what an individual pathologist could generate. If two or three pathologists get together, the best that they could do from federal funding would be in the order of $1.5 million each. So it would be a $3 million or $4 million business with their associated costs. There would be about 10 members of the AAPP that would be of that ilk. Then there

seems to be other groups with turnovers of the order of $15 million to $20 million per year. But to get to the size of the three other organisations, you frankly have to do that with a lot of capital support and it is all done by acquisition. That is what has happened to the industry.

Mr Kindon—The fourth largest one, which is a bit spread out but is still large when you put them together, is the Catholic health pathology system. You have St John of God, Mater and St Vincent’s. They are all in the AAPP, but when you add them together as a group they are quite large.

CHAIR—My knowledge of pathology is very limited, but in Queensland we have Sullivan Nicolaides Pathology and QML—

Dr Guerin—And QHPS.

CHAIR—So if I am a GP, what makes me choose QML? What makes me choose Sullivan Nicolaides Pathology? Incentives?

Mr Kindon—Alphabetical order!

Dr Guerin—It goes on. That is why the AAPP is strongly supportive of the legislative review that has been done. We strongly support the fact that the Minister for Health and Ageing has signed that off and it is currently with the Prime Minister, because there are ramifications of the legislative review beyond the pathology area. Selection is generally based on three things. One is the fact that there is a personal relationship between the pathologist and the individual. Facetiously, one could say, ‘It’s because they went to med school together.’ In fact, it is because you see the capability of your colleagues in the two or three years of the clinical medicine applications and as students. Secondly, there is the quality. Let me give a compliment to you. The fact is that Sullivan Nicolaides Pathology, my direct competitor, and QML are two highly reputable pathology laboratories of a very high standard. They were the first to implement such things as ISO 4000 and 9882 before it was ever required. The third thing—unfortunately, it boils down to Deborah Hutton—is ‘Location, location, location’. You come out of your doctor’s surgery and you are looking for where you can get your blood taken. Where is the local collection centre? That is what it boils down to. In fact, if I had to be fair, I would say it was probably the reverse.

CHAIR—My doctor chooses the bloke he hits off with at 12 o’clock on Wednesday!

Mr ENTSCH—As with many areas of the medical profession, there is a shortage of qualified pathologists. You made the point that the demand on services is continuing to spiral. A lot of that demand, as you said, was patient driven; there is also a tendency for doctors to click the mouse on every square. So you wonder how much of the service provided and charged out is through overservicing. If we were to get it back to a reasonable level of meeting the services required, is there any way that can be achieved to help with that ever-increasing demand?

Dr Guerin—There are plenty of examples of overservicing. In *Medicine Australia*, the local doctor rag, a couple of weeks ago a doctor was quoted as saying that 0.1 per cent of doctors should be in jail. That is probably true.

Mr ENTSCH—When you appreciate that for the cost of provision of medical services there is no limit—

Mr Kindon—There are two brakes on us, though. There is something called a ‘cone’ in pathology. A doctor can order as many pathology tests as he wants, but Medicare only pays for three.

Mr GEORGANAS—Per individual?

Mr Kindon—Per visit, yes. A lot of doctors still order a lot more than three tests, but Medicare only pays for three of them, though the lab still does them. We worked out the hidden cost to us: about $100 million worth of pathology a year is done that never gets billed.

Mr ENTSCH—It never gets used.

Mr Kindon—It gets used, but we do not get paid.

Mr GEORGANAS—Can you explain that further?

Dr Guerin—What we know from statistics is that, if you look at all of the episodes that occur in pathology, it ends up that there are currently about 2.05 items per episode.

Mr Kindon—Two tests, that is.

Dr Guerin—We are saying that the third, fourth and so on are done for nothing.

Mr GEORGANAS—Is that an agreement that you have?

Mr Kindon—It is the government’s earlier fee attrition thing.

Dr Guerin—This is one of those things that sneaks up on you from behind, because it was done years ago back in the era of the sink test and all these types of things to stop this overordering—doctors ordering every test they could think of. The situation then was to bring in this control by saying, ‘You only get paid for the three most expensive; if you order four, five or six, you don’t get paid.’ What has happened is that, as medical practice has changed, there are more medico-legal concerns and the complexity of medicine has increased, they are ordering more pathology, so we are actually hitting that. Last year my organisation did $31 million worth of pathology for free. This year we expect to do $42 million—and if there are reporters in this room I would be pleased if you did not report that! There is an increment of 33 per cent.

Mr ENTSCH—How can you sustain that?

Dr Guerin—That is why we are here.

Mr ENTSCH—How would you deal with it without an open chequebook?

CHAIR—Do you want it increased to four?

Mr Kindon—Not under the cap. We have a double cap now: we have a cone and we have a global funding cap over that. If you let the cone off, it will immediately bash us up against the funding cap, so we would be no better off.

Dr Guerin—One of the fastest ways to deal with a lot of the excess in pathology testing would be to improve the communication, specifically between public and private.

CHAIR—You cannot charge the patient?

Mr Kindon—Not for those unclaimed tests, no.

Dr Guerin—In fact, we can. We can just privately bill.

Mr ENTSCH—That is the gap. They would pay the difference.

Dr Guerin—You cannot do both. You charge either the patient or Medicare. You cannot do both—end of story.

CHAIR—But the patient can then claim it back on Medicare. If you charge the patient—

Mr Kindon—If you bulk-bill part of the episode—and 88 per cent of all pathology testing is bulk-billed; 92 per cent is at scheduled fee or less—you cannot bulk-bill part of the episode and the charge the patient for some other stuff.

CHAIR—So you would have to charge the patient?

Dr Guerin—You would have to set to work and charge the patient for the entire episode.

CHAIR—The patient would be able to claim only three tests back from Medicare.

Dr Guerin—That is correct.

Mr Kindon—They would be paying full for the rest.

Ms HALL—Putting it simply, if a patient were given an account for six tests as opposed to being bulk-billed, they can go off and claim the rebate on three of those six and maybe have to wear the rest. So they would be paid for the tests with the three highest costs associated with them.

Mr Kindon—It is one of those reforms that came in—

CHAIR—Why wouldn't the doctor send somebody to you twice?

Mr Kindon—That did happen a little bit. All of these things are subject to abuse.

Dr Guerin—We are back to his call!

Mr Kindon—None of these policies came in for medical reasons; they came in for funding reasons. Back in 1992 or whenever this happened, the government said: ‘You’re going to get a five per cent fee cut. How do you want it?’ So we worked out that, if you brought the cone in, it would target those who are way at the wrong end of the spectrum, doing every test in the book for every patient. They got the rough end of the pineapple in that reform, whereas the ethical practices, in doing the right thing, minimised the damage. That was the rationale behind it.

Mr ENTSCH—Those myriad tests are not usually done for medical reasons. They are done for convenience or to satisfy a patient who has decided that they want to shop around, as you said, for a few more tests. People want every test that is available, which may include ones that are not necessary.

Ms HALL—Or the doctor wants protection.

Mr ENTSCH—Do you go back to the doctor who wants to tick every box and say: ‘We’re only funded to do three. Are all these necessary?’

Dr Guerin—We do it to a degree. More importantly, I think, is that doctors are trying to protect themselves. I take your point: ‘Why don’t I call you in today and I’ll do a haemoglobin and then I’ll do electrolytes? Come back tomorrow or the day after and then I’ll do the liver functions’ and whatever else. The problem with that is that the government has now got to pay for the $24 consult fee twice. So there are costs in that, and it is not convenient to the patient.

Mr Kindon—But they are not under the cap.

Dr Guerin—So the doctor can use a mental list or his computer for, say, ‘tiredness’—bang, and up it comes—and he says, ‘I’ll have one of these, one of those’ and whatever else. To be fair to my medical colleagues, very few of them, in my view, over order. At one grasp, they have to look at all of the clinical scenarios and decide on the possible tests that can confirm or deny their diagnosis. So they hit the button and do them all.

The proper way, in theory, is to do it by selection. If I think a patient has tiredness, then do they have anaemia? The first thing I will do is a haemoglobin test. If their haemoglobin is normal, I will stop testing. If the haemoglobin is abnormal, then what is the cause of that? The most common cause will be an iron deficiency. So I will do a serum iron or transferrin or ferritin test.

So you can go through an algorithm to get to the appropriate answer. That is not the way we currently practise medicine, because we are not set up to do it—plus the fact that the pathology laboratories are specifically barred from doing that type of thing, because it becomes pathologist determined testing.

Mr Kindon—You cannot do self-referred work.

Dr Guerin—The second point that I want to sneak in under this—and it is one of the major issues—is the failure of communication. A patient goes to a doctor in the community at large. The doctor does a whole series of tests. Then the patient goes to hospital for whatever reason—

they suddenly get very ill—and all of those tests are repeated. So the AAPP is a very strong advocate of HealthConnect.

Ms HALL—That has been a strong message to the committee.

Dr Guerin—We are very keen to support it, and what we need is support from the government to implement it. The AAPP is the perfect organisation for it, because in one fell swoop you can get 95 per cent of pathology sending the same message—'Oh, and by the way'. It is estimated that of the total IT messaging that goes around, 40 per cent is generated by pathology. So, in one fell swoop, the government could end up with a huge boost to HealthConnect just by getting to that—

Mr ENTSCH—It is overservicing. They are basically doing the same service.

CHAIR—It is duplicating.

Mr ENTSCH—It is overservicing through duplication.

CHAIR—It is sharing of information. That is all it is.

Mr Kindon—That is an important issue. The Quality Use of Pathology Program is full of promise but has not delivered much so far. One of the issues there is to get a project running that looks at these algorithms in computer programs that sends you down particular appropriate tracks rather than shotgun tracks. We are big promoters of study into that.

The only other thing I would mention in terms of the future is a project we would like to look at. We believe that early diagnosis and detection of disease through pathology saves a lot of money somewhere else in the system. Where and how much is intuitive—nobody knows. Work should be done on that. Take pap smears, for instance. The incidence of cervical cancer has dropped by 50 per cent over the 10 years since the pap smear program was introduced. There is one concrete example of savings to the community—medical, social and economic.

Ms HALL—So that is another recommendation for the committee?

Mr Kindon—Savings elsewhere in the system through early diagnosis and detection, yes.

Ms HALL—I move that the handout provided to us this morning be accepted as evidence.

CHAIR—There being no objection, it is so ordered. We may need to come back to you. I think the committee would be interested in visiting a large lab. We will be in Sydney and Adelaide in coming weeks. James can talk to you about possibly arranging a visit.

Mr Kindon—The two biggest are in Sydney.

Dr Guerin—The two biggest laboratories are in North Ryde in Sydney.

CHAIR—We might have a look at one in the public sector in Adelaide.

Dr Guerin—I would be happy to arrange that in IMVS, the Children's or Flinders.

CHAIR—Thank you.

Ms HALL—Maybe you could organise for us to see both a public and a private.

Dr Guerin—Surprise, surprise, we actually get on very well together. We would be delighted to be able to assist you in looking at both public and private.

Ms HALL—That would be great.

CHAIR—We may need to ask you some more questions and seek information either in writing or in another appearance. We could be in touch. Thank you very much.

[11.41 am]

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

VALE, Mr Brian, Chief Executive Officer, Medical Industry Association of Australia

CHAIR—Welcome, gentlemen. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament and the giving of false or misleading evidence is a serious matter which may be regarded as a contempt of parliament. I am required to say that. Now I invite you to make a brief introductory statement before we proceed to questions.

Mr Vale—Chairman and committee members, thank you. David and I are pleased to be appearing today on behalf of medical device manufacturers and suppliers, who I believe play a critically important role in the delivery of better health outcomes to Australian patients. This appearance follows on from our submission to your committee. In reviewing your terms of reference on how the government can take a leading role in improving the efficient delivery of highest quality health care to all Australians, I note that, while medical practitioners, hospitals, health professionals, agencies and levels of government are referred to, suppliers of their medical tools of trade are not.

Providers of medical devices support both the public and the private sectors in making available the latest in medical technology, and I believe that this is now readily acknowledged by the Australian health care environment. I would like to emphasise this point by referencing the 31 August 2005 Productivity Commission research report *Impacts of advances in medical technology in Australia*, which observed:

> ... overall, it would appear that advances in medical technology have delivered substantial benefits.

I believe that there has been some tendency to not fully involve suppliers of medical devices in health care dialogue. Perhaps wrongly, we have been often regarded as a cost rather than as an asset which enables Australians to enjoy better health, productivity and longevity. The Productivity Commission found that:

> ... arguably advances in medical technology have provided value for money.

But the debate over medical technology and its costs is a complex one. The Productivity Commission reflects some community concerns that medical technology drives costs because previously untreatable conditions are now treatable and treatment of older and younger patients is possible where previously it was not. Even lower per unit costs which have reduced risks and thresholds for intervention have been cited for facilitating high levels of use and hence higher spending overall.

However, according to the Productivity Commission, medical technology can also assist worker participation, although such evaluations are difficult. Nevertheless, Access Economics

has valued improved health in Australia between 1960 and 1999 at $5.4 trillion. The Productivity Commission referenced another study that estimated that GDP per capita increased by around four per cent for each extra year of life expectancy. The Productivity Commission noted:

... the available evidence suggests that advances in medical technology have delivered benefits across a range of areas—contributing, for instance, to observed increases in length and quality of life, improvements in productivity, and improved living standards ...

I would like to comment briefly on the government's prostheses benefits reforms, which came into full operation in October last year. The Minister for Health and Ageing is authorised under the National Health Act to determine which prostheses and what amounts are to be reimbursed to privately insured patients by health funds. Patient gaps, although now possible, occur in less than 1.3 per cent of the more than 9,000 listings. The new process was developed in consultation with our association and suppliers on behalf of all suppliers and other stakeholders, and the process involves all critical stakeholders in the ongoing management.

While we retain some reservations regarding its impact on access to new medical technology, we are encouraged by the consultative approach of the Minister for Health and Ageing, Tony Abbott. I note here that parliament requires a report on the reforms at the two-year mark and we will of course be pleased to contribute at that time. We see industry participation in the prostheses process as a useful model in other areas, such as the Medical Services Advisory Committee, where delays and lack of transparency remain of some concern.

The MIAA submission to this inquiry covers other areas of significant concern such as regulatory delays in the approval process, and I trust that this committee will reflect on the high costs and some of the inefficiencies that attach to that process. I would be happy to field any questions on this issue. In conclusion, MIAA and the medical device suppliers have much to contribute to Australia's health care debate. We look forward to being regarded as an essential participant in the development and, where appropriate, the administration of reforms.

CHAIR—Can you outline for us the difference between how the system works in the public sector and the private sector? Does the private sector charge the same amount for prostheses as they charge in the public sector, or does the public sector not have the same access to prostheses as the private sector?

Ms HALL—Do they have the same prostheses?

CHAIR—I will give you the example of stents, used in angioplasty. You have a treated stent available in a private hospital which I believe is not available in the public sector. How do you deal with that as an industry—one and the other, private and public?

Mr Vale—I will ask Mr Ross to speak to that, if I may, but one of the challenges will be to give you a clear answer without stepping into a product area. Once you look at particular products, you will find that some of them do find the public sector quickly and easily and others do not. With that caveat, perhaps I could ask David to say a few words about that.

Mr Ross—If I could firstly set the funding scene: as you would know, in public hospitals the funds are particularly under pressure, so in the choice of prostheses in a public hospital the

funding issues that come to bear on that public hospital will be paramount. So doctors in public hospitals might not have such a free choice in the selection of prostheses that are used on patients.

Ms HALL—So you are saying it is cost driven?

CHAIR—The hospital does not buy them.

Mr Ross—It is cost driven, yes. Obviously, from a public hospital's perspective, the cheaper the prostheses they choose, the more patients they can treat within their budget constraints. The same sorts of problems do not beset private hospitals, and the way that the process works at the moment is that new technology is most readily available through the prosthesis benefits arrangements, which the government has legislated to control of late. So the choice in the public sector is rather more restricted than in the private sector. Through that, of course, there is a difference in the technology that might be available. So we have this situation where a less expensive prosthesis might be used on a patient in a public hospital than might be available and chosen in a private hospital.

There are other reasons why costs would vary and we, on purpose, do not get involved with our members on pricing issues, for obvious reasons. But we do observe that there are reasons why the prices vary. The public hospitals might purchase prostheses on the basis of tenders. They give commitment to volume over a certain amount of time, so that commands a certain discount, if you like. That is also combined with the fact that they are purchasing less-expensive prostheses, which means that they can achieve some savings. If you are comparing the prostheses available for a particular procedure in a public hospital and in a private hospital, we are not necessarily talking about the same prostheses. You might be talking about a hip joint, but there are many to be selected within the category of the hip and it will depend on what the doctor chooses and what is available to him to choose.

There are other factors that could impact on the cost of prostheses in public and private hospitals to do with technology being introduced into the system. There is a reasonably slow uptake in the public sector at times, and sometimes a supplier might introduce that technology into the public sector to encourage its use. It might be a training hospital, so they make prostheses available especially to try and encourage uptake. These are some of the reasons why there could be a price differential.

Mr ENTSCH—I was interested in your introduction and your comments with regard to your perception of a lack of recognition of your sector within government on this. You did not make reference to the action agenda that is currently going through on medical devices which in itself is recognition of the significance of your sector, which is working with government. I am wondering how far advanced you are with the action agenda. Have you got to the point where recommendations are being made that could be made available to the committee? They could be of value.

Mr Vale—I take your point, but my comment was that there has not been evident engagement with the sector for some time, but that has changed over the last year or two. I flagged that what Minister Abbott has done with regard to prostheses reforms potentially sets a very good model for the future. I think the nature and level of the communication with the regulator the

government has driven is new and refreshing. The action agenda is potentially a major step forward. We have to wait and see what the government and cabinet consideration of that is, but, to go to your specific question about whether there are recommendations within the action agenda itself, yes, there are. There are recommendations within that that will bring profile to the industry and that will address the issues we see as difficult regulatory and reimbursement environments that exist today. If that is supported—and I think it will be—by a regulator that has a service delivery role to industry and recognises it and tries to help industry get that leg-up as well as deliver the public protection role that is arguably their paramount role, then I think that is a good direction change.

Mr ENTSCH—Would you be able to provide this committee with those recommendations? How far away are you from getting those recommendations—I guess that is the first question—in the action agenda process? Is it possible to provide us with copies of the recommendations—not the government response, because that will come once it is considered by cabinet? Given the time frame that the action agenda has now been working, there must be a series of recommendations that you are getting close to finalising that could be provided to this committee for consideration. We are going to be putting out a report in the near future.

Mr Vale—As a member of the strategic industry leaders group I am aware that the recommendations were considered on 15 March and that they are currently being written up. It is obviously not in my purview to suggest how the department would handle their release.

Mr ENTSCH—But it would be very useful for us, given what we are doing—

Mr Vale—To your point, yes.

Mr ENTSCH—to be able to have a look at that. If they are within the department, there may be an opportunity for us to find out whether we can have a look at what recommendations were considered, because it could be very useful.

CHAIR—This is a very technical area for us.

Mr ENTSCH—I must say that I was running the medical devices action agenda then, so I can understand that.

Ms HALL—On page 12 of your submission, which I think is the area you want us to ask questions on, you say that 'regulations of safety and efficacy should be subject to government cost impact assessments.' Your final point on that page states:

> As a starting point, to reduce costs and improve healthcare outcomes, the Parliamentary committee is urged to investigate and recommend reforms to the existing legislative and regulatory regime to overcome these identified issues.

Would you like to talk us through those issues and how they impact on cost and access to the health devices that patients in Australia need?

Mr Vale—I would be happy to endeavour to do so and I will move through it step by step. Please pull me up if there is a question on any element, and I will keep it concise. Firstly, I think it is important to recognise that the Australian market is quite small in global terms. It is less

than two per cent of medical devices, and I use that term to include the in-vitro diagnostics, which are the laboratory tests that I think the previous presenters use in their diagnoses. So we are less than two per cent.

From Mr Entsch's experience with the action agenda, the papers suggest that we import about 98 per cent. We would say that it is well over 90 per cent, but the bulk of the product is imported. The bulk of the product comes out of major regulatory regimes such as those in Europe or through the FDA, where they have been approved to enter the market through a series of different means. We have a regulatory environment in Australia that is very closely harmonised with the European environment and what is called the Global Harmonization Task Force model, so our Australian system of regulation is very close to that. There are differences, and those differences are awkward for us, but it is generally harmonised.

However, we repeat: a lot of the regulatory work is done in those jurisdictions overseas. We particularly do that around some of the higher risk products. That is an expensive process because there is only one source to go to in Australia for what is called the conformity assessment, and that is the Therapeutic Goods Administration itself. As this committee would know, that agency is 100 per cent cost-recovered. In my seven years or so with this industry the cost to the therapeutic goods area has moved from somewhere in the order of $25 million to about $75 million. The cost-recovery process has the effect of removing competition, so to speak, from the marketplace and prices for services are not being determined by competition, because it is a monopoly delivery of services and it is related only to the need to recover the costs of running the agency.

So we have a very good regulatory model. Our suggestion would be that there are better ways to deliver the process. The costs today that are generated invariably find their way to the bottom line of the products. So consumers end up paying more, whether they are private consumers or public consumers, because industry in such a small market generally cannot absorb all of the costs, although it does absorb some.

So the question would be: what do we need to do in the Australian environment—beyond that which has been done, for instance, for the Swiss, French, Germans and Americans under equally credible regimes—which is necessary and which must, therefore, justifiably add cost? What could we say? We could say that we trust each other and work together to recognise each other's work and, therefore, we can constrain those costs.

Ms HALL—I refer to the case study that you have on page 13, looking at the Cochlear Nucleus Freedom System, where you go through the comparisons as to the different countries. That links to what you have just said.

Mr Vale—This is but one example but it is a good one because it is a product that is very well known to people and a great Australian success story. We see it as a difficult environment today for companies to step up in this cost regime in the way that companies like this have. As for the bulk of the market for a company like this, in excess of 95 per cent is offshore and the accreditation process that puts on the mark is delivered by an offshore agency. That is globally recognised. But to then sell this product in the Australia market, the company has to have it certified again by the TGA.

Mr GEORGANAS—Does this apply only to the highly technical equipment that is brought in? Does the straightforward equipment that comes in go through the same regulatory system or is it a different situation?

Mr Vale—It is, but the levels of assessment and such are very varied. At the simplest end, for things like walking sticks or commodes—what we call class 1 medical devices—it will be self-certification by the manufacturer, and that is it. But once you start to get to something in class 1 that has got measurements on it, then you get into an environment where the regulator has an interest.

Mr ENTSCH—I think it is fair to say that a lot of the issues relate to the TGA's assessment time frames. I think it is also fair to say that there has been some movement by the TGA to address some of the issues. However, I think there is still a long way to go. My understanding is that one of the major issues as to competitiveness, particularly with Australian products, is the time frame. Your submission shows that an Australian product was able to be assessed by the European Union in four months but that it took 12 months for us to do it in our own country.

Ms HALL—I think that is a good example.

Mr ENTSCH—That is in your election agenda stuff recommendations, isn't it?

Mr Vale—It is, and I think you have quite rightly made the point. I go back again to the slightly different environment that the government has encouraged within the TGA, one that sees it engaging more—and that is where the business plan time lines that were released late last year set some very clear targets which will work much better for industry if they are met. The two dimensions are time and cost—and cost is not there.

Ms HALL—You recommend that we look more carefully at the Australian Healthcare Reform Alliance recommendations, that we examine what they have had to say a little bit more closely and that we develop a national policy and strategy that looks at rationalising resources and coordinating our approach. Would you expand on that, please.

Mr Vale—I think this was the point we made with regard to access and technology assessments. Was it that one?

Ms HALL—Your submission refers to Australia's multilayered system of health care. I am referring to page 14. I am referring to the part where you say that in general terms you believe:

> ... many of the arguments put forward by the Australian Healthcare Reform Alliance deserve closer examination and consideration by Australian Parliaments and governments.

I would like you to expand on that a little bit more and then look at the issue of cost-effectiveness, rationalisation and access.

Mr Vale—There are many layers of assessment in getting products, once they have cleared the therapeutic goods pathway—and that is the first step, to be approved for therapeutic use—into the marketplace, depending on whether it is a public or private situation. At the risk of generalising, the bulk of the product sales in medical devices flows into the public sector in

Australia. But if you focus on some of the high-technology products, you will find the reverse: you will find 70 or 80 per cent in some of the very high-technology cardiac implantables going into the private sector.

In the public sector you have to face the different state systems and the tendering processes that they apply. Queensland is fairly centralised, but in New South Wales, for instance, in the past you had to deal with 15 area health services. That has now been rationalised to, I think, eight. Each of those may choose to do product trials around like products, so suppliers will find themselves providing examples and data and supporting trials going on in many places in a single state—and that is in addition to what is happening across the states. Then there is the federal environment, which is not a large buyer, and that is largely through the DVA. On top of that, going to the issues you touched upon—such as cost-effectiveness—there are the layers that were developing, which I believe the Productivity Commission commented on, around health technology assessments. It would be terrific if that could be consolidated into some sort of model so that, once you do it for Australians in an Australian health care system, you do not have to replicate it at the state level.

Mr Ross—In the private system, once you have a device registered with the TGA it can be used in the public sector. It can be used in the private sector too, but it needs to go through the reimbursement process. Items that have not gone through that process do not get reimbursed, generally speaking. If I come up with a new device that requires a new procedure I would have to take it to the Medical Services Advisory Committee, which can take anything from 1½ years upwards—maybe 12 to 15 months if I am lucky. Once it has gone through the Medical Services Advisory Committee and the procedure is accorded an MBS number, a procedure number, I can go to the prosthesis and devices committee and apply to have the item listed on the prosthesis list. If I just happen to miss the cut-off for that it can take up to 11 months to get it listed. If I do catch the cut-off it will take at least 4½ months.

Ms HALL—That is similar to the last issue we were discussing.

Mr Ross—We have an elongated process. It means that it can take several years for new technology to work its way into the Australian health care system—noting that new technology may well be more expensive than old technology. The new technology is hardly going to be picked up in a hurry by public hospitals. There is the problem of the delay in getting an item, which could be life-saving—we have had some examples there—to patients.

Ms HALL—What are the examples?

Mr Ross—An example I am aware of is a company called Sirtex that have an item called SIRSpheres, which are small radiated elements, which are injected into the liver for liver cancer. It is almost a treatment of last resort. This one took some time to get through. In fact, it was reimbursed by Medicaid in the US before it eventually received the reimbursement tick in the last prosthesis list in February this year. That is one area where it has taken some time. They had to go through MSAC. In fact, it took them two attempts to get it through. We expect it will have an MBS number any time now, but it has certainly been approved by the minister.

Mr Vale—I remember Dr Wooldridge saying to us some years ago that clearing the therapeutic goods pathway is no automatic indication that somebody is going to pay for the

product. I think suppliers accept that. What we have encouraged government to try to do through the prosthesis reform process is to at least bring the two things more together, so that you do not finish one step—the therapeutic goods step—and then have to step into another. Suppliers understand that. There is an effort to try and get these closer together now because too often we have seen that, by the time a product gets through the Therapeutic Goods Administration and the reimbursement process, it is old technology.

Mr Ross—That has been recognised in the industry action agenda. Certainly it has been picked up with more enthusiasm in that action agenda than it has in the health care environment. That is pleasing.

Mr ENTSCH—With cutting edge technology, by the time you get them to approve it and it is in use here it is obsolete.

Mr Vale—Some of these technologies change between the six- and the nine-month mark. The stents that you referred to before are an example. That is the kind of window. Australia is such a small market and if it is just too hard to get here then some of those technologies may not find their way here.

Mr ENTSCH—We would like a copy of the recommendations. That would be very useful. Thank you.

CHAIR—I think we need to do a bit of deliberating on this. Maybe then we will need to ask you some more questions if you could provide us with some answers a bit later, in writing or in person.

Mr Vale—We would be very happy to do so at any stage.

CHAIR—We probably need to talk to the TGA about this issue and we have not done that. Do you wish to add anything more?

Mr Vale—No, we would like to express our appreciation for the chance to put these technology issues forward. We hope the committee's efforts will generate opportunities for Australian industry to get this leg up and move forward in a competitive way.

Mr ENTSCH—We do have some of the best technologies in the world.

[12.18 pm]

DOWLING, Mr John, President, Tasmanian Branch of the Pharmacy Guild and Chairman, Health Economics Committee, The Pharmacy Guild of Australia

TATCHELL, Dr Michael, Director, Health Economics, The Pharmacy Guild of Australia

CHAIR—Welcome. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the parliament. Giving false or misleading evidence is a serious matter which may be regarded as a contempt of parliament. I am required to read that statement out. I invite you to make a brief introductory statement before we proceed to questions.

Mr Dowling—First of all, we would like to thank you for the opportunity to appear before the committee and to speak to our submission. You are probably aware that the Pharmacy Guild is an employers association. We represent the owners of community pharmacies in the country. There are close to 5,000 community pharmacies in Australia and we represent around 90 per cent of those.

The delivery of pharmaceutical services and advice through a network of community pharmacies is integral to the efficient and effective running of the Pharmaceutical Benefits Scheme. Through this scheme, which is the envy of the world, patients have access to a wide range of affordable, cost-effective medicines wherever they live and in a timely fashion. As well, as we point out in our submission, a viable network of community pharmacies provides a cost-effective platform for the delivery of a wide range of health services to the Australian community. Our skills and accessibility mean that pharmacies can be better utilised to generate cost savings throughout the whole of the health system, not only the PBS.

A year ago, when we prepared our submission to this inquiry, the negotiations between the guild and the government on the fourth community pharmacy agreement had only just commenced. They continued for a further six months or so until the agreement was finally signed in November last year by the Minister for Health and Ageing, Tony Abbott, and the then guild president, John Bronger. The new agreement is now up and running and will continue until 30 June 2010.

Many issues that we raised in our submission are addressed in the agreement. Therefore, we think it will be useful for the committee if we spend a few minutes to give you a quick outline of some of the relevant points of the fourth community pharmacy agreement. As a preamble, I think it is fair to say that the underlying aim of all the guild-government agreements has been to improve the efficient and effective delivery of high-quality health care to all Australians—and this of course is the primary objective of this inquiry. The three main parts of the agreement relate to remuneration, the location rules for pharmacies and the professional services and programs area.

Firstly, with regard to remuneration, the agreement sets out the various Commonwealth payments to pharmacists and now, for the first time, to pharmacy wholesalers as part of that

agreement for delivering their part of PBS medicines to the community. A total of around $11 billion will be paid to pharmacists and wholesalers over the five years of the agreement. In the arrangements of the fourth agreement, we agreed to a $350 million reduction in the payments to pharmacy that would have occurred under the forward estimates, so as part of the agreement negotiations we effectively gave the government $350 million in projected savings, basically. The overall aim is to ensure that pharmacists receive fair and adequate remuneration for the pharmaceutical benefits they supply, so that a stable environment is created for community pharmacy, thereby enabling it to remain viable for the long-term benefit of all Australians.

For the first time in our agreements with the government, there are to be special arrangements for pharmaceutical wholesalers. A community service obligation funding pool is being established, aimed at ensuring that, first of all, all community pharmacies are able to obtain supply of the full range of PBS medicines, irrespective of the size or location of the pharmacy, the breadth of the PBS product range, the cost of the PBS medicines or the cost of their distribution and supply to pharmacy; and that, secondly, all Australians have timely access to PBS medicines they require, regardless of the cost of the medicine or where they live. Payments from the CSO funding pool of $150 million per annum will be made to the eligible wholesale distributors of PBS medicines who meet the specified service standards that are prescribed under that CSO. The aim is to pay the wholesalers for the additional costs that they incur in providing the full range of PBS medicines to any pharmacy in Australia, generally within 24 hours of the order being placed for that prescription item.

This is a very important initiative which is intended to ensure the continuation of Australia's unique pharmaceutical wholesaling delivery system. We say 'unique' because there are few countries in the world where the population is spread so widely and in many parts so sparsely. Without the CSO initiative, there was a very real prospect that full-line pharmaceutical wholesaling services to rural and remote areas of Australia would have been at risk. The CSO effectively tries to safeguard against that. So, basically, the CSO is giving all the consumers in Australia the chance to access the PBS, no matter where they are or how expensive it is to deliver those products.

Secondly, the location rules regarding pharmacies ensure continual access to community pharmacies for persons throughout Australia. That is the main aim of the location rules in the agreement. The guild and the government have agreed to a number of amendments to the rules, which are intended to provide greater flexibility to respond to community need for pharmacy services and to improve access to pharmacy services. Members of this committee will no doubt be familiar with these amendments, as I believe they are currently passing through parliament.

Thirdly, there is the professional pharmacy programs and services part of the agreement, which I think should be of particular interest here. More than $500 million has been set aside in this agreement in order to fund a range of professional pharmacy programs and services aimed at optimising the effectiveness and value of the health system in general, and of the PBS in particular. The main funding priorities for this pool of funds are medication management reviews, which were occurring during the third agreement. You are probably familiar with those; they have been a big success. We are hoping to expand on those and get more people having access to them. People like them because they have pharmacists going to their homes and looking at their medications, which leads to the better use of medicines. So they help to reduce

the number of adverse drug events experienced by the elderly and by others who use multiple medicines.

There are various areas in rural pharmacy, including rural pharmacy allowances, which help to maintain and improve access to community pharmacy services for people in rural and remote parts of Australia. We are very conscious of making sure we maintain that network all over the country so that all Australians have access to pharmaceutical services. We aim to improve access to community pharmacy services by Indigenous Australians.

Ms HALL—How?

Mr Dowling—Through things like section 100 allowances, whereby we fund pharmacies to provide pharmacists to the Aboriginal health centres. They are funded to go and visit, and some of these visits involve the chartering of planes and that sort of thing so it is very difficult to give some of these people access to same sorts of pharmacy services that the rest of Australia enjoys, because of their remote locations and the facilities that are in those locations. So we think the best method is to have a community pharmacy go in and educate the workers there to provide pharmaceuticals in a manner that may be an imprest type of system or something like that.

Mr ENTSCH—And you would go through the clinics too, wouldn't you? You could feed this through the remote area clinics?

Mr Dowling—Yes. It is a very unique problem, which the government has identified, so as a part of the agreement we are working on ways to provide better access.

Ms HALL—Traditionally that has been an issue in Aboriginal communities, and particularly in areas where there is no AMS.

Mr Dowling—Yes. We have also the Better Community Health Program, which takes up the bulk of that $500 million in funding. This program will fund various types of innovative projects and pharmacies as part of primary care and community health. For example, there is funding for pilot programs to deliver diabetes and asthma services through pharmacies. There is funding available for pharmacists who provide dose administration aids, such as Webster packs and those sorts of things, to patients in the community who use multiple medications. There are various other aspects such as a medication profile, which is a summary of what people take, with the alternatives, such as the different generic names of different drugs so as to avoid confusion. It gives a brief description of what they are used for and the best way to take them. So these things will help improve quality use of medicines.

In conclusion, we would like to share with the committee the latest statistics in the PBS growth. There seems to be a bit of information out there, which we have been getting, that people are not really aware that the PBS has dropped off quite considerably in growth over the last 12 months or so. For some years the PBS has been the fastest growing component of Australia's health system. Treasury's 2002 *Intergenerational report* pointed this out and estimated that by 2042, in the absence of corrective policy measures, the PBS would account for more than three per cent of gross domestic product, compared with the current level of about 0.06 per cent.

Since the release of that report, the government has introduced a number of measures aimed at controlling the growth in the cost of the PBS. In particular these have included the 30-odd per cent increase in the patient copayment in January and the 12½ per cent generics measure, which took effect in August 2005. Together, those two measures alone will generate PBS savings of close to $2 billion over the next four years. In addition to that, as I mentioned previously, as part of the agreement we have also given up $350 million worth of PBS savings as part of the fourth agreement negotiations. So the impact of these and other measures has been fairly dramatic. I should add that the 20-day rule and those sorts of things have also had an impact in pulling back the growth of the PBS.

Mr GEORGANAS—I am sorry to interrupt you, but did the new 20-day rule measures come in after the agreement?

Mr Dowling—Yes. There has always been a 20-day rule—

Ms HALL—But now they have tightened it up.

Mr Dowling—Yes, they have toughened it up.

Mr GEORGANAS—But that was not part of the agreement?

Mr Dowling—No, that was a separate measure. But, again, all these things affect the PBS growth.

CHAIR—For the record, can you explain how the 20-day rule works now?

Mr Dowling—What happens now is that, if somebody wants their medication—and it is not all medications; it is primarily chronic medications—within 20 days, they can receive it under the immediate supply provisions, but, in the first instance, that will not count towards their safety net calculation. When they reach a certain number of prescriptions in the year, they then receive them at a concessional rate if they are a general patient or for free if they are a pensioner or concessional patient. So it will not count towards that total and once they have reached their total they will not get that lower co-payment. If a pensioner, for example, has reached the safety net and is getting their medication for free, and they want something within the 20 days, it will not be free; they will have to pay the $4.70.

Mr GEORGANAS—Would that affect people living in rural communities who perhaps do not know when they are next going to visit a town?

Mr Dowling—There are all sorts of issues with it. We are having a fair bit of discussion about it.

Mr GEORGANAS—People might be travelling, for instance.

Mr Dowling—There are lots of issues. Recently I had somebody who put their insulin on the top shelf of their refrigerator and it froze, so they had to throw it away and come and get more. That was within the 20 days, which would not count towards their safety net. We have been asking for some sort of discretion—

Mr GEORGANAS—A provision to allow for these sorts of things.

Mr Dowling—Yes. We had people under the old provisions who we know were lying to us—trying to hoard medication. We certainly do not want to encourage people to hoard medication, but we also know that in some circumstances there is a legitimate reason why they need their medication early.

Ms HALL—And people have been penalised.

Mr Dowling—Yes. We have been arguing that there should be some degree of discretion for pharmacists where there is a real need so that people are not disadvantaged.

Mr GEORGANAS—And certainly where the pharmacist has an ongoing relationship with that person.

Mr Dowling—Yes. I like having the ability to use the tool to say, 'That won't count towards your safety net,' or, 'That will cost you $4.70.' You know some people will end up coming in two years later with 20 boxes that have gone out of date and you say, 'Why did you get them?' Some people just feel they are entitled to hoard these things. We certainly want to stop that and we are quite happy to work with the government to do that.

CHAIR—Roughly how much would that be costing the PBS?

Dr Tatchell—I do not think we have a figure.

Mr Dowling—It is very hard to ascertain.

Dr Tatchell—We can tell you what the expected savings are—I think it is about $70 million over four years.

Mr Dowling—It is a substantial amount of money.

Mr GEORGANAS—So it would be fair to say that there is approximately $70 million of hoarding going on.

Dr Tatchell—I suppose so.

Ms HALL—Maybe not $70 million of hoarding, specifically.

Mr Dowling—Some of it comes from the fact that, towards the end of the year, people have always tried to stock up on their medications while they were free. For most people, all that means is it takes them longer to reach the safety net in the next year, so it is a pointless exercise—it is only delaying it—unless their medication is changed. That is where the issue is. If they have decided to try and get three or four months of stuff for free and, for instance, in January the GP decides to change them, it has been wasted. That is the type of thing we want to discourage. What we are basically saying is that the impact of these measures and the other measures has been fairly dramatic. PBS growth, both in volume and in spending terms, has fallen to levels not seen for at least two decades. We have a couple of graphs here.

CHAIR—So the PBS is still growing but at a lower rate?

Mr Dowling—At a much lower rate. These two graphs, from Medicare Australia and the Department of Health and Ageing, show a steep decline in growth in the past two years, so there is growth. The trend line represents the year ending comparison of prescription volumes and PBS spending. For example, the final point on the volume graph—

Ms HALL—That is negative growth.

Mr Dowling—Yes. It shows that the number of PBS prescriptions processed in the 12 months to February was 0.8 per cent lower than during the same 12-month period to February 2005. It also shows that in the 12 months to December 2005 PBS prescription numbers were one per cent lower than in the same period to December 2004. So actual numbers have reduced—

CHAIR—Could you go through that again?

Dr Tatchell—The top graph shows PBS volumes. They are rolling 12-month figures. You take a full 12 months of figures and with each passing month you drop a month off and add one on. It gives a more accurate representation of what is happening over time. The top graph relates to PBS volume growth and the bottom graph relates to PBS expenditure growth over the period since July 2002.

Mr Dowling—So while expenditure growth is growing, it is actually growing at a lower rate than inflation. Government measures have had a fairly dramatic effect—basically doing what they were supposed to do.

Ms HALL—Which do you think has kicked in the most?

Dr Tatchell—There has been a combination of effects.

Ms HALL—In the PBS volumes it is February and with the actual expenditure growth it would probably hit in about December, wouldn’t it—or maybe late January?

Mr Dowling—The first drop in the 12½ per cent came in on 1 August last year. That immediately had an effect. All the drugs in that category dropped by 12½ per cent, not just the generics. They had a fairly significant effect on PBS costs. It was very effective in claiming some savings from generic medicines.

Ms HALL—It was going down before then.

Dr Tatchell—The biggest effect was the copayment increase, which came in on 1January 2005.

Mr Dowling—Which is of some concern.

Ms HALL—It is, isn’t it?

Mr Dowling—I spoke to Peter Costello about this recently. He was talking about how we are supporting this now when we did not support it before. As I said to him, we did not not support the measure; we argued for a graduated increase, because what tends to happen when you have a large increase is that people stop taking their medication. They come back again over time, usually, but history has shown that whenever there is a big increase, people stop taking things that do not make them feel any better. They stop taking the antihypertensives and the cholesterol-lowering medications—these sorts of things. Of course, they are the things which 10 years down the track, when they have a stroke or heart-attack, cause massive extra expenses in the health system.

Ms HALL—That is exactly right.

Mr Dowling—You need to be careful to manage things. As I said, we did not oppose an increase; we opposed a large increase.

Ms HALL—Have you found that within your members?

Mr Dowling—That is what the figures are showing with the copayment increase. A large proportion of Australians have not all of a sudden just got healthier; they have just stopped taking medication.

Ms HALL—That is an important message for us.

CHAIR—Where does the doctor fit into that graph? Do they stop prescribing?

Mr Dowling—No. They patients just stop having them filled or they do not have them filled as often.

Mr GEORGANAS—You are talking about the aspirin heart tablets, for example?

Ms HALL—For hypertension.

Mr Dowling—Yes, things for high blood pressure or high cholesterol. They are the two classic ones. You do not normally feel any different whether you take them or not.

Mr GEORGANAS—So why doesn’t the doctor continued to prescribe them?

Mr Dowling—They do.

Mr GEORGANAS—The patients choose not to?

Mr Dowling—It is very hard for doctors to assess compliance. A lot of people do not see their GP that regularly. There can be problems. People will come back and their blood pressure is still high, so the doctor thinks he needs to increase the dose. It is just because they are not taking it in a compliant manner.

Mr GEORGANAS—Are there cases of this—are you aware of certain cases?

Mr Dowling—I do not think there has been any studies done, but anecdotally you can pick it up in pharmacies.

Mr GEORGANAS—Okay.

CHAIR—There is no evidence that doctors are prescribing less?

Mr Dowling—No.

CHAIR—But there is evidence that volumes are down and expenditure is down?

Mr Dowling—Yes. As I said, hopefully it will slowly build back up as people—

Ms HALL—Become compliant again.

Mr Dowling—Yes.

CHAIR—What about prescription of cheaper generics? Does that come up in there?

Mr Dowling—There is a slightly cheaper copayment for the generics, so hopefully that would mean that people are a bit less likely to stop taking their medication. That fits in there.

CHAIR—Sorry, the PBS expenditure?

Mr Dowling—Yes, that includes generics.

Mr GEORGANAS—Because generics cost less.

CHAIR—But that is government expenditure on the PBS?

Mr Dowling—Yes.

CHAIR—That is not including the copayment?

Mr Dowling—No.

Ms HALL—The copayment is what you or I pay.

Mr Dowling—Yes, that is right.

Dr Tatchell—A lot of generics are priced below the maximum patient copayment.

Mr GEORGANAS—Is that reflected in here—that is what the chair is asking?

Mr Dowling—Yes, it would be, actually—I know what you are saying: the increased copayment means that some things have fallen under the copayment level and therefore they are not in fact in the figures. Yes, that is right. Instead of the government paying for them—

CHAIR—It is paid for by the patients. That was the purpose of the copayment.

Mr Dowling—Yes, that is right. So hopefully the figures are not as bad as they may look. Hopefully the compliance has been better than is shown by the raw figures.

Ms HALL—So long term you suspect that if people remain noncompliant it will be reflected in other areas within the health system?

Mr Dowling—Certainly. But, as I said, what we are hoping—

Ms HALL—So rather than it being the PBS that is growing, it will be growing in, say, expenditures in public hospitals where people are presenting with heart attacks and strokes?

Mr Dowling—Yes. This is the whole thing about the cost-effectiveness of the PBS. I think everybody realises that a dollar spent on drugs ends up saving X number of dollars down the track. That is why it is a very cost-effective way of treating people. Obviously, if you can prevent a stroke, even if it costs you $5,000 worth of drugs over 10 years to prevent that stroke, it is much better than actually spending the money to rehabilitate somebody after a stroke, which is enormously expensive.

Mr GEORGANAS—It is like spending a bit of money to take out a little bit of insurance?

Mr Dowling—Yes.

Ms HALL—And costs in providing residential care in aged care facilities?

Mr Dowling—Yes, all those things. And keeping people in the workforce and in productivity alone. We always talk about people working longer with the ageing population. The longer you can keep people active and healthy and willing to work, the more productive they are—they are paying taxes and actually contributing. We certainly believe that the PBS should not be looked at as a cost centre but as an investment centre. Of course, it has to be a sound investment—you cannot be wasting taxpayers' money. But we like to think that we work with government to try to get the most cost-effective way of operating the PBS and providing other services through pharmacies that can save the health system money. I think we have a pretty good record of trying to work with government on those areas.

CHAIR—Does the guild have a view on the dispensing of pharmaceuticals in hospitals—private and public?

Mr Dowling—As in PBS dispensing?

CHAIR—Yes.

Mr Dowling—I do not know if you can add anything, Michael, but we are concerned about the PBS dispensing in public hospitals if those figures were to come into the overall figures—they previously would have been a state government issue—and made it look like the PBS was blowing out and we were blamed for it.

CHAIR—Do we know the expenditure on pharmaceuticals in the public sector?

Mr Dowling—I don’t.

Dr Tatchell—We don’t, but the department would.

Ms HALL—The figures are available.

Mr Dowling—I do not know how far you are looking at all this, but my opinion and I think the guild’s opinion is that the current system of state and federal health areas is pretty inefficient. There is a lot of cost shifting. I look after a small private and a public hospital in my pharmacy. Things like the oncology stuff is never a cost centre for the state government—they push it out to outpatient clinics so it is federally funded. There are all sorts of things going on in the states to try to maximise the contribution from the federal government. You tend to have a lot of, I suppose, waste with it not being run efficiently because people are trying to minimise their own costs. I personally believe—and it is probably not a stated position of the guild—that if we can all sit down and get one overarching health system controlled federally it would be a hell of a lot more efficient.

CHAIR—That is why we are here.

Ms HALL—That is what I like to hear.

CHAIR—We have got to have a national agenda in health—

Mr Dowling—Yes, absolutely.

CHAIR—and fund the states to achieve it.

Ms HALL—Deliver it, yes.

Mr Dowling—The PBS in public hospitals is a small part of that. At least it is allowing them to fund some of their pharmaceuticals through the federal scheme and, in return, they actually save on some of the efficiencies, I believe. Those sorts of areas do need to be expanded in all sorts of areas. It may take a fair amount of time, but I think the end aim should be to have a much more efficient health system. In a country the size of Australia, I believe it is just mad to have so many different people running different health agendas.

CHAIR—Yes.

Mr Dowling—I understand the political difficulties of the states not wanting to let go.

CHAIR—It is the lack of political will.

Mr Dowling—The two messages to flow from the effect on PBS growth are firstly that the government policy measures to control the growth in the PBS are working very well and are having the desired effect. Secondly, as a consequence of the first, we do not believe now is the time for the government to be considering further measures to control PBS growth. Obviously,

as we are talking about all these savings, pharmacy is wearing our fair share of that not just the savings from the agreement but as all these volumes and costs come down it means that is also affecting pharmacy incomes.

CHAIR—Have you put in your submission to the budget process this year?

Mr Dowling—We are awaiting consultation on the generic measures that were spoken about. We have been told there will be consultation with us prior to that going forward. We have very serious concerns about that.

CHAIR—When you put in the submission, could we have a copy?

Dr Tatchell—Yes. We are not putting anything in this budget process. The decision has been put off for—we have been told—six months. It is really the next budget process.

CHAIR—Is it the wish of the committee that these figures concerning the PBS volume growth rate and the PBS expenditure growth rate be accepted as evidence? There being no objection it is so ordered.

Mr ENTSCH—In the time from when you originally put your submission through and the acceptance of the agreement, most of your stuff has already been dealt with.

Mr Dowling—Yes, at the moment. As we were alluding to, obviously, there has been an IDC talking about further savings to the PBS and that is what we are concerned about. I was one of the negotiators to the agreement and we never hid the fact that we did receive generic discounts and that was part of our industry structure. The fact is that over the last 10 years with the increase in the mark-up on pharmaceuticals and the increase in our dispensing fees, which is indexed to WCI9 which nowhere near keeps pace with our actual cost increases, the only way that pharmacy has been able to remain fairly viable is the terms of trade we have with our suppliers, including the generic people. As I said that was not hidden as part of the negotiations. Then to find out that there is an IDC going on which is looking at taking that away, we feel that the agreement would really need to be renegotiated because it was not envisaged that there would be further major structural change in the industry.

Mr GEORGANAS—There are the revised negotiations of what you agreed on with the PBS and these bits and pieces coming out continuously such as the 20-day rule and a few other things. Can you see that having an effect on community pharmacies after the PBS has been agreed on? I know it has taken a number of years to agree on.

Mr Dowling—We are not happy with the way that we do not have any discretion in things like the 20-day rule. It is going to be a fairly significant impost on us. It is not so bad now because we are just explaining to people that it will not count towards their safety net but, at the moment, that is not actually taking money out of their pocket. Once they reach their safety net—most reach it in about the middle of the year—and we have to start telling them that they will not get it for free, it is going to cost them $4.70, that is when we are going to have issues. We are going to have to spend a lot of time trying to explain to people why they have to pay for things. Overall, I suppose we agree with the concept but we feel there needs to be some changes to the rules around it so that we have some sort of discretion when needed.

As I said, the thing that has concerned us the most is that we negotiated the agreement in good faith. The idea was to provide stability and security for pharmacy for five years. Once it was signed, a lot of our members went out and invested in things like pharmacy refits, they spent large amounts of money, they employed staff, they did all these sorts of things thinking that they would have a pretty stable environment for five years. Then to find out via the newspapers that there may be a significant change in our terms of trade for, say, the generics has got a lot of people very worried. We have been successful in having that decision delayed and we hope we will have significant consultation.

We are quite happy to work with the government. There are lots of areas where we think we can save money—such as PBS Online. Once they sort out the technical problems, we have lots of suggestions we can use as part of PBS Online to save money—such as the inappropriate prescribing of items. Often things that should not be first line drugs are used that way, such as somebody with a sports injury getting prescribed, say, Celebrex. You have a very expensive drug being prescribed when a very cheap drug would be perfectly appropriate. All these sorts of things can be picked up once we get onto an electronic system and we can provide input into that process. There are a lot of things we can do which we feel can save the government money.

We talked before about the focus on medications, but pharmacy is a platform. We have this very good network of community pharmacies. A lot of the infrastructure is covered by the retailing activities and whatnot. We have this well distributed and very accessible structure that we think can provide other services to the community at a low cost, and certainly at a lower cost than probably anybody else in the health system—things such as: the monitoring of warfarin levels, cholesterol and blood pressure; wound care; assistance for people with diabetes and asthma; disease management programs; and screening. We have a program that we are looking at getting up for screening of type 2 diabetics. There are a huge number of undiagnosed type 2 diabetics in the country. We could do a simple test whereby a person fills in a questionnaire and if they fail the questionnaire, we give them a blood test. Then if it looks like they may have diabetes, we refer them onto their GP. Earlier diagnosis of type 2 diabetes is an enormous saving to the health system; people do not end up with amputations and losing their sight and all those sorts of things.

There is a lot of waste in pharmacy because people come in regularly; they do not have to make an appointment. If we can provide those services from that platform, it would be a tremendous use of efficient resources for the whole country. We are trying to position pharmacy to keep ourselves viable so pharmacists are willing to embrace it. We do not want pharmacists to turn into more of a retailer than a health professional because that is what they have to do to survive. We would prefer to be focusing on provision of health areas because they have the skills—they have four years at university and then a year doing pre-registration training. Why waste all that training to be selling nappies? We are not using a resource that could be used more efficiently.

CHAIR—Are you happy with the way Diabetes Australia picks and chooses pharmacies to distribute their products?

Mr Dowling—The whole Diabetes Australia thing is an issue for us, but it is one that we have not made too much of a fuss about. Basically, Diabetes Australia survives on the fact that a lot of pharmacies distribute their products for nothing and actually at a cost, because they have the cost

of holding the stock and the cost if it goes out of date which they do not get reimbursed for. Pharmacies do it because they hope to pick up the insulin prescriptions and the other things to compensate for that. Diabetes Australia is riding on the back of these pharmacies, and that is why they only allow certain subagencies to distribute their products. They need to ensure that some pharmacies have an advantage over other pharmacies because if all pharmacies were doing it they would not be getting any more insulin prescriptions and therefore there would be no benefit to them in being a subagent. We have disagreed with the Diabetes Australia mode of delivery, and we have argued that pharmacies should have some sort of incentive for doing that, but whilst pharmacies continue to do it for nothing, it is a bit hard to—

CHAIR—The difficulty with my pharmacist in Maroochydore in Queensland is that while it is a tourist town and he is open quite late, the supplier of diabetic products in the Sunshine Plaza closes at 5.30 pm. They are not available—

Mr GEORGANAS—The guy who is open late does not sell diabetic products?

CHAIR—He cannot. He is not allowed to.

Mr Dowling—They will not give him a subagency.

Dr Tatchell—It causes problems.

Mr Dowling—In most areas, they will allocate one subagency. The idea is that it gives that person the incentive to do it. We have done studies. The Frank Sirianni study showed that the average diabetic subagency was losing $14,000 a year or something—

Dr Tatchell—Something along those lines, yes.

Mr Dowling—on that side of it.

CHAIR—If so many of them want to do it, they want to lose money.

Mr Dowling—It is because they get the extra insulin prescriptions and all that sort of stuff.

Ms HALL—They gain on roundabout.

CHAIR—It balances out.

Mr Dowling—Yes, it counteracts. But, again, if they offered it to every pharmacy, there would be no incentive. As you were saying, it is not a very fair method when you cannot go to your regular pharmacy for them. I have a pharmacy about 10 kilometres from Devonport, in Latrobe, Tasmania, yet people have to travel—

CHAIR—There is a nice restaurant there.

Mr Dowling—Which one—Glo Glo's?

CHAIR—Yes.

Mr Dowling—I am about 50 metres away.

CHAIR—The committee went down there and visited Glo Glo's about three or four weeks ago.

Mr Dowling—I have the pharmacy at Latrobe, but I have to send people to Devonport, which is where the subagency for Diabetes Australia is. It is quite inconvenient for people, but I have no choice.

Mr GEORGANAS—I will go on to another area that we have not touched on—and I suspect you have not spoken about it in your submission because it was obviously negotiated in the PBS—and that is pharmacies in supermarkets. What do you think about that in light of what has taken place in the last couple of weeks, where I think it was Coles that just purchased the largest internet pharmacy?

Mr Dowling—They just bought Pharmacy Direct.

Mr GEORGANAS—How will that affect you? We know there is a push by the big multinationals for this.

Mr Dowling—Firstly, the fact that Coles Myer has bought Pharmacy Direct is pretty indicative of their mode of pharmacy. They bought a low-cost, low-service delivery method which is purely about moving product. This is one of the largest pharmacies in the country because it is purely a mail-order, internet type pharmacy. There is no personal service. They do not have customers coming in for advice; they are just moving product. We all know that that is what supermarkets do, and they do it very well. They are very efficient at moving product.

CHAIR—Is it cheaper for the patient?

Mr Dowling—PBS prescriptions are not. Private prescriptions are—well, I should not say they are. Sometimes they are not. It depends. It is very competitive out there now. In the old days I suppose pharmacists had a bigger mark-up on the private prescriptions, but that has become very competitive. When you take into account the costs of mailing it and the delay, to be perfectly honest, it could often be a bit cheaper overall. But, then again, you are not getting the same level of service. It is a factory, basically, that manufactures prescriptions. Coles Myer obviously see that as a model that suits them and I think, if we ended up with pharmacies in supermarkets, that is the sort of model you would be looking at, not what we believe is the best model of pharmacy.

Mr GEORGANAS—What about internet suppliers from overseas? There is a problem I was reading about recently where you might order some Lipitor but that is not what you get.

Mr Dowling—The counterfeit stuff?

Mr GEORGANAS—Yes.

Mr Dowling—Yes, and all sorts of things. My branch director in Tasmania recently sent off to India and got—

Mr ENTSCH—There was a big thing on *Four Corners* about the Indian companies.

Ms HALL—Some of the most addictive drugs are involved in that.

Mr Dowling—That is right: things that need a prescription. She just sent off for them and got this package in the mail—I cannot remember what it actually was now.

CHAIR—An exact copy.

Mr Dowling—But she also sent off to an Australian mail order pharmacy and had six or eight packets of Sudafed come through in the mail.

Mr ENTSCH—That is interesting.

Mr Dowling—When you talk about trying to stop the drug runners buying pseudoephedrine, she did it as simply as mailing off an order to this type of place that Coles has bought and getting a package in the mail.

Mr ENTSCH—It is amazing when I turn on my computer—there must be a whispering campaign somewhere—because every morning there are about 50 offers for Viagra alone on my computer. Somebody is telling us tales out of school somewhere.

Ms HALL—You should get a screen put on your computer.

Mr ENTSCH—I cannot get rid of the bloody things.

Mr GEORGANAS—I cannot get rid of them either.

Mr Dowling—I cannot screen for those sorts of things because, if I put Viagra in as a screen, I would miss out on a lot of the stuff I am supposed to get.

Mr ENTSCH—There are at least 50 every morning.

Mr GEORGANAS—Following on from that, if pharmaceuticals were sold in supermarkets, what effect would that have on the community? Would there be any services that we would lose?

Mr Dowling—Yes. A lot of these things that we are trying to deliver, to expand the role of pharmacists, would not suit a supermarket environment—for example, wound care. Are they going to have a separate area to patch up people's cuts and abrasions et cetera? A lot of services, which are more state issues, we provide for no cost—things like, say, the methadone program and the needle availability program. There is no way in the world supermarkets will provide those sorts of things. A lot of what we do involves the relationship with our customers. Most pharmacies tend to have a pretty good relationship with their local customers. Over time, you learn things about them which help you pick up things that they possibly should not be taking or buying over the counter. People feel comfortable going to their local pharmacist and asking

questions about things which they might not be happy doing in a supermarket. What might happen instead is they might go to a doctor and then there is a big extra cost.

I cannot understate the triage role of pharmacies. It often gets overlooked, but every day in our pharmacies people are coming in asking for advice on anything from a scraped knee to a red eye or whatever. There are so many things where, with our level of training, if somebody comes in with a red eye and you ask a few questions, it is either something that you can treat in the pharmacy or something they need to see a doctor about.

In those two situations there, if we were not there, a lot of the people who we could treat would go to a doctor, so there would be an extra cost. Or a lot of people would not go to a doctor and they would say, 'It'll be right,' and at times they could lose an eye. It is a primary health screening role. In many situations where we can sell something to somebody to fix their minor problem it does not cost the federal government any money at all; it is actually the consumer paying for it, and they are willing to pay for those sorts of things.

CHAIR—Every group that has appeared before us has spoken about workforce issues. What is the situation regarding workforce issues in pharmacies?

Mr Dowling—We have done a lot of work on it. There has been a fairly large study showing there was going to be a very severe shortage of pharmacists. The pharmacy schools have responded by expanding the intake. In the medium term we still have a problem, but hopefully that will resolve as the pharmacy schools have more graduates.

Within the industry we are also trying to restructure how we operate as far as work flows and things go. We are trying to get rid of some of the tasks that a pharmacist does not need to be involved in—some of the actual mechanics of dispensing, for example—to free up the pharmacist to do more of the cognitive work, so the pharmacist can spend more time counselling patients, doing home medicine reviews, wound care or these types of things that we are trying to bring into pharmacy. We have been very focused on trying to take the skills of pharmacists, take the actual network of pharmacy and enable that to be used more efficiently by the government.

Ms HALL—I am sure I read somewhere within the last week that the shortage was so great that there was going to be a need to import pharmacists from overseas.

Mr Dowling—In the short term, we have issues. Especially in country areas, there are a lot of problems getting pharmacists, but even in some of the major capital cities there is now a shortage. I believe, anecdotally, over the last probably 12 months it has eased a bit. For a while, it was desperate. You had pharmacists who did not have a holiday for two years because they just could not get out of the pharmacy. I know from speaking to Ian Marshall in Darwin that Darwin is still very bad. People have spent seven days a week in their pharmacy for months and months because they cannot get anybody to relieve them. Again, it is a fairly typical problem. There are a lot of people holding on to their turf and doing things they do not need to do. I suppose GPs are the classic example: they complain about how busy they are, but then they do not want to give up roles to somebody else. It is a matter of the efficient use of the workforces.

CHAIR—It may be necessary for us to come back to you when we have received evidence from other places. We will be in contact either in writing or in person.

Mr Dowling—We would be more than happy to provide any further information. As I said, I think it is a good idea having a look at it.

CHAIR—If you follow the evidence we receive on our web site and you see anything you feel you want to comment on as a guild, please do, especially from the point of view of financing. Thank you for making the effort to come here.

Mr Dowling—Thank you.

Proceedings suspended from 1.05 pm to 1.55 pm

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

ROFF, Mr Michael, Executive Director, Australian Private Hospitals Association

FISHER, Mrs Lucy Christine Anne, Executive Director, Private Hospitals Association of Queensland

CHAIR—Welcome. I am required to say this, so do not take it personally. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter which may be regarded as a contempt of parliament. Do you wish to make a brief introductory statement before we proceed to questions?

Mr Roff—I do. Thank you for the invitation to APHA to provide evidence at today's hearing. We have appeared before the committee at previous public hearings and also in the valuable roundtable discussions that were held in Sydney. Today, on behalf of APHA, I would like to take the opportunity to update the committee on recent developments within the private health care sector that have occurred since we last appeared.

The first of those is in relation to portability. As the committee would be aware, the Minister for Health and Ageing, the Hon. Tony Abbott, announced on 1 December last year that the government had restored portability of private health insurance for contributors. APHA welcomed this announcement by the minister that the Australian government had moved to protect consumer rights by enshrining portability arrangements for those with health cover when switching from one insurer to another. In particular, the practice of health insurance funds imposing benefit limitations on transferring members has been outlawed. In his media release, the minister proposed that the private sector develop a code of conduct in relation to portability and contracting issues. Since that time, APHA has actively and constructively participated in discussions with health insurance companies and the medical profession, and these discussions are ongoing.

In relation to benefits paid to private hospitals and day facilities, APHA remains extremely concerned about the contracting environment between health insurers and the private hospitals sector. As the committee is aware, most patients receiving treatment in the private hospitals sector are covered by the provisions of hospital purchaser provider agreements negotiated between hospitals and health insurers. In most cases, this means that hospital owners and operators agree to accept payment by the patient's insurer in lieu of levying charges on the patient.

The key concern of APHA is that, outside of the major corporate hospital groups, these agreements are increasingly made on a take-it-or-leave-it basis, with health insurers protected by both their market power and the provisions of the Trade Practices Act. The outcome of this imbalance in power can be clearly demonstrated by the declining share of benefits received by the sector and also in the failure of average increases—or decreases, in some cases—to keep pace with inflation, let alone health inflation. For example, the proportion of health fund benefits

paid to private hospitals and day surgeries has declined from 56 per cent of total benefits in 1996-97 to 47.9 per cent in 2004-05. Also, examined on a per episode basis, the average benefit paid to private hospitals and day surgeries has actually declined by 2.7 per cent over the calendar years 2003 to 2005. This decline has occurred despite the well-known fact that health care costs are increasing by around 2½ times the rate of inflation. With the committee's indulgence, I would like to table a document that provides an indication of the trends in benefit payments by health insurers, drawing on the most up-to-date data available.

CHAIR—Mr Georganas has moved that it be received as an exhibit. As there is no objection, it is so ordered. Please proceed.

Mr Roff—I come to an example of one of the key drivers of increasing health costs. My colleague Mrs Fisher will be able to provide the committee with details of how the recent public sector nursing offer in Queensland will impact on private hospital costs in that state.

Finally, I come to the training of health and medical professionals. Generally speaking, the private hospitals sector is seldom genuinely engaged by government in the development and implementation of appropriate workforce policy. This is despite the reality—that the overwhelming majority of the medical workforce and allied health workforce are private practitioners—and the fact that the private hospitals sector itself employs around 30,000 nurses. Contrary to popular perceptions, private hospitals are investing heavily in the education and training of the health workforce. APHA recently commissioned an independent assessment of the effort of the private hospitals sector in health workforce education and training, the findings of which are quite compelling. A report prepared for APHA by the Allen Consulting Group in 2005 estimates that the private hospitals sector as a whole would spend at least $36 million each year on providing education and training for doctors, nurses and allied health workers. The Allen Consulting Group also found that only a little over $1 million of that $36 million was recovered by way of fees or external funding. The key issues that need to be addressed before there is an expansion of the role of the private sector in the training of medical professionals include agreed funding arrangements and resolution of any outstanding professional indemnity concerns.

APHA has met recently with the Royal Australasian College of Surgeons to discuss ways in which the two organisations can work together. We will be continuing to liaise with the college. In addition, APHA's vice-president has met recently with consultants who will report to the Department of Health and Ageing on the medical workforce and training, to provide first-hand experience on the issues around medical training in private hospitals. Thank you again for the invitation to appear today. I am happy to take questions.

CHAIR—Thank you, Mr Roff. Health insurance premiums went up about five or six per cent recently. How much of that is going to you?

Mr Roff—'Not enough' is the short answer. It is difficult to say. From the figures that we have handed up, you can see that less than half of all the total benefits paid by health insurance funds actually go to private hospitals. Once again, the committee should be aware that the premium increases granted to health funds do not flow to private hospitals in the same quantum, so there would be very few—if any—private hospitals getting five or six per cent increases. Most of the increases that are granted would be below the level of the CPI.

CHAIR—So when you have your hospital contracts with the funds in place and the fees go up in the middle of those contracts, you do not benefit from the increase in fees until when?

Mr Roff—That depends on the terms of the contracts. Contracts range anywhere from 12 months to three years. The longer term contracts will have some form of indexation built in but there is no correlation between the premium increases granted to health funds and the benefits paid to private hospitals. The funds will often justify their premium increases on the basis that hospital costs are increasing and they need to meet those costs. In fact, one year we saw the justifications given by health funds for their premium increases. Most of them mentioned things like increasing hospital costs and increasing nursing wages, but then there is no attempt on the part of the health funds to actually meet the level of those cost increases being experienced by hospitals.

Mr GEORGANAS—Would you be able to give us a breakdown on where the recent six per cent increase in health fund premiums went in terms of doctors et cetera?

Mr Roff—It is in the table. The four columns on the far right give a breakdown: ancillary benefits, medical benefits, prosthesis. About 48 per cent goes to hospitals. You can see where the rest goes and how that has changed over time.

CHAIR—If the fees go up by six per cent, you would expect an increase in each of those areas proportionately, wouldn't you, to remain constant?

Mr Mackey—Part of the problem is that the bulk of any increase only covers increased use. It is extra medical services, extra hospital visits, extra visits to other practitioners and extra prosthesis that are fitted. The actual increase in cost of providing those services is not built in.

Mr ENTSCH—You do not get an increase for the procedure; it is the volume.

Mr Mackey—Yes. In some cases there will be a marginal increase; others may not have seen an increase for four or five years. It depends on their negotiating capacity. The biggest problem is that the increasing costs are not catered for.

Mr Roff—By way of example on the point that Paul has just made, in calendar year 2005 the number of insured episodes in private hospitals increased by 3½ per cent. There is more money in total going into private hospitals because we are doing more work, but it is not keeping pace with the increase in costs, or even the increase in volume.

CHAIR—What is your view on the privatisation of Medibank?

Mr Roff—Our view is that we are less concerned with the ownership of Medibank Private than we are with their behaviour in the marketplace. As evidenced by the tendering process they went through over the last 12 months or so, we do not think that their behaviour in the marketplace could be any worse, regardless of who owned them.

Mr GEORGANAS—So it was pretty bad in other words.

Mr Roff—They are certainly operating like a for-profit fund at the moment. We are not too concerned one way or the other about the ownership of Medibank.

CHAIR—Is there too much market concentration in Medibank? I know that in my area the private hospitals get screwed by Medibank. Two hospitals 10 kilometres apart can get paid a totally different amount for the same procedure. In the past it has been possible, because the government is the shareholder—even though they are a totally independent corporation—to persuade them to review their practices in that regard. I would not feel as confident of that outcome if it was not in government ownership.

Mr Roff—I agree with you. I think this issue was canvassed at the roundtable in Sydney. It is probably a direct consequence of government ownership that to some degree political pressure can be brought to bear when their behaviour is not acceptable in the marketplace. I think to some extent that moderated the outcome of their recent contracting round. It is a bit like 'how long is a piece of string', because it depends on what form they are privatised in as to whether or not that market power will remain, whether it will increase the market power in some geographic markets of other players or whether it will be split up totally. So it is a bit hard to give a definitive answer.

CHAIR—You are not concerned about an impact on private hospitals?

Mr Roff—Once again, we do not think their behaviour could be any worse than it has been for the last 12 months.

Ms HALL—I would like to go back to some of the issues we discussed at the roundtable—the relationship between private hospitals and the insurance companies, the determination of what is best for a patient who needs to receive treatment in a private hospital and the ability of the private health insurance industry to impact on that. It goes to contracts and a number of the issues that you have raised over a period of time. Would you like to comment?

Mr Roff—Decisions about what clinical treatment is appropriate for a particular patient in a private hospital are usually made by the treating specialist before the admission to hospital, but there are some practices of health funds that can impact on those decisions, both in the setting of the treatment and in the financial consequences for the patient. Some of those sorts of things relate to benefit limitations and exclusions. We have seen examples in the past where a patient may have opted for an exclusionary product at some stage in their life and never updated or reviewed their cover, and the fund certainly has not come back to them and said, 'You signed up when you were 30 and excluded cardiac treatment. You're now in your mid-50s; perhaps you'd like to look at taking out cardiac cover.' That does not happen in any systemic way that I am aware of, although a number of funds say they undertake those sorts of practices.

The result is that you can get a patient admitted and treated for a condition in the belief that they are covered, only to find out subsequently that they are not. In some cases that is caught before the treatment is actually provided, in which case they will make an informed decision about whether they go to the private hospital and pay out of their own pocket or seek treatment in a public hospital with the attendant problems around waiting lists. But we still continue to have problems with health funds providing eligibility verification, particularly after hours, so the hospital cannot check whether the patient has the cover that they say they have. In cases of

emergency we have had people brought in to have cardiac surgery on a Friday night, for example. They have an expensive procedure and spend a couple of days in intensive care and coronary care, and, by the time the hospital is able to check with the fund, it is discovered that they had an exclusion and the patient is not covered for an episode that may cost $30,000 or $40,000.

CHAIR—You would not tell them until they got better, would you!

Mr GEORGANAS—How does the hospital recover this money and what procedure do they take?

Mr Roff—In a lot of cases it is simply written off as a bad debt. Depending on the circumstances of the patient they may be able to negotiate to receive some of the cost towards that treatment. But, if the patient says, ‘I don’t have the money; sue me for it,’ the hospital is going to be reluctant to go down that path and potentially bankrupt a patient.

CHAIR—What about the cost of the surgeon in that instance?

Mr Roff—Once again, that is a separate financial arrangement between the patient and the treating doctor, but at least a portion of that fee would be covered by Medicare.

Ms HALL—This morning we spoke to the Australian Nursing Federation, and one of the suggestions that they made in their submission was that private hospitals be directly funded. What is your thought about that, and how do you think that would go in alleviating the problems that you told us about down in Sydney and that you reiterated today?

Mr Roff—It depends who they are talking about being the direct funding source. Would it be directly funded by the consumer, by government?

Ms HALL—Say it was the federal government directly funding you, as opposed to funding the health insurance companies.

Mr Roff—That does happen to some extent now with the Department of Veterans’ Affairs, through their private patient program.

Ms HALL—It does. That is right.

Mr Roff—Expanding that more generally is something that we probably do not have a specific view on, but there would be issues there. I assume you are talking about the removal of all health insurance, so effectively what we would become is privately operated public hospitals taking public patients on contract, because everybody would be a public patient.

Ms HALL—Not necessarily. I do not think that is what is in their submission.

CHAIR—They feel that the 30 per cent rebate could be better used by putting it into the public system.

Ms HALL—Then people could take out insurance to cover any gap. Also, they recommend in their submission that there be the ability for the public system to buy beds, but that would be done through the public system.

Mr Roff—That already happens on a fairly ad hoc basis, and we talked when we last appeared about the process that was taking place in New South Wales. There have been media reports about the waiting list patients, particularly for eye surgery, who have gone to private hospitals in New South Wales, and I understand a similar process is now under way in Victoria. So there is a capacity there now for the public sector to purchase services in private hospitals.

Ms HALL—Just a thought from left field: could the Private Hospitals Association itself develop a scheme whereby people could purchase their insurance through you?

Mr Roff—Only if we became a registered health benefits organisation.

Ms HALL—Yes, but I am looking for some other way that we could do it that was a bit more creative.

Mr Roff—There have been attempts in the past, but anything that did not fall within the strict regulatory definition of a health fund was stamped out fairly quickly.

Mr GEORGANAS—There is also the national competition policy. You may have an unfair advantage or disadvantage all the other players in the industry.

Ms HALL—What about the contracts? How are they going?

CHAIR—Jill, could I just interrupt you? This is the section in the Nursing Federation submission.

Ms HALL—Yes, paragraph 7.4. I will read it out:

> 7.4 The rebate in essence funds private health insurance companies and not private hospitals. Ian McAuley argues cogently on this point and has done much work on the breakdown of the rebate dollar and how much goes on administration and how much ends up supporting the provision of private hospital services. He asserts that if public money is used to support the private system it should go directly to private hospitals as subsidies for offering services to patients, including public patients. This would certainly decrease public hospital waiting lists (McAuley, 2004). We need to support the private system in a manner that is complementary to the public system, not in direct competition.

That is basically what I would like you to comment on.

Mr Roff—I guess we would say that we are providing services which are complementary to the public system. I have seen some of this analysis by Ian McAuley, but I have also seen analysis by a gentleman by the name of Paul Gross. One thing that McAuley's analysis ignores is the deadweight cost of tax collection or collecting government revenue, which Gross has estimated can be up to 20 per cent. If you factor that in, the rebate looks even more attractive as a method of providing assistance than it does just on the raw figures. But I would challenge the first question: that the rebate funds private health insurance companies and not private hospitals. Certainly there is a proportion of the rebate that does flow through to private hospitals, but as we have seen it is less than half. Private hospitals are not the only thing that health insurance currently pays for, and certainly the growth in costs of prostheses and also medical gap cover has led to the decline in the proportion of the health insurance dollar that we get. But I think that, if

you go back to the policy principle that the rebate is there to provide assistance and support in recognition of those who take responsibility for funding the costs of their own health care and thereby giving up the free public bed that they are entitled to, that is the support that is provided by the rebate.

Ms HALL—So you have a different position to that of the nurses?

Mr Roff—Yes.

Mr Mackey—I will just add slightly to Michael's answer. I think there is often not a complete picture when administrative costs are compared between the private health insurance companies. I am not wanting to defend them overly in that way—do not get me wrong—but they are pretty well always only compared to the Health Insurance Commission's, or Medicare Australia's, administration of Medicare. They do not ever factor in the administrative costs of state governments or the administrative costs of the Commonwealth health department and their involvement in the provision of public hospital services. So I do not believe it is an accurate comparison.

CHAIR—Before we go in camera—I take it that that is a presentation by you, Lucy?

Mrs Fisher—Yes.

CHAIR—Is there anything you can say on the public record that does not breach commerciality in confidence or whatever, just so that we have something on the public record as to the areas you are going to cover? If you do not feel comfortable with that, I am quite happy to go in camera.

Mrs Fisher—Certainly I am prepared to say that obviously a wage increase of that magnitude does have a significant impact on the private sector, simply because, as Michael has alluded to, our hospitals operate on fixed prices for a given term. So, when you have a wage impost like this in the public sector, it significantly exceeds the budget expectations of both hospitals and funders. Obviously funders put in their premium applications each year based on anticipated costs. Our hospitals would have budgeted around four per cent per annum. When something like this comes up, it makes it extremely difficult to fund that within those existing contractual arrangements.

Ms HALL—Can I just interrupt for a moment. So that it is on *Hansard*, when you said 'the impact of that', you were referring to the Queensland government offer to public sector nurses?

Mrs Fisher—Yes.

Mr Mackey—There is probably a wider point that could also be made just prior to—

CHAIR—Sure.

Mr Mackey—This is a time when both the private sector and the government are looking to the private sector to try to expand, for example, the training of medical specialists in the private sector. Those increased costs are not only in the nursing area but also in salaried medical officers

and trainee doctors so that will increase the costs dramatically of training doctors. Part of the trouble is that over time trainee doctors have become de facto employees of the states and territories, through their public hospitals, so they are not receiving the full range of training—they are working. We need to go back to a time when they are actually training. Those sorts of ad hoc decisions, such as the one that has occurred in Queensland, will not help that to occur.

Ms HALL—I cannot argue against any worker getting a pay increase?

Mr Mackey—I am not arguing against it, either—

Ms HALL—I cannot argue against decisions of the Queensland government on this one.

CHAIR—But it is important to look at the impact.

Mr Mackey—I would be the last person to argue about increased costs, but part of the trouble is if you inadequately fund your state health system for year after year and then there is a massive catch-up in a short period, that causes problems across the board and it will cause problems in the state, as well as in the private sector.

CHAIR—Is it the wish of the committee that evidence from the witnesses before us now be taken in camera? There being no objection, will members of the public please withdraw.

Evidence was then taken in camera but later resumed in public—

CHAIR—Witnesses, we are back on the record. For the purposes of the *Hansard* public meeting record: Mrs Fisher, I asked you the question as to what recommendation you would like this committee to make to government to address the problem in Queensland.

Mrs Fisher—In relation to the wage issue, it was to look at an interim premium increase for Queensland, at a rate that would obviously have to be actuarially determined, to enable private hospitals and insurers to have sufficient funds to be able to ensure that nurses in the private sector are able to have increases that are at a percentage and within time frames similar to those of the public sector.

Ms HALL—Mrs Fisher, was there something that you wanted to say about removing the differential that currently exists between benefits paid and premiums in different states?

CHAIR—Please explain that firstly, Mrs Fisher, and then say what we should do about it.

Mrs Fisher—The average benefit received by hospitals across the states for the same episode of care is significantly variable to the point that between some states it is a double-digit percentage and several hundred dollars. The reasons for that are largely historical and the time has probably come, given increases in the cost of living and increases in technology, to actually have an in-depth analysis of that and ensure that the dollars paid per episode of care are more—

CHAIR—equalised—

Ms HALL—across Australia.

Mrs Fisher—Yes, are equalised and the premiums set on a national basis.

Mr Roff—And perhaps taking that one step further, another option—and this is perhaps a broader way of addressing this general issue of cost increases—is to have some degree of deregulation around the health fund premium setting process, because at the moment they are limited to a once a year increase. This has been part of the problem. The health funds developed their applications and had them signed off by Christmas, to be submitted in early January to the Commonwealth government. The announcement of this pay offer in Queensland came after that had been done, so the health funds had not factored this sort of cost increase into their own premium increases. If there were perhaps some deregulation around the timing or approval process for premium increases, there would be more flexible arrangements to be able to take account of these extraordinary one-off events.

CHAIR—Can we put on the record something to the effect that we have this sea change phenomenon which is affecting Queensland more than any other state. All the problems we are reporting are from the other states.

Ms HALL—Let me put it like this. I think that problem exists in the coastal regions all the way up the coast.

Mrs Fisher—Would you like me to reiterate the numbers for the record?

CHAIR—Yes, please.

Mrs Fisher—In the year to June 2004, Queensland accounted for more than one-third of Australia's total population growth, for the third consecutive year. Of the net population growth of 81,000 that year, 69.6 per cent was from interstate and overseas migration. Significantly, 58 per cent of this was persons over 45 years of age. This will obviously increase future demand for private services as many of these people are self-funded and likely to be privately insured.

Ms HALL—Witnesses, would you like to say on the record what you said a little bit earlier when you answered my question?

CHAIR—Before we do that, I move that we accept the confidential documents as exhibits. As there is no objection, it is so ordered.

Mr GEORGANAS—Chair, for the record perhaps we should move that we consider the recommendations that have been put forward by the Australian Private Hospitals Association when we look at what to put into our recommendations.

CHAIR—We will do that later.

Mr Mackey—If the committee were minded to make some sort of recommendation on an interim premium increase, an associated issue is the lack of transparency in the reasons given for a premium increase and the way benefits are paid. If, as part of that process, it were possible to get a new system in place where, for example, a health fund says that they need a nine per cent increase in premiums and four per cent of that is because of increased salaries, three per cent is due to another reason and so on, there is transparency as to how that is paid.

CHAIR—They have to give that information to the government—

Mr Mackey—But there is no scrutiny.

CHAIR—when they get it approved. Because of commercial-in-confidence issues between funds, that information is not published.

Mr Roff—At the moment they do not break it down—

CHAIR—They do for the government. They have to justify for the government exactly why they need premium increases.

Mr Mackey—But there is no scrutiny by the department as to how they disburse it.

Mr GEORGANAS—You need that scrutiny when there is an increase.

Mrs Fisher—Yes, that there is some matching between what they have asked for and why they have asked for it and that it is flowing through.

Ms HALL—You want greater accountability and greater transparency.

CHAIR—My argument is that, as the Commonwealth government effectively pays 30 per cent of all premiums, it has a vested interest, and it should have say in how those premiums are collected and how they are spent and in making that public.

Mr Mackey—A classic example of a future premium increase would be exactly for this reason, and there would need to be some scrutiny that benefits paid were for that reason.

Mrs Fisher—It is probably also worth noting on the record that one of our issues is being funded on a per episode basis. Under our current funding models, we do not get a contribution towards the education and training of our staff or the capital refurbishment and equipment expenses, and that is a deficiency.

Ms HALL—That is the exact comment I wanted to put on the record.

Mrs Fisher—Years ago when margins were nine and 10 per cent, there was sufficient within a hospital's margin to meet that. Now we have margins which are significantly lower than that and there is simply not the margin there to be able to make that provision for the future. In Queensland, it will be particularly acute, given the government's commitment to additional capital infrastructure over the next five years. Obviously, the private sector is going to need to keep pace with that and, in view of the increasing requirements from consumers, that will be very difficult within current margin levels.

CHAIR—There are two new hospitals on the Gold Coast and Sunshine Coast at $500 million each—that is in today's dollars.

Mrs Fisher—That is a lot of money.

CHAIR—Is there anything else that we need to cover?

Mr Roff—Not that I can think of, but I am happy to provide any further information.

CHAIR—When we are writing our report, we may need to contact you again, either by phone or in writing. Thank you for appearing before us today.

Resolved (on motion by **Ms Hall**):

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

Committee adjourned at 3.03 pm