



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

MONDAY, 30 MAY 2011

CANBERRA

BY AUTHORITY OF THE SENATE

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**SENATE
COMMUNITY AFFAIRS LEGISLATION COMMITTEE**

Monday, 30 May 2011

Senators in attendance: Senators Adams, Back, Bilyk, Boyce, Cormann, Fierravanti-Wells, Fifield, Furner, McEwen, Moore, Parry and Siewert

HEALTH AND AGEING PORTFOLIO

In Attendance

Senator McLucas, Parliamentary Secretary for Disabilities and Carers

Department of Health and Ageing

Executive

Ms Jane Halton, Secretary

Ms Rosemary Huxtable, Deputy Secretary

Ms Megan Morris, Acting Deputy Secretary

Professor Chris Baggoley, Acting Chief Medical Officer

Mr David Learmonth, Deputy Secretary

Mr Chris Reid, General Counsel

Ms Rosemary Bryant, Chief Nurse and Midwifery Officer

Ms Kerry Flanagan, Acting Deputy Secretary

Mr Paul Madden, Chief Information and Knowledge Officer

Mr Andrew Stuart, Acting Deputy Secretary, DoHA National Alignment

Business Group

Ms Margaret Lyons, Chief Operating Officer

Ms Samantha Palmer, General Manager, Communication and People Strategy

Mr Joseph Colbert, Assistant Secretary, People Branch

Mr David Paull, Acting Secretary, Corporate Support Branch

Ms April Purry, Acting Secretary, Legal Services Branch

Mr Gary Davis, Assistant Secretary, IT Solutions Development Branch

Ms Kerrie Reyn, Assistant Secretary, IT Strategy and Service Delivery Branch

Mr Adam Davey, Assistant Secretary, Health Campaigns Branch

Ms Julie Schneller, Acting Secretary, Online, Services and External Relations Branch

Mr Gary Aisbitt, Principal Client and Technical Services Adviser

Ms Susan Parker, Director, Health Campaigns Branch

Portfolio Strategies Division

Mr Peter Morris, First Assistant Secretary

Ms Kylie Jonasson, Assistant Secretary, Budget Branch

Ms Debbie Morrison, Acting Assistant Secretary, Ministerial and Parliamentary Support Branch

Mrs Susan Azmi, Acting Assistant Secretary, Policy Strategies Branch

Ms Alice Creelman, Assistant Secretary, International Strategies Branch

Mr Greg Coombs, Assistant Secretary, Economic and Statistical Analysis Branch

Transition Office

Mr Graeme Head, Chief Executive Officer

Dr Tony Sherbon, Deputy Chief Executive Officer

Mr Peter Broadhead, Acting First Assistant Secretary

Mr David Mackay, Assistant Secretary, Implementation, Systems and Reporting

Ms Shirley Browne, Assistant Secretary, Stakeholder Engagement and Communications

Professor Richard Marshall, Assistant Secretary, Hospital Financing and Reforms

Audit and Fraud Control

Mr Colin Cronin, Assistant Secretary, Audit and Fraud Control Branch

Strategic Review Taskforce

Mr Ben Vincent, Acting Assistant Secretary, DoHA National Alignment

Office of the Chief Financial Officer

Mr John Barbeler, Chief Financial Officer

Mr Malcolm Bowditch, Director, Finance Branch

Outcome 1–Population health**Population Health Division**

Mr Nathan Smyth, First Assistant Secretary

Ms Melinda Bromley, Assistant Secretary

Ms Janet Quigley, Assistant Secretary, Healthy Living Branch

Mr Damian Coburn, Assistant Secretary, Population Health Strategy Unit

Regulatory Policy and Governance Division

Ms Mary McDonald, First Assistant Secretary, Regulatory Policy and Governance Division

Ms Donna Burton, Assistant Secretary, Blood Organ and Regulatory Policy Branch

Ms Kathy Dennis, Assistant Secretary, Research Regulation and Food Branch

Ms Teresa Ward, Assistant Secretary, Office of Hearing Services

Ms Anne Kingdon, Assistant Secretary, Governance, Safety and Quality Branch

Mental Health and Chronic Disease Division

Ms Georgie Harman, First Assistant Secretary, Mental Health and Chronic Disease Division

Mr Alan Singh, Assistant Secretary, Mental Health Reform Taskforce

Ms Virginia Hart, Assistant Secretary, Mental Health Reform Branch

Ms Colleen Krestensen, Assistant Secretary, Mental Health and Suicide Prevention Programs Branch

Mr Simon Cotterell, Assistant Secretary, Drug Strategy Branch

Mr Leo Kennedy, Assistant Secretary, Chronic Disease and Alcohol Branch

Mr Michael Culhane, Assistant Secretary, Cancer Services Branch

Associate Professor Rosemary Knight, Principal Adviser, Cancer and Chronic Disease

Therapeutic Goods Administration

Dr Rohan Hammett, National Manager

Dr Megan Keaney, Principal Medical Adviser

Mr Stephen Dellar, Principal Adviser, Regulatory Reform

Ms Jenny Hefford, Chief Regulatory Officer

Ms Philippa Horner, Principal Legal Adviser

Dr Larry Kelly, Group Coordinator, Monitoring and Compliance Group

Ms Judy Develin, Group Coordinator, Market Authorisation Group

Mr Peter Bickerton, Acting Principal Adviser (Operations)

Australian Institute of Health and Welfare

Mr David Kalisch, Director

Mr Andrew Kettle, Group Head, Business Group

National Industrial Chemicals Notification and Assessment Scheme

Dr Marion Healy, Director

Food Standards Australia New Zealand

Mr Steve McCutcheon, Chief Executive Officer

Dr Robyn Cleland, Acting General Manager, Food Standards (Canberra)

Dr Andrew Bartholomaeus, General Manager, Risk Assessment

Dr Paul Brent, Chief Scientist

Mr Peter May, General Manager, Legal and Regulatory Affairs

Australian Radiation Protection and Nuclear Safety Agency

Professor Peter Johnston, Acting Chief Executive Officer

Mr George Savvides, Chief Financial Officer, Corporate Office

Office of the Gene Technology Regulator

Dr Joe Smith, Regulator

Dr Michael Dornbusch, Assistant Secretary

Australian National Preventive Health Agency

Dr Rhonda Galbally, Chief Executive Officer

Dr Lisa Studdert, Manager, Policy and Programs

Mr John Kalokerinos, Manager, Operations and Knowledge

Outcome 2—Access to pharmaceutical services

Pharmaceutical Benefits Division

Ms Felicity McNeill, Acting First Assistant Secretary

Dr John Primrose, Medical Adviser

Mr Kim Bessell, Principal Pharmacy Adviser

Ms Adriana Platona, Assistant Secretary, Pharmaceutical Evaluation Branch

Mr Nick Henderson, Acting Assistant Secretary, Policy and Analysis Branch

Mr David Reddy, Acting Assistant Secretary, Access and Systems Branch

Ms Beryl Janz, Assistant Secretary, Community Pharmacy Branch

Outcome 3–Access to medical services

Medical Benefits Division

Mr Richard Bartlett, First Assistant Secretary

Mr Peter Woodley, Assistant Secretary, Private Health Insurance Branch

Ms Penny Shakespeare, Assistant Secretary, Medicare Benefits Branch

Ms Elizabeth Hoole, Acting Assistant Secretary, Health Technology and Medical Services Group

Mr Shane Porter, Acting Assistant Secretary, Medicare Financing and Analysis Branch

Ms Fifi Cahill, Acting Assistant Secretary, Diagnostic Services

Professional Services Review

Dr Tony Webber, Director

Mr Luke Twyford, Acting Executive Officer

Outcome 4–Aged care and population ageing

Ageing and Aged Care Division

Ms Carolyn Smith, First Assistant Secretary

Mr Russell de Burgh, Assistant Secretary, Office for an Ageing Australia

Mr Keith Tracey-Patte, Assistant Secretary, Budget Finance and Information Branch

Ms Kate McCauley, Assistant Secretary, Policy and Evaluation Branch

Prof. David Cullen, Assistant Secretary, Policy and Evaluation Branch

Ms Samantha Robertson, Assistant Secretary, Residential Program Management Branch

Ms Tracy Mackey, Assistant Secretary, Community Programs and Carers Branch

Ms Rachel Balmanno, Assistant Secretary, Home and Community Care Reform Branch

Office of Aged Care, Quality and Compliance

Mr Iain Scott, First Assistant Secretary

Ms Lucelle Veneros, Assistant Secretary, CIS Operations Branch

Ms Fiona Nicholls, Assistant Secretary, Aged Care Workforce and Better Practice Programs Branch

Ms Violeta Stefanoska, Assistant Secretary, Prudential and Approved Provider Regulation Branch

Ms Lyn Murphy, Assistant Secretary, Quality and Monitoring Branch

Dr Sue Hunt, Senior Nurse Advisor

Outcome 5–Primary care**Primary and Ambulatory Care Division**

Mr Mark Booth, Acting First Assistant Secretary

Ms Sharon Appleyard, Assistant Secretary, Policy Development

Mr Lou Andreatta, Assistant Secretary, Workforce Distribution

Ms Meredith Taylor, Assistant Secretary, GP superclinics

Mr Rob Cameron, Assistant Secretary, Rural Health Services and Policy

Ms Vicki Murphy, Assistant Secretary, Service Access Programs

Ms Jennie Roe, Assistant Secretary, Practice Support

Outcome 6–Rural health**Primary and Ambulatory Care Division**

See Outcome 5

Outcome 7–Hearing services**Regulatory Policy and Governance Division**

See Outcome 1

Outcome 9–Private Health**Medical Benefits Division**

See Outcome 3

Outcome 10–Health system capacity and quality**eHealth Division**

Ms Fionna Granger, First Assistant Secretary, eHealth Division

Ms Liz Forman, Assistant Secretary, eHealth Strategy

Ms Sharon McCarter, Assistant Secretary, eHealth Systems

National e-Health Transition Authority

Mr Peter Fleming, Chief Executive Officer

Regulatory Policy and Governance Division

See Outcome 1

Mental Health and Chronic Disease Division

See Outcome 1

National Breast and Ovarian Cancer Centre

Dr Helen Zorbas, Chief Executive Officer

Cancer Australia

Dr Helen Zorbas, Chief Executive Officer

National Health and Medical Research Council

Professor Warwick Anderson, Chief Executive Officer

Mr Tony Kingdon, General Manager and Head, Planning and Operations Group

Dr Clive Morris, Head, Research Group

Professor John McCallum, Head, Research Translation Group

Outcome 11–Mental health

Mental Health and Chronic Disease Division

See Outcome 1

Outcome 12–Health workforce capacity

Health Workforce Division

Ms Maria Jolly, Acting First Assistant Secretary

Mr David Hallinan, Assistant Secretary, Medical Education and Training Branch

Ms Bernadette Walker, Acting Assistant Secretary, Nursing, Allied and Indigenous Workforce Branch

Ms Gay Santiago, Assistant Secretary, Workforce Development Branch

Health Workforce Australia

Mr Mark Cormack, Chief Executive Officer

Mr Roberto Bria, Executive Director, Corporate and Finance

Professor Liz Framer, Executive Director, Workforce Innovation and Reform

Outcome 13–Acute care

Acute Care Division

Mr Mark Thomann, First Assistant Secretary

Dr Andrew Singer, Principal Medical Adviser

Mr Charles Maskell-Knight, Principal Adviser

Ms Gillian Shaw, Acting Assistant Secretary, Hospital Policy Branch

Ms Veronica Hancock, Assistant Secretary, Hospital Development, Indemnity and Dental

Dr David Martin, Acting Assistant Secretary, Healthcare Services Information

Ms Ann Smith, Assistant Secretary, National Partnership Agreement

Australian Organ and Tissue Donation and Transplant Authority

Ms Yael Cass, Chief Executive Officer

Dr Gerry O'Callaghan, National Medical Director

Ms Judy Harrison, Acting Chief Financial Officer

Ms Elizabeth Flynn, Acting General Manager

Outcome 14–Biosecurity and emergency response

Office of Health Protection

Ms Jennifer Bryant, First Assistant Secretary

Ms Fay Holden, Assistant Secretary, Health Protection Policy Branch

Ms Sally Goodspeed, Assistant Secretary, Communicable Disease and Surveillance Branch

Dr Gary Lum, Assistant Secretary, Health Emergency Management Branch

Mr Graeme Barden, Assistant Secretary, Office of Chemical Safety and Environmental Health

Ms Julianne Quaine, Assistant Secretary, Immunisation Branch

Dr Jenny Firman, Medical Officer, Office of Health Protection

Committee met at 09:01

CHAIR (Senator Moore): I declare open this meeting of the Senate Community Affairs Legislation Committee. The Senate has referred to the committee the particulars of proposed expenditure for 2011-12 and related documents for the Health and Ageing portfolio. The committee must report to the Senate on 21 June 2011 and has set Friday 22 July 2011 as the date for the return of answers to questions taken on notice. Senators are reminded that any written questions on notice should be provided to the committee secretariat by close of business Friday 10 June, which is Friday week. Officers and senators are familiar with the rules of the Senate governing estimates hearings. If you have any questions you can ask each other but you can also ask the secretariat because there are people in this room who have got immense experience in this process. I particularly draw the attention of witnesses to an order of the Senate of 13 May 2009 specifying the process by which a claim of public interest immunity should be raised and which I now incorporate in *Hansard*.

The extract read as follows—

Public interest immunity claims

That the Senate—

- (a) notes that ministers and officers have continued to refuse to provide information to Senate committees without properly raising claims of public interest immunity as required by past resolutions of the Senate;
- (b) reaffirms the principles of past resolutions of the Senate by this order, to provide ministers and officers with guidance as to the proper process for raising public interest immunity claims and to consolidate those past resolutions of the Senate;
- (c) orders that the following operate as an order of continuing effect:
 - (1) If:
 - (a) a Senate committee, or a senator in the course of proceedings of a committee, requests information or a document from a Commonwealth department or agency; and
 - (b) an officer of the department or agency to whom the request is directed believes that it may not be in the public interest to disclose the information or document to the committee, the officer shall state to the committee the ground on which the officer believes that it may not be in the public interest to disclose the information or document to the committee, and specify the harm to the public interest that could result from the disclosure of the information or document.
 - (2) If, after receiving the officer's statement under paragraph (1), the committee or the senator requests the officer to refer the question of the disclosure of the information or document to a responsible minister, the officer shall refer that question to the minister.
 - (3) If a minister, on a reference by an officer under paragraph (2), concludes that it would not be in the public interest to disclose the information or document to the committee, the minister shall provide to the committee a statement of the ground for that conclusion, specifying the harm to the public interest that could result from the disclosure of the information or document.
 - (4) A minister, in a statement under paragraph (3), shall indicate whether the harm to the public interest that could result from the disclosure of the information or document to the committee

could result only from the publication of the information or document by the committee, or could result, equally or in part, from the disclosure of the information or document to the committee as in camera evidence.

- (5) If, after considering a statement by a minister provided under paragraph (3), the committee concludes that the statement does not sufficiently justify the withholding of the information or document from the committee, the committee shall report the matter to the Senate.
- (6) A decision by a committee not to report a matter to the Senate under paragraph (5) does not prevent a senator from raising the matter in the Senate in accordance with other procedures of the Senate.
- (7) A statement that information or a document is not published, or is confidential, or consists of advice to, or internal deliberations of, government, in the absence of specification of the harm to the public interest that could result from the disclosure of the information or document, is not a statement that meets the requirements of paragraph (1) or (4).
- (8) If a minister concludes that a statement under paragraph (3) should more appropriately be made by the head of an agency, by reason of the independence of that agency from ministerial direction or control, the minister shall inform the committee of that conclusion and the reason for that conclusion, and shall refer the matter to the head of the agency, who shall then be required to provide a statement in accordance with paragraph (3).

(Extract, Senate Standing Orders, pp 124-125)

I welcome Senator McLucas, the departmental secretary, Ms Jane Halton, and officers of the Department of Health and Ageing. Senator McLucas, would you like to make an opening statement?

Senator McLucas: No thank you, Chair.

CHAIR: Ms Halton, would you like to make an opening statement?

Ms Halton: No thank you, Chair.

[09:02]

Department of Health and Ageing

CHAIR: The committee will begin today's proceedings with cross outcomes/corporate matters and then follow the order as set out in the circulated program. We have allocated times for each of these areas and they will be what we will stick to unless it has been pre-negotiated not to. We have listed the breaks, so the first break that you can look forward to is 10.30 am. We will go from there. Ms Halton, I just want to ask a general question to kick off about the post-flood cyclone initiatives in the department. We asked last time about impact on staff, buildings and that kind of things and you were saying that you had processes in place. As it is the next estimates, is it possible to just give us an update on the people and the property issues that have extended since the early part of this year?

Ms Halton: Yes, certainly, Senator and thank you. I think as we mentioned last time we had not had property issues. In fact, I think I told you about in Townsville in particular where our power came back on early because we were in the same building as the energy company, so it had its advantages. Although, we could not get into the building because the McDonald's drive-through was so chock-a-block so the staff had to walk past the drive through. In terms of individuals, and I will ask one of my deputies to correct me if I am wrong as they have been up to Brisbane more recently than me, people are back at work. I think we discussed last time the fact that we did have a number of staff, one of whom in particular who lost

everything. People are back in the workplace. Obviously these things take much longer to get over than just the short amount of time. I think the short message is people are back and where care has needed to be provided, that has been provided and is continuing to be provided in terms of post-flood impacts personally. In terms of the operations of the department, we are up and running.

CHAIR: Thank you, Ms Halton.

Ms Halton: Thank you for your question.

Senator SIEWERT: I want to follow up on tobacco FOIs. This is all right to do it here is it not? I know I ask this every time. People must be expecting I will be asking about this surely?[9.05]

Ms Halton: Yes we are, but I suspect you will you find that we are expecting it under that item. Is general counsel here? Where is Chris Reid?

Senator SIEWERT: Maybe because it usually takes you a while to get information, if I ask it here, maybe—?

Ms Halton: Ask what you would like and then I would be delighted to come back to it.

Senator SIEWERT: What I would like to know please is have there been any new FOIs since I last asked.

Ms Halton: Yes.

Senator SIEWERT: Could I please have a list of the usual, that is, the number, who they are and what they want?

Ms Halton: Yes.

Senator SIEWERT: So that is since the last time, please?

Ms Halton: In addition there has also been correspondence with the Ombudsman.

Senator SIEWERT: Anything that you could make available, I would appreciate that please.

Ms Halton: Yes.

Senator SIEWERT: An update on the staffing numbers also please? If you remember last time we had a discussion about the staffing and the costs?

Ms Halton: Yes.

Senator SIEWERT: If you could give us an update on the total cost now and the number of staff that you are having to dedicate to processing FOIs?

Ms Halton: Yes.

Senator SIEWERT: Do other agencies get FOI requests on tobacco that are then subsequently referred to you?

Ms Halton: The answer to that is other agencies have got FOI requests on tobacco. Do they then get referred to us?

Mr Reid: Some of them get referred to us and some of them do not. Other agencies do and have received FOI applications in relation to tobacco. They are referred to this department to the extent that they relate to documents of the department. To the extent that they relate to

documents of other departments then they tend to be dealt with by those departments. Obviously we liaise.

Ms Halton: Are we aware of which ones?

Mr Reid: We are made aware of those; we liaise in relation to those applications.

Ms Halton: When we come back we can tell you how many new ones we have had and from where, an indication of the staffing and we will also give you an indication of which other ones we are aware of.

Senator SIEWERT: That would be appreciated. Do I have to ask each department? If I want to know totally across government who has received them, I have to ask each agency, do I not?

Ms Halton: Yes, you do.

Senator SIEWERT: So if you could give me the ones that you are aware of from other agencies that would be appreciated, thank you.

Ms Halton: Yes, happy to do that.

Senator SIEWERT: Thank you.

Ms Halton: I will get someone working on it right now.

Senator SIEWERT: Thank you.

CHAIR: We will come back to that.

Senator FIERRAVANTI-WELLS: Ms Halton, first of all I thank you for the updated schedule of GP superclinics. I notice it was dated 19 May in anticipation of my request, so thank you very much.

Ms Halton: The most up-to-date, Senator.

Senator FIERRAVANTI-WELLS: My questions in relation to COAG health reform are basically now the big picture, the timing issues, so I think it is probably best dealt with at this point.

Ms Halton: The people are here.

Senator FIERRAVANTI-WELLS: We can just get that out of the way and anything later might be nitty-gritty stuff, but this is just the timing.

Ms Halton: The big picture guys are here.

Senator FIERRAVANTI-WELLS: The big picture guys are here, good. Given that the COAG agreement, the heads of agreement to sign a new health reform agreement signed on 13 February said that the new agreement had to be signed by 1 July, at what stage are the negotiations at, given in particular the headlines and given some of the stories that have been in the press? I am happy to hand you up the copies of the articles, but I think you have seen them in recent months starting back from March, post the New South Wales election. The headlines are about allegedly the Prime Minister sidelining the states, health reform warnings, the states objections in relation to bureaucracy, and that sort of thing. I will take those as being read. Where are we at with these negotiations?

Ms Halton: I will ask Mr Head to go into some detail. Mr Maskell-Knight and I were having this discussion last night. We are at the point in health care discussions, at which,

given I have done a number of them, feels quite familiar and exactly where I would expect us to be at this point. We have a certain amount of heat and light and we are now getting down to some tin tacks just in terms of getting the document finalised. We are exactly where I would have thought we would be at this point. Mr Head can give you the more precise geographical location.

Senator FIERRAVANTI-WELLS: Mr Rimmer seemed 'confident'.

Ms Halton: I think that is not misplaced actually. The reality is these negotiations have a cadence to them. When you have done a couple, you sort of know whether you are on the right kind of cadence, and we are.

Senator FIERRAVANTI-WELLS: Right, so Mr Head, are we on track to sign the agreement by 1 July?

Mr Head: As the secretary indicated, we are chugging along through the process. The process is led, as contemplated in the heads of agreement, by the Department of Prime Minister and Cabinet, working with a deputy secretary/directors-general group from states and territories. That is the forum within which the detailed agreement is being negotiated. There are extremely regular meetings of that group and a range of processes including detailed consultation with states and territories on issues that are raised through that process. As the secretary indicated, we are full tilt on it at the moment and very optimistic about working through the issues.

Senator FIERRAVANTI-WELLS: Can you confirm that Minister Roxon held a telephone conference with all the state ministers last week? Is it foreshadowed that there will need to be a face-to-face meeting before the legislation proceeds any further?

Ms Halton: There was a ministers' meeting last week, yes that is correct, and you are correct it was by telephone. I do not know that it has actually been confirmed but I believe there will be a health ministers' meeting soon, yes.

Senator FIERRAVANTI-WELLS: When is that happening?

Ms Halton: To be honest, I have not actually seen a confirmation. I believe 7 June but I am not sure about that. I can check.

Senator FIERRAVANTI-WELLS: 7 June, or to be confirmed. There will be a meeting but we are not sure if it is 7 June?

Ms Halton: As is always the case, these things are subject to people's diaries. My understanding is that everyone is attempting to find a date and I believe that is where we have landed but I am not sure. We will confirm that.

Senator FIERRAVANTI-WELLS: In light of the comments that have been made by New South Wales, Victoria and in fact especially today by Premier Baillieu and Premier Barnett in Western Australia, what happens if no agreement is signed? What is the process from there, assuming no agreement is signed?

Mr Head: All governments have committed through the heads of agreement process to develop and sign an agreement. We are in the middle of a negotiation. There are issues arising, as you would expect. We anticipate that the processes that are in place are working through those issues quite adequately.

Senator FIERRAVANTI-WELLS: I am very concerned because reading from the press statements, some of the comments that the states are making are very strident. Reading between the lines, it does not look like there is a lot of harmony in wanting to reach an agreement. You must have a plan B in case there is no agreement signed by 1 July?

Mr Head: The issues you refer to relating to the National Health Performance Authority are the subject of very constructive discussions between the states and territories and ourselves at present. As I have indicated when I appeared before this committee recently, I believe that most of those issues can be satisfactorily resolved through that process.

Senator FIERRAVANTI-WELLS: Do I read into your answer that there is no plan B? You are all very confident that this is going to happen by 1 July but what if it does not happen? Is there a plan B?

Mr Head: It is my role in this process to work on the negotiations with states and territories—

Senator FIERRAVANTI-WELLS: Yes, I know, thank you, but it is must surely be your role as well to contemplate that potentially there may not be an agreement? I would be sure you have got a plan B, there must be?

Mr Head: Governments have committed to an agreement within certain parameters. It is the detail around those parameters which we are currently working through with states and territories.

Senator FIERRAVANTI-WELLS: Are you telling me that there has been absolutely no planning done in the event that there is no agreement signed on 1 July?

Mr Head: What I am telling you is that the efforts of agencies are around working constructively with the states and territories around the issues that they are raising through this process and there is a constructive dialogue—

Senator FIERRAVANTI-WELLS: I appreciate that but my point is this.

Ms Halton: Sorry, Senator, I think there may be a misapprehension here. Previously we had time limited health care agreements; we do not actually have that any more. We have an arrangement in terms of the way the Commonwealth and state funding arrangements work, which is in place.

Senator FIERRAVANTI-WELLS: In other words the money will keep flowing even though you do not have an agreement?

Ms Halton: We do not necessarily give them the growth funding under those circumstances but the mechanism to provide funding for health systems remains in place. It is a misapprehension to suggest that the whole world comes to an end if the deal is not done. As Mr Head has said, in fact governments already have an agreement. It is the detail that is now being worked out.

Senator FIERRAVANTI-WELLS: I appreciate that, but with the time lines so specified in relation to 1 July, it is a legitimate question to ask what happens if there is no agreement. Given the strident comments that are in the press and what appears to be less agreement than there is agreement, if I can put it in those terms, there are real problems here and it does not look like—

Ms Halton: No, Senator, I actually have to disagree with you there quite strongly. There are some points which we are looking to have clarification. I think actually in any good negotiation I would imagine that the citizens of Western Australia and Victoria and all the other states would want their state governments to prosecute the best arrangement that they can for their citizens. When we get towards the end of these discussions, I would exactly expect to see what you are seeing now, which is an increase in public statements about what the final issues that the jurisdiction of concern will be prosecuting most vigorously. That does not presage in any way, shape or form the likelihood that this will not be concluded. On the contrary, I think what it demonstrates to you is that we are at the last part of those negotiations.

Senator FIERRAVANTI-WELLS: To come back to my question, is there a plan B?

Ms Halton: The plan B, as you put it, is that we already have an arrangement which continues. This is to give effect to the agreement that was struck by states and territories with the Prime Minister at COAG. So plan B is the existing arrangements.

Senator FIERRAVANTI-WELLS: In other words, if there is no agreement it is just business as usual?

Ms Halton: Yes, business as usual.

Senator FIERRAVANTI-WELLS: That could go on indefinitely if there is no agreement struck?

Ms Halton: Plan B, which is the current circumstance, can continue under the way the arrangements are struck between us and the states and territories.

Senator FIERRAVANTI-WELLS: Perhaps I might go to some of the specific authorities. The heads of agreement and the various mark 1 and 2 arrangements set out a series of authorities. Let us just start with the National Performance Authority. Its start up date is 1 July, the legislation has been introduced into the House of Representatives and it has not proceeded any further. Could you tell me where we are at with that?

Mr Head: We are continuing to liaise with states and territories around specific issues. When I appeared before the Senate recently to talk specifically about the bill, I indicated at the time that the minister had indicated her willingness to consider a number of parliamentary amendments. Also as I presented in my evidence, the performance and accountability framework that COAG agreed to is an important part of that package. We are working through a number of issues with states and territories around refinements to that process.

Senator FIERRAVANTI-WELLS: We do not know where the legislation is at, at the moment? Given the matters that were raised in the Senate inquiry, it would almost seem that the legislation requires a redraft. What actions are being taken to address the problems that were raised as far as the Senate inquiry is concerned and where are we at with the legislation?

Mr Head: Where we are at is in completing discussions with states and territories around both issues they have raised in respect of the legislation and a number of refinements that are related to that that they have sought in the performance and accountability framework. Those discussions are proceeding over the next week or so.

Senator FIERRAVANTI-WELLS: Senator McLucas, 1 July is now pending. I have the assurances it is all going to happen. What is the situation here, where are we at with that

legislation? It almost requires an entire redraft. It just seems to have stalled. Where are we at? When are we going to deal with this?

Senator McLucas: I do not know that I can add anything more than Mr Head has provided you.

Senator FIERRAVANTI-WELLS: So we do not know, is that basically the situation? We do not know.

CHAIR: Senator, I am just going to step in now. In terms of talking over the witnesses—

Senator FIERRAVANTI-WELLS: I appreciate that, I was just sort of—

CHAIR: I know but it is just that if you do it early it might just get into standard practice. Could we let the witnesses finish before we continue with the question? I know you are working through a process. I do know that, but if you could just think about that?

Senator FIERRAVANTI-WELLS: Okay.

CHAIR: Minister, did you have anything to add?

Senator McLucas: I was going to indicate that I understand the legislation is in the House of Representatives. There has been a legislative inquiry. I will make contact with the minister's office to see if there is anything further that I can assist you with.

Senator FIERRAVANTI-WELLS: The budget portfolio statements include this:

From 1 July, the National Health Performance Authority (NHPA) will begin to produce Hospital Performance Reports that will assess the performance of every hospital, both public and private, and every Local Hospital Network against a range of performance indicators. As a result, hospital performance will be monitored and reported on at the local level on a nationally consistent basis.

If you do not have the authority established that is obviously not going to happen?

Senator McLucas: I think the intention is to have it established.

Senator FIERRAVANTI-WELLS: In that case, it is now almost the beginning of June. We have four weeks. How is this going to happen?

Senator McLucas: As I said, I will provide you further information in terms of the passage of the legislation.

Senator FIERRAVANTI-WELLS: Given that the legislation to establish the authority has not even been passed by the parliament, how is this budget objective going to be met?

Ms Halton: The stated intention is to have to the performance authority up and running. You have rightly made the point that we are in the final throes, if I can use that language without sounding too dramatic, in the final stages, would perhaps be more appropriate, of discussions with the states and territories. You have also rightly made the point there has been an inquiry into the legislation. As we bring together all of those pieces, and as you would be aware, there remain a number of sitting weeks. In fact the legislation is quite simple legislation. If it needs any final tweaking, that can be done which would enable this to commence at the beginning of the new financial year. At the end of the day, because it is a negotiation, we cannot tell you what precisely the timetable will be. Because I do not actually have my crystal ball functioning. It would be my expectation that it will be concluded and therefore we will be in a position to finalise that legislation and then the performance authority will be established.

Senator FIERRAVANTI-WELLS: Can you just give me a time line then? The first of July is almost four weeks away. How long will it actually take even if the legislation is passed to actually establish the authority?

Ms Halton: What we have done in the past is effectively have ready the shell of the administrative arrangements. We have done this a number of times and that is exactly our intention here. So, the authority can be established quite quickly, in fact very quickly. Now, will it be the full operation on day 1? No, clearly not, but it is not expected that there will be these kinds of reports on day 1. It will take some time for the performance authority to actually produce its first report.

Mr Head: If I might add, one of the pivotal pieces of work that the performance authority would require in order to begin the process of developing those reports is the performance and accountability framework. The process that is under way allows for COAG consideration of that in July this year, which means that there is a highly developed framework for the new authority to begin its work. Often there would be a developmental process with a new agency like this, but it will actually have the framework including the initial indicators against which it will be reporting from day 1 of its operation.

Senator FIERRAVANTI-WELLS: It makes the point does it not, that you are just creating a new bureaucracy? You already have a framework, but you are creating a new bureaucracy to do things that, obviously based on what you have just told me, you can already do. We will not labour the point. This is not only months behind schedule, but given that this whole thing was promised four years ago, to come to this particular point and not have your house in order in relation to getting this legislation says a lot about the disorganisation of this minister and this government.

CHAIR: I think that was a comment, not a question.

Senator FIERRAVANTI-WELLS: That is a comment. You can take that as a comment.

CHAIR: The idea of the estimates is questions.

Senator FIERRAVANTI-WELLS: You can take that as a comment.

Senator McLucas: For the record, I think that both Ms Halton and Mr Head have indicated that we are at a point in the negotiations with states and territories which is fairly ordinary. This is the normal process that you go through. Ms Halton has talked about the way that these negotiations occur and that it is as expected. I think your observation about the process is inaccurate. I think we are progressing in a fairly expected way and that this is just the normal way business is done around a significant health negotiation between a Commonwealth government and the states and territories.

Senator FIERRAVANTI-WELLS: We will go through each of the authorities. For something that has been on your books since Kevin Rudd promised major reform, here we are at this point in time and you have not got the legislation passed. I think my comments are fairly—

Senator McLucas: As I said, I will be very happy to provide you further information.

Senator FIERRAVANTI-WELLS: You have got four weeks and you are expecting to establish an authority with no legislation passed. I think it is ridiculous, but anyway let us

move on. Last year there was a media release issued by Mr Swan and Ms Roxon guaranteeing that there would be no net increase in bureaucracy under this reform, stating:

There will be no increase in bureaucracy under this reform - because as a condition of the funding any increase in the number of local staff working at Local Hospital Networks must be matched by a reduction in head office staff numbers in health departments and regional bureaucracies.

Are you monitoring existing staff numbers in health bureaucracies in the states and also at a federal level to ensure that this condition is met?

Mr Broadhead: We are anticipating, and I think this is on the record now, a reduction in the core staffing numbers of the department of about 420. We are anticipating that the two new authorities will increase numbers by 110 so there will be a net reduction as between the core departmental staff and the staff of these two new authorities over the coming year.

Senator FIERRAVANTI-WELLS: Including numbers in the Local Hospital Networks?

Mr Broadhead: We do not obviously have counts of the staff in Local Hospital Networks because they are a state entity and in a number of instances are still in the process of being created. It is my understanding that in general they are using existing staff when they are creating those entities. It is a structural reorganisation, it is changing governance arrangements but to my knowledge there is not any great increase in the number of management staff associated with that.

Senator FIERRAVANTI-WELLS: Given the comments made by Mr Swan and Ms Roxon, are you monitoring staff numbers, obviously you are in the federal department but what about in the state bureaucracies?

Ms Halton: The undertaking that was given by all of government is a matter for each government to then be responsible and accountable for. As part of the agreement, we do not have an agreement that we will monitor that part of their delivery; that is their responsibility. As Mr Broadhead has indicated, we are monitoring our part of that deal. He has just given you an indication of the numbers.

Senator FIERRAVANTI-WELLS: As I understand the comment made by Mr Swan and Ms Roxon in their media release, it says that it 'must be matched by a reduction in head office staff numbers in health departments and general bureaucracies'. If that is the sort of statement that the Treasurer is making, there must be some mechanism by which you monitor that or you are just going to take the states on their word?

Ms Halton: I have not actually got that supposed press release.

Senator FIERRAVANTI-WELLS: It was on 3 March 2010.

Ms Halton: I do not have it and I cannot make any—

Senator FIERRAVANTI-WELLS: No, perhaps you might like to go back to it. If I recall, there were actually comments made by Kevin Rudd in relation to assurances about no extra bureaucracy. I do not actually have that quote.

Ms Halton: I actually think that the no bureaucracy comment actually had a broader context around it which I would have to ask Mr Broadhead whether he can remember. It was in the context of health expenditure or some other such a thing. We can go and find that broader context to that comment if you like.

Senator FIERRAVANTI-WELLS: It says the condition of funding. That was the statement; I have just read it out from the press release. I do not have the whole press release in front of me. In summary, the bottom line is that despite conditions of funding being no increase in local staff, there is no mechanism at a federal level to monitor if there are staff increases in the state bureaucracies as this is a matter for the states. Is that it in a nutshell?

Ms Halton: We are just trying to find you the quote to put this whole thing into context because I think we run the risk of misleading people who might be watching this broadcast as to what the actual commitment was. If I cannot find it now I will ensure that we do find it. I have read it in the last couple of days. I think it is in that document. Is it there? No. Well, we are going to have to find it. It is something relative to the amount of health expenditure or some other such thing. You would be aware that historically the AIHW has given an indication of what overhead is carried in terms of health expenditure. As to the precise nature of what the performance authority will report on, that has yet to be determined. Have you found it? Someone has found it.

There are two statements in the documents which are relevant, firstly: 'Reforms outlined in this Agreement should be delivered with no net increase in bureaucracy across Commonwealth and State governments, as a proportion of the ongoing health workforce', and 'The Commonwealth and State governments, in establishing LHNs, will ensure there is no net increase in the number of ongoing health bureaucrats, as a proportion of the health workforce'. I think that is the same thought.

In terms of whether we have specified now, prior to the negotiations being finalised, what the accountability in this area will be, the answer is no. Do I expect, however, (1) that we would continue to have a view of this because AIHW has always given us some sense of what the overhead that is carried by health is, the answer is yes; and (2) would it be legitimately something the performance authority would look at, the answer is also yes. But, I cannot prejudge exactly what they will stick in the framework. Do I have something right this minute? No. Would I expect it to be looked at on an ongoing basis? Yes.

Senator FIERRAVANTI-WELLS: But we did not have a starting point in terms of the current numbers of people that are working in the health bureaucracy, both at federal and the state level. I am just trying to understand how you are going to measure this. Mr Swan and Ms Roxon, in their joint ministerial releases, have made this assertion about no net increase to bureaucracy, but how are you going to deliver that? What is your starting point to measure that?

Ms Halton: To start with, I have just actually read you the completely accurate quotes. I do not have that press release but I can tell you the quotes that have been used more broadly, which are the accurate quotes about what the reference point is. I have also indicated to you that the AIHW does have a view about what is the administrative overhead of health. That will continue to be looked at.

Senator FIERRAVANTI-WELLS: Perhaps it might assist us, Ms Halton, if you take that on notice?

Ms Halton: Sure.

Senator FIERRAVANTI-WELLS: And can we just understand what the starting numbers were of bureaucracies both at a state and federal level when all this started. It seems so long ago, four years ago.

Ms Halton: Certainly, Senator.

Senator FIERRAVANTI-WELLS: That would be helpful so at least we know what we are dealing with in the figure. Out of interest I really would appreciate if we could do at least the comparison between what were the numbers in the bureaucracies at both federal and state level when we first started this discussion, when it was first mooted under health agreement mark 1, and now, as at 1 July. If we could have an assessment of what the bureaucracy numbers are then we can start at least getting a line in the sand in terms of these numbers.

Ms Halton: On notice I will give you a sense of the administrative overhead. What I will not do on notice is prejudge a discussion between us and the states about what the facts are here because I am not going to have a question answered on notice then used later in a context which has not been agreed. What we are doing with the state colleagues at the moment is we have just gone through why this is slightly topical, because we are getting down to the difficult issues. I am happy to take the question on notice, but what I am not happy to do is to set an artificial line in terms of the numbers, which is not something which our state and territory colleagues agree with. I am happy to point you to what would be our starting point in those discussions. I am very happy to point you to that. But what I am not happy to do is to say categorically that would be the agreed starting point, because we have not done that yet. We will show you where our references are and the basis for our negotiations with the states but I am not going to say that that is unequivocally the case, because sometimes in negotiations it turns out that there was an error or there was an issue.

Senator FIERRAVANTI-WELLS: But you must have had some idea when you first started this. You cannot just boldly go out and say there will be no net increase in bureaucracy if you do not have a starting point where you assess what the numbers are right from the beginning.

Ms Halton: That is my point. I am happy to tell you what our starting point was, which is coming from the AIHW. My point is that in discussions with the states it may prove that there are issues about the counting rules, for example. Essentially, I am happy to tell you what my starting point is. What I cannot tell you yet is what my finishing point will be.

Senator FIERRAVANTI-WELLS: Let us look at the Independent Hospital Pricing Authority. The legislation for the independent pricing authority was to be introduced to the parliament between January and March this year. What is the time line for this authority? For it to be operational in the next quarter, again, are these time lines going to be met?

Mr Head: The time line establishment of the Independent Hospital Pricing Authority was one of the things that was amended through the heads of agreement process in February. The initial start date for the pricing authority was to have been July this year. The heads of agreement process recognises that finalising the functions of that authority requires the deliberations on other aspects of the financial arrangements and those matters are to be settled through the COAG process, with legislation introduced as soon as possible after that.

Senator FIERRAVANTI-WELLS: What clause is that in that second agreement?

Mr Head: Clause 27 of the agreement indicates that the IHPA is to be established as soon as possible.

Senator FIERRAVANTI-WELLS: I see. That is one of the variations. Do we have a time line for that?

Mr Head: As I indicated, the final functions that will be within the IHPA's remit are to be determined through the COAG deliberations in July, and the legislation will be introduced as soon as possible after that. It is a relatively straightforward drafting exercise.

Senator FIERRAVANTI-WELLS: But we do not know. The thing that worries me is that apart from the immediate issues with the heads of the agreement, it just seems to me that these time lines are slipping side wards. You are not meeting your own targets, and I am just conscious about you placing a lot of faith in this 1 July deadline. It is very clear that some of the states are very concerned about the parameters of these authorities. They go beyond what is set out in this agreement. To me, that is a fundamental issue still on the table. So, how can we guarantee that 1 July will be met? If the states are complaining that these authorities, and in particular the performance authority, going way beyond the power of what is set out in the heads of agreement, how are you going to resolve this? How are you going to meet these time lines?

Mr Head: As I have indicated before in respect of the performance authority, there are in fact a relatively small number of issues that remain unresolved with states and territories. I believe that we can be very confident that they can be worked through. With respect to the Independent Hospital Pricing Authority the time line for establishing that was changed by all governments agreeing to the heads of agreement so that its functions could be settled through the COAG deliberations in the middle of the year.

Senator FIERRAVANTI-WELLS: I might just go to the Local Hospital Networks. Firstly, according to the agreement, they are due to commence operation from 1 July. There were to be around 150 but now I think there are about 46. Is that the case?

Mr Head: The number of 46 did not take into account the numbers that would emerge through Western Australia having signed the heads of agreement nor the number of Victorian LHNs. You will recall from earlier evidence that Victoria had an extension in resolving its boundaries due to its state election. We do not have finally resolved boundaries with Western Australia yet, but the final number will be closer to the larger number you indicated.

Senator FIERRAVANTI-WELLS: We have traversed page 14 of the mark 1 agreement where Local Hospital Networks were billed as nationally funded and locally controlled, but I think that myth has been dispensed with. Clearly, from page 14 of the mark 1 agreement, the governing councils will include clinical expertise, but external to the Local Hospital Networks wherever practical. Most of the states appear to be re-jigging their existing health services. There does not seem to be much information that is recent from those websites. Do we know if all the states and territories apart from Victoria and WA have established their Local Hospital Networks and we do not know the numbers, or we are still establishing those?

Mr Broadhead: It is my understanding that New South Wales came into operation from 1 January this year with 18 LHNs. I believe the ACT has recently passed legislation creating its LHN, although it has a particular set of arrangements under the April agreement because it is a smaller jurisdiction, about how it goes about that. Victoria has indicated an intention to

continue with I think 86 governing boards of local hospitals, and the rest are in train. We expect many to be established by 1 July this year and the rest to be established by 1 July next year.

Senator FIERRAVANTI-WELLS: How many are going to be operational by 1 July this year?

Mr Broadhead: I do not have an exact number because I am not aware at what stage legislation is at, for example, in Queensland, which is establishing 17. I do not know precisely at what point.

Senator FIERRAVANTI-WELLS: It is going to rely on the states. So, that is another question mark that is not being resolved by 1 July.

Mr Broadhead: It has always been the case under both the April agreement and the February heads of agreement that the responsibility for creating LHNs has been a state responsibility. They generally have to pass legislation to do that. Obviously, the rate at which legislation moves through relevant state parliaments and so on is not entirely predictable.

Senator FIERRAVANTI-WELLS: Do we know when all the LHNs will be operative?

Mr Broadhead: We expect most of them will be operative this year and the last of them to be operative by 1 July next year.

Senator FIERRAVANTI-WELLS: Does that mean the governing councils for each of these has been established?

Mr Broadhead: No, not they have been established but through the year they are being established. In the case of New South Wales, they have already been established with effect from 1 January this year. Victoria continues with its existing governing councils. You could say they are already established as well. Others will come online as and when their legislation is passed and their appointments are made.

Senator FIERRAVANTI-WELLS: South Australia's website says the governing council for Local Hospital Networks will be 'finalised by 1 July'. How are they going to be ready to start operations? Is that purely a matter for the South Australian government?

Mr Broadhead: Under the February heads of agreement, essentially the existing arrangement for Commonwealth-state funding continues through until 1 July next year. Indeed, in terms of Commonwealth contribution, for a further two years after that. In terms of the revised funding arrangements, LHNs only need to be in effect from 1 July next year under the heads of agreement. Originally, there was a proposal under the April 2010 agreement for things to change from 1 July this year in respect of funding arrangements, but that is no longer the case. It is now 1 July next year.

Senator FIERRAVANTI-WELLS: So 1 July next year for all of them?

Mr Broadhead: Yes.

Senator FIERRAVANTI-WELLS: Are we still sticking to the same criteria that were on page 14 of hospital agreement mark 1?

Mr Broadhead: The characteristics of LHNs are not different in the new heads of agreement than they were in the previous agreement.

Senator FIERRAVANTI-WELLS: From the heads of agreement it does not look like 10 has been altered.

Mr Broadhead: No. Clause 44 in the heads of agreement on page 7 and following deals with local governance:

The parties agree that LHNs, to be established by States, will be single or small groups of public hospitals with a geographic or functional connection that are large enough to operate efficiently and provide a range of hospital services, and small enough to enable the LHNs to be effectively managed to deliver high-quality services.

Senator FIERRAVANTI-WELLS: Clearly, there are going to be LHNs all over the countryside that will differ from each other. They might have the same characteristics but they are not all the same and certainly not conforming to what appears to have been envisaged on page 14. That is the first point. If they are not all the same, how are they going to work and how are you going to fund organisations that are different in characteristic but you are going to fund them in the same way?

Mr Broadhead: The general characteristics will be the same, we believe. Obviously, in our federation, each state will have to move its own legislation, and there may be some differences. For example, South Australia already has an act under which it can create new separate legal entities without having to move new legislation; whereas in the case of New South Wales they actually passed new legislation. Inevitably, in a federation with different parliaments moving different acts or making amendments to existing arrangements, there will be some differences between each of the state and territories. The general characteristics we believe will be as provided for in the heads of agreement and as originally set out in the April 2010 agreement. The key feature from our point of view, in governance terms, is that they will have a governing council. They will be separate legal entities. They will have separate bank accounts and therefore can receive funds in their own right. That is in addition to the geographic area. Not all of them are geographic. Some, for example, are based around particular functions, as suggested by the heads of agreement; so there are networks that are for paediatric hospitals, for example. They are all within the parameters set out in the agreements to the extent they have already been established. I do need to note that both the Northern Territory and the ACT under the April 2010 agreement were given some room to move on this because in small jurisdictions there is a question as to how many layers of governments you need and how best to articulate that. For example, the ACT only has one state hospital and one denominational hospital to include in the arrangement.

Senator FIERRAVANTI-WELLS: So at best, we do not know how many there are going to be yet. They are certainly not all going to be the same. We do not know how the funding is actually going to work and we do not know if they are all going to be according to the same formula that is set out in A10 of the agreement and, most especially, whether the clinical expertise in relation to each of them will be local.

Mr Broadhead: I can give you some idea of the numbers we are expecting. For example, New South Wales has initially established 18. As I said, we have learned that Victoria is proposing 86. Queensland is proposing 17. Western Australia we have no figure for, although there has been some discussions. South Australia is establishing five. Tasmania is establishing three. The Australian Capital Territory I believe has now established one, or at least is in the

process of establishing one. The Northern Territory is proposing to establish two. That is my understanding.

Senator FIERRAVANTI-WELLS: Looking at the time, I might just ask some questions in relation to Lead Clinicians Groups. These were promised by Kevin Rudd at the AMA national conference in May last year after mark I was signed. A year later, where are we at with this? The minister recently said in her 20 May 2011 press release that clinicians would be front and centre of health care. If you contrast that with a press release by the AMA where the outgoing AMA President, Dr Pesce, concluded that things have gone dramatically backwards in 12 months, where are we at with this? Where are these lead clinicians? It seems to have been an afterthought in the first place, so what is their role now? I have not quite understood where they fit in here.

Dr Sherbon: A position paper has been distributed from the Commonwealth to a wide range of key stakeholders, including the state and territories, outlining a Commonwealth preferred position on Lead Clinician Groups. Those stakeholders and state and territories have until June 15 to comment. Thereafter we will finalise the position and begin to recruit to the proposed National Lead Clinicians Group, should it be supported, and its local equivalents.

Senator FIERRAVANTI-WELLS: They are supposed to be phased in, in July. The minister's press release says: 'The first set of Local Lead Clinician Groups and a National Lead Clinicians Group are expected to be phased in from July 2011,' which is four weeks away. Do we know how many there are in total across the countryside?

Dr Sherbon: That will be determined in consultation with state and territories. The proposed position on the Lead Clinicians Groups at local level is that they be based on Local Hospital Networks. As you heard from earlier answers to questions, that is still open. We anticipate being able to implement progressively from July local LCGs across the country.

Senator FIERRAVANTI-WELLS: So, we do not know how many there will be across the countryside? Do we know how many of these groups will be attached to the various Local Hospital Networks? How many of them have been formed? Do we have an idea of how many have been formed?

Dr Sherbon: Lead Clinicians Groups?

Senator FIERRAVANTI-WELLS: Yes.

Dr Sherbon: As I said in an earlier answer, the discussion is out for consultation. We have not formed any yet.

Senator FIERRAVANTI-WELLS: So you do not know how many?

Dr Sherbon: We will do so soon after the completion of discussions with the key stakeholders and the state and territories. As you have heard, we know that there will be 18 LHNs within New South Wales, so we will be able to form those 18 Local Lead Clinician Groups fairly quickly after 1 July subject to the agreement of the stakeholders and state and territories that we are consulting at the moment.

Senator FIERRAVANTI-WELLS: Despite what the minister put out on 20 May, we do not know how many will commence operation by 1 July?

Dr Sherbon: We know that the National Lead Clinicians Group process is well on track. As the minister said, there will be a progressive implementation of Local Lead Clinician Groups from July onwards, and that is on track as well.

Senator FIERRAVANTI-WELLS: Yes, but nothing is going to happen on 1 July? You cannot tell me how many there are going to be across the country, you do not know how many are being formed now, you do not know how many will commence operation from 1 July? Do we have a time line on this?

Dr Sherbon: As I mentioned earlier and as was included in the—

Senator FIERRAVANTI-WELLS: No, you are not mentioning anything, Dr Sherbon. You are just telling me bureaucratic gobbledegook. I just want a time line.

CHAIR: Senator—

Senator FIERRAVANTI-WELLS: You must have an idea of how many numbers.

CHAIR: Senator, I do not like yelling, but when I actually call your name it would be nice if you actually stopped. That last little exchange will not appear in *Hansard* at all because it was two people speaking concurrently. We will just wind it back; you can make your comment then the officer can make his response.

Senator FIERRAVANTI-WELLS: Can I have a time line? I mean if the minister goes out and says that the first set will be phased in from 1 July somebody must have an idea who is in this first set. There must be somebody in the department that has worked out which of these groups are going to be part of the first set. There must be, Dr Sherbon. You cannot just sit there and tell me it will be in the Never-Never. You must have worked it out.

Dr Sherbon: As I mentioned in an answer to your earlier question we will progressively implement Local Lead Clinician Groups from July, as in the minister's media release.

Senator FIERRAVANTI-WELLS: You do not know?

Dr Sherbon: As I said, we will progress those implementations subject to state and territory cooperation, and the input of key stakeholders with whom we are consulting with at this very moment in time. I also mentioned earlier that the National Lead Clinicians Group process is on track for implementation in July.

Senator FIERRAVANTI-WELLS: Dr Sherbon, is this not another one of those big promises that were made by Kevin Rudd and now we are just quietly seeing it ditched? You cannot give me—

Ms Halton: Senator—

Senator FIERRAVANTI-WELLS: No, Ms Halton, in the absence of at least some concrete time line about formation, commencement and operations, I can only conclude that this thing was a bit of an afterthought by Mr Rudd and is now sort of floating along without any proper direction.

Ms Halton: I will point to a number of things. Firstly, as Dr Sherbon has pointed out, the minister has now released the position statement. He has indicated the process that the process which we are in sole control of is well underway. As we have already discussed, we are in the process of negotiating with states on a whole number of things. We cannot prejudge or pre-empt what the outcome of those negotiations will be because it would not be appropriate. Dr Sherbon cannot speculate about where those discussions will get to, and therefore what

might be the first of these groups. He cannot speculate. I am sorry if that is a frustrating answer, but frankly if he did start speculating I would be hopping in and telling him to stop it. The bottom line is the process is proceeding, the document is out there, and once these discussions and negotiations with the states have reached a conclusion, these details will be able to be given to you.

Senator FIERRAVANTI-WELLS: All right, Ms Halton, I will leave it there and move on to Medicare Locals. I never really did get a precise answer as to what a Medicare Local is. I must say, somebody summed it up the other day in a conversation I was having. They said 'Is this a place where you can get a refund and a beer?' I replied that if the licensee—

Ms Halton: In that order, Senator?

Senator FIERRAVANTI-WELLS: If the licensee was Ms Roxon there certainly would not be a lot of fun, and no pokies there. It really is a misnomer. We have gone through this process about what a Medicare Local is, but that sort of response just goes to show that people actually think it is a physical place. Anyway, let us go to your Budget Paper No. 2 in which you talk about Medicare Locals and after-hours care. You will be providing \$45 million over four years to bring forward the establishment date for 15 Medicare Locals to 1 January 2012. This measure also provides for fast-tracking of reforms to afterhours GP services by funding each Medicare Local to plan and arrange for the provision of afterhours services in their region. Their role still remains fuzzy and the states and the stakeholders still remain unclear about their role. This seems to imply that the role may be far bigger than the government has outlined thus far, and certainly what the states are aware of. Where are we at with that? They seem to be expanding. We have seen them in mental health. They will take over responsibility for afterhours care. In this budget it was revealed that they will be funded to employ part-time child liaison officers as part of mental health funding. They will take over incentives that have previously been paid to general practice and ATAPS and allied health professionals to provide care in aged care facilities. My point is that they are expanding. Everywhere we look in this budget there are more things for Medicare locals to do. You are only talking about 15 Medicare locals to 1 January 2012. You have increasing responsibilities and only 15 by 1 January 2012.

Ms Halton: Is that a question or a statement?

Senator FIERRAVANTI-WELLS: What happens to the rest of Australia in relation to those various responsibilities and added responsibilities that you are giving Medicare locals?

Ms Halton: I will say a couple of things and then I will ask Ms Morris to come to some of the detail. When we started this reform process we always said that it would take us a while to implement these reforms, because they need to be done thoroughly and properly. So, yes, it is the case that we are moving in the first instance, and we have already advertised for the first 15 of Medicare locals. As I said, Ms Morris can take you through where we are up to. However, Medicare locals will obviously cover the whole country. Yes, you are right; they will have a number of functions which are about reasserting, if I can put it in that way, the absolutely fundamental role that primary health care has in our health care system. What we are looking to do is build that network carefully. In fact the process for the first 15 is incredibly well underway. Ms Morris, what is the timetable for those?

Ms Morris: The timetable as announced was that they start from 1 July this year.

Senator FIERRAVANTI-WELLS: That is the 15?

Ms Morris: The first 15. The second 15—and it was always around 15—in the second tranche will be from 1 January next year, and the remainder from 1 July.

Senator FIERRAVANTI-WELLS: Does that mean fully operational? What do you mean by fully operational? We saw it with the GP superclinics.

Ms Morris: I know it is one of your favourite questions, Senator, on being fully operational.

Senator FIERRAVANTI-WELLS: It is. You put out this map which implied that you had GP superclinics and coverage all over Australia. Then when push came to shove you only had one or two that were actually fully operational. What does fully operational mean to the Commonwealth in relation to Medicare locals that are starting on 1 July?

Ms Morris: The first tranche of Medicare locals will be drawn from high performing divisions of general practice. I know it is not in the question you have just asked, but you said earlier that what they will do is unclear. I would actually refer you to the guidelines for Medicare locals which were put out publically in February this year, which had quite a lot of detail in them. It was against those guidelines that divisions applied to the participating first tranche of Medicare locals. Not all but a large part of what Medicare locals will be required to do is already undertaken by divisions of general practice, especially the higher performing ones. You talked about additional responsibilities. What the Commonwealth already does is use the divisions basically as a platform for delivery of a wide range of primary health care programs. Medicare locals will continue to have this function, and it will be expanded on. As things were announced in the budget, Medicare locals will be the point of roll out for additional programs for primary care.

Senator FIERRAVANTI-WELLS: Does operational mean that there is a shopfront? We went through this with GP superclinics. Does that mean that there will be a sign post saying Medicare local with a Commonwealth logo? What is the physical part of all of this? Does the minister have to turn up and cut the ribbon like they had to do with the GP superclinics?

Ms Morris: They are not service delivery organisations. They are not the place to which patients go to get services. They will coordinate services and they will broker services as divisions of general practice do now.

Senator FIERRAVANTI-WELLS: I know, but will they have an office?

Ms Morris: Yes, they will have an office as divisions do now. They will have an office with a sign on it.

Senator FIERRAVANTI-WELLS: I appreciate that, Ms Morris. Now there is an entity called division of general practice operating in a particular spot. It becomes Medicare local on 1 July. Does that mean that the office will change and it will have Medicare local on top of it? What do you envisage the physical part of it will be?

Ms Morris: As to the physical part, yes, there will be some signage. It will be letterhead or whatever. It will be an office doing business, and that will come into effect once funding agreements are concluded with the successful first tranche.

Senator FIERRAVANTI-WELLS: Does the funding agreement included clauses about Commonwealth recognition or signage? Does it include that the minister comes along and

cuts the ribbon? Are we now going to see Minister Roxon memorial Medicare local? It is a legitimate question, Ms Morris. Do not dismiss it as—

Ms Morris: I was not dismissing it. I was just—

Senator FIERRAVANTI-WELLS: It is a legitimate question. We went through this with GP superclinics. In fact ad nauseam we went through it with GP superclinics.

Ms Morris: I am trying to answer.

CHAIR: I am intervening now on behalf of the officer; there was no attempt from that officer to dismiss that question.

Ms Morris: No.

CHAIR: Having that on the record is not appropriate. Ms Morris?

Ms Morris: Senator, I was about to refer your question to my colleague Mark Booth, who is the Acting First Assistant Secretary of Primary and Ambulatory Care Division, because he is more familiar with the content of the funding agreements than I am. Sorry, I was not trying to dismiss you. I was trying to find the right person to answer the question.

Senator FIERRAVANTI-WELLS: No, that is fine. Thank you.

Mr Booth: As of 1 July, the first 15 will have been announced. We expect that by 1 July the funding agreements will be in place or will be negotiated with the individual Medicare locals. Those funding agreements will highlight the performance standards that we expect the individual Medicare locals to meet. As Ms Morris said, the initial work will be based on the current work of the divisions of general practice, but there are going to be expanded areas which are put into the invitation to apply documentation that we completed in February. That outlines the wider range and the wider span of services and activities that we expect Medicare locals to carry out.

Senator FIERRAVANTI-WELLS: There will be a standard funding agreement which will vary depending on name and location, is that what you envisage?

Mr Booth: There will be a standard funding agreement. It will vary. We have said from the beginning when Medicare locals were announced that Medicare locals would differ according to different parts of the country depending on the type of population and the type of area that they were in. There may be some variation in terms of the location, whether it is urban, regional rural, but we would expect them to have standard clauses.

Senator FIERRAVANTI-WELLS: That funding agreement will then define what that particular Medicare local will do? For example, they may be one of the Medicare locals that might have a part-time child liaison officer, taking out your announcement out of mental health, or, for example, the residential aged care facility. Do I understand you correctly, that each of those funding agreements will vary depending on what particular services that Medicare local is providing or what activities that Medicare local is undertaking?

Mr Booth: We will have a standard funding agreement with Medicare local. As I said before, that may vary according to the type of area that it is in. It is also intended that the Medicare locals do everything that current divisions of general practice do at the moment. As we know, divisions across the country perform different functions, so again, in that sense there will be differences across the country.

Senator FIERRAVANTI-WELLS: Have they been told, for example, that these new incentives for treatment in residential aged care are being transferred to Medicare locals, just to pick something that was in the recent budget?

Mr Booth: They have not been announced yet, so we cannot—

Ms Morris: In the changes to aged care—I think I have the right ones, but aged care is not my area—it was quite clear from when Medicare locals were announced last year in 2010 that there would be a range of specific initiatives that would be run through Medicare locals, one of which was to do with residential aged care.

Senator FIERRAVANTI-WELLS: Yes, and they are now part of that and we will deal with that over the next three years.

Ms Halton: No, 18 months. Perhaps I can assist here. I will talk about budget measures that need a home, so aged care is what we are talking about. You have just gone through the timetable of rollout, which is a staged, phased timetable. In a particular geographic area where the institution that will be available will be the Medicare local, it is our expectation that for that particular initiative in the 15 or so that will be announced and rolled out from 1 July, yes, they would take responsibility.

As Ms Morris says, I think that is fairly well known because that budget measure was fairly prominent, particularly to the people who are interested in these matters. I think that is not an issue. Clearly a contract which will have a standard form, as Mr Booth has indicated, has not yet been offered to the first tranche because they have not been told they are the first tranche. As soon as that announcement is made they will be in receipt of said contract, which will contain all of that detail.

Senator FIERRAVANTI-WELLS: If they have not received a contract yet, how are they going to be operational from 1 July?

Ms Halton: Clearly they cannot have a contract to sign, because they have not been told they have been selected yet. Remember the first group, we have always said, will be founded on high performing divisions. Your point, which went to the rollout of GP superclinics, you will recall, and I know you have been to a number of them, that a number of them were completely greenfield; they had to be built, they had to acquire staff and that takes an amount of time. In the approximately 15 that we are talking about here in this first tranche, we have always said they will be founded on high performing divisions, that is, people with premises and staff. I do want to underscore here that we have always said high performing divisions, but it is not the same as what a division does. There is a whole raft of changed expectations, which again is not secret, so people know what they are bidding for. In fact I think it is fair to say, Mr Booth, that the panel assessing the submissions were pleasantly surprised by the detail and sophistication of people's proposals?

Mr Booth: Yes.

Ms Halton: That means, I think, we have confidence that once the announcement is made these organisations will be well placed to deal with the detail in the contract, but also to move quickly to implement. It is quite different, in my view, to the world of GP superclinics where you are actually getting out a shovel, digging, building and erecting things, and then getting the staff inside, versus this where there are staff and premises already.

Senator FIERRAVANTI-WELLS: Ms Halton, my question went more to the actual operation and the signage—the changing of all that. That is my question to Ms Morris. It is now the beginning of June. The first of July is looming. They do not know who is selected. The contracts have not been signed. Mr Booth, will they be signed by 1 July for the first 15?

Senator McLucas: Can I answer that? In my discussions with divisions in my area there is an enormous amount of excitement about the potential that we are looking at.

Senator FIERRAVANTI-WELLS: Senator McLucas, I am not criticising one way or another. I have asked a simple question. The government has said there will be 15 operational by 1 July. It is the beginning of June and 1 July is looming. You have told me this morning that contracts have not been signed and you have not even nominated the first 15. No contracts have been signed. My question to Mr Booth is: how can you guarantee that they will be operational given those parameters? That is my question. I am not saying my opinion one way or the other. I am just asking a purely logistical question. Mr Booth?

Mr Booth: As soon as we know the first tranche, we have obviously been working on the contracts so that we have the draft contracts all ready. As has been previously stated, the first tranche is going to be based on the high performing divisions, so we know that a lot of these divisions are actually doing a lot of the work that we would expect Medicare locals to be doing. We are getting the draft contracts ready in preparation so as soon as the first tranche is announced we are ready to move as quickly as we can to get those funding agreements up and running.

Senator FIERRAVANTI-WELLS: Work your way back from 1 July. Do we know when the announcement is going to be made?

Mr Booth: We do not know when the announcement is going to be made yet.

Senator FIERRAVANTI-WELLS: We do not know when the announcement is going to be made. So as soon as the announcement is made you have to go through a process of contract signing, supposedly signage, I would assume that you will expect them to have some office facility, et cetera.

Ms Morris: They already do.

Senator McLucas: They do.

Senator FIERRAVANTI-WELLS: All 15 that you have identified, Ms Morris?

Senator McLucas: They are divisions.

Ms Morris: They are all divisions of general practice.

Senator FIERRAVANTI-WELLS: Okay, that is fine.

Ms Morris: Yes, they all operate.

Senator McLucas: Yes.

Senator FIERRAVANTI-WELLS: Going back to my question before, are you going to have to change the signage?

Senator McLucas: We are not worried about the signage; I am actually worried about the function of these things.

Senator FIERRAVANTI-WELLS: Senator McLucas, you may not be worried about the signage now but you were worried about the signage and the letterhead, and the minister

turning up to cut the ribbon with GP superclinics all over the countryside. Hence I am asking the question to Ms Morris—

Senator McLucas: A completely different proposal, as the secretary has outlined to you

Senator FIERRAVANTI-WELLS: Obviously it was a priority before and I am asking if it is a priority now within the next month.

Senator McLucas: I am worried about the function of Medicare locals, and I suggest to you there is enormous excitement in the divisions.

Senator FIERRAVANTI-WELLS: There might be, but that is not my question. My question to Ms Morris and to Mr Booth is: within this four-week framework, is it anticipated that contracts will be signed, signage will be altered and letterheads et cetera will be put in place, and does that include the minister turning up to the 15 and cutting a ribbon?

Ms Morris: I think that is a question for the minister and her priority about services delivered versus signage. I think that Senator McLucas has addressed that.

Ms Halton: Perhaps I can assist here. Letterhead, these days, as we all know, is a matter of changing technical things on computers.

Senator FIERRAVANTI-WELLS: No, no, Ms Halton, can I just ask you this, last time—

CHAIR: Can we let the Senator finish the sentence?

Senator FIERRAVANTI-WELLS: With GP superclinics the reason was that it had to have some sort of Commonwealth acknowledgement. That is my point to Ms Morris. What are the requirements for Commonwealth acknowledgement, noting that with GP superclinics there were requirements in relation to a whole range of things that were mandatory in relation to the operations of that GP superclinic. That is the basis of my question, Ms Halton.

Ms Halton: I can assist you by pointing out that it is standard Commonwealth practice, and has been as long as I have been a bureaucrat, which is regrettably now rather a long time—

Senator FIERRAVANTI-WELLS: You love it, Ms Halton!

Ms Halton: That is true too. Let us be clear: every government I have ever worked for has rightly asked for acknowledgement of Commonwealth funding, and recognition of funding that, therefore, taxpayers provide to services. That is a perfectly sensible thing that every government I have ever worked for has done. In terms of these services, as either Ms Morris or Mr Booth pointed out, they will not have a shopfront function and they will not have patients. In terms of letting people know who is the funder of this service, which is the crucial point, that does not necessarily need to focus so much on what people see visually as they arrive at the service. It is important in their documentation that that is acknowledged. It is always our obligation to make sure that services we fund are acknowledged, that that is where they get their funding, and we will do that.

The point I was in the process of making is letterheads and things of that ilk will have to say who they are. That is easily done. That is a computer activity. It is not necessarily the days when we used to shred vast containers of paper when department names got changed. You just do it on the computer. As to the minister's desire or otherwise to go and visit each service, I would imagine she will want, in time, to go and visit these services, because she

takes an interest in these things. They will start their operation on the date that they sign their contract, which we anticipate will take not much time at all. It is my expectation that they will be operating on 1 July. As to the minister going to visit them, she probably will, and frankly I expect I will go and visit some of them too, but they will not be focussed on public physical manifestations because we do not expect the public to walk through their door.

CHAIR: I have been given a list of people who wish to ask questions in this area from your party. It was an hour for you, 15 minutes from Senator Boyce and 15 minutes from Senator Adams, and now 65 minutes have been used. In terms of the timeframe I am putting that on record to see where you stand now, because we do not want to go beyond quarter to 11 on this particular item before moving into population health.

Senator FIERRAVANTI-WELLS: I am just going to keep going.

CHAIR: It is your decision.

Senator FIERRAVANTI-WELLS: I would like to ask some questions in relation to beds. From 1 July the Commonwealth was to invest \$1.6 billion to fund the capital and recurrent costs of 1,316 additional subacute beds. One year on, can you give me the outcomes thus far—the total of these beds and how many have been rolled out and are operational, including a breakdown by state? Please also provide an agreed timetable with the states for rollout over the current budget and over the years until 2013-14? I ask this in particular because you would be aware of articles recently in the *Daily Telegraph*, for example one of 16 May, stating that New South Wales Labor had counted cots, bassinets and dialysis recliner chairs as beds and that instead of 22,000 acute beds in New South Wales hospitals there were 11,000.

Ms Flanagan: We actually do not have the officers here. Would it be possible to ask that in outcome 13? They can give you detail of the implementation plans that have been approved for subacute care beds.

Senator FIERRAVANTI-WELLS: What about emergency departments and the budget announcements? Are they best dealt with in that section, outcome 13?

Ms Flanagan: In outcome 13.

Senator FIERRAVANTI-WELLS: My 15 minutes are very close. What about the elective surgery? In portfolio budget statement at page 1,505 you talk about net reductions in the number of staff in the core department from some 4,060 to an estimated 3,900 and an estimated 3,640 in 2012-13. Are they full-time equivalent or absolute numbers?

Ms Halton: Full-time equivalent.

Senator FIERRAVANTI-WELLS: How many of these staff will go to the various authorities? I understood that there will be new staff in the various authorities. I will put some questions on notice about that.

Ms Halton: Yes, sure.

Senator FIERRAVANTI-WELLS: Your total of 159 grant programs will be consolidated into 18 new or expanded flexible funds. What impact will this have on individual programs? For example, in mental health—and I will come to this later—it is very difficult to follow programs as it is; it is all under one funding. Is this going to make it much harder to follow what is happening in individual programs?

Ms Halton: Basically we carry a significant administration overhead for every separate program line item and, because of the desire to streamline the way we administer, those programs have been streamlined. I think you actually quoted the language, and it is accurate. We have put a number of individual programs together into these funding pools which then provide government with flexibility, but it also provides a significant reduction in administrative overhead.

Senator FIERRAVANTI-WELLS: I will put the rest of my questions on notice, thanks.

Senator BOYCE: Ms Halton, has the department provided any advice at all to the Multi-Party Climate Change Committee?

Ms Halton: Not directly.

Senator BOYCE: You have provided it to the department?

Ms Halton: Obviously we work with the Department of Climate Change and Energy Efficiency and usually I do know when we turn up at committee hearings. I do not believe we have appeared in front of the committee itself or delivered information direct to the committee. We are in quite regular dialogue with the department of climate change but we have not actually had any direct relationship that I am aware of.

Senator BOYCE: Would you perhaps be able to take that question on notice and provide me with an answer? When you say aware of, what does that mean?

Ms Halton: No, let me put it this way. We have not. If I am incorrect I will come back and correct later on today.

Senator BOYCE: Have you provided any advice to the department of the environment for the use of the climate change committee? That might be another way to put the question.

Ms Halton: I can tell you that I think that is a hard question to answer. We know that we deal with the department of climate change on all manner of issues. I can tell you with complete confidence, because in fact I was only just reading an email about one part of it two seconds ago, that we are providing information to the department of climate change. What they are using that for I think is difficult for me to answer.

Senator BOYCE: Could you give us a general outline of the type of information you are providing?

Ms Halton: Let me take that on notice.

Senator BOYCE: You do not see any concerns with making public the type of information being provided?

Ms Halton: It would be in a general sort of frame. I can tell you that we have been thinking about aged care, for example, the impact in terms of climate policies on aged care services. I know that we have been doing that but beyond that I will have to take it on notice.

Senator BOYCE: So the impacts of a carbon tax on aged care services?

Ms Halton: Yes, that is right. Not only that, we had a conversation a little while ago about air-conditioning versus fans, for example, with regards to heat stress.

Senator BOYCE: What was that, a health assessment of—

Ms Halton: Climatic incidents.

Senator BOYCE: You were not looking at the actual cost or the power usage comparison there, were you?

Ms Halton: Because I was not involved myself in those discussions I would have to take that on notice. My understanding is that we have done some work with climate change and a number of others about increasing variability in temperatures as a consequence of climate change and the implications that might have. For us of course it goes to everything from the costs that services might meet but also the air-conditioning versus fans and what you do in terms of the number of people who might be impacted by increasing numbers of hot days—emergency services impacts, all of those kinds of things.

Senator BOYCE: If you would be able to provide me with whatever information you could about when the advice was given and as much information as possible about that advice, that would be helpful.

Ms Halton: Yes. It might well be that the answer has to be framed somewhat in terms of us participating with climate change and considering issues around that because I do not know that you can characterise all of our interactions with climate change as being us writing some learned tome or piece of advice and sending it to them. The reality is a lot of what we do is work with another department on issues and particularly to draw their attention to what might be implications that we can identify.

Senator BOYCE: Where there are written learned tomes of advice I would like to receive those, and if it is not possible to publish them to tell me why you cannot publish them.

Ms Halton: Yes. As I say I suspect the tomes of advice are less frequent than the working together on particular issues, but we will come back on notice about what we can say.

Senator BOYCE: Thank you very much. I had questions relating to plain packaging.

CHAIR: The break is very close and that is going to be a stream of questioning. We might take the 15-minute tea break now and come back at 10.45 am.

Ms Halton: If it is about plain packaging it would be my expectation we will do that under the relevant program, not whole of portfolio.

Senator BOYCE: Okay, that was the question. Should it be done here? The other area I had questions about—I was not sure whether it would come in here or later—was a report in today's paper regarding an inquiry which your department did or organised to have done into Diabetes Australia.

Ms Halton: That should be done under the relevant program because the relevant people will not be here yet.

Senator BOYCE: Sorry? When?

Ms Halton: That will be done under outcome 2.

Senator BOYCE: Okay, thank you.

CHAIR: Are there any other questions? If not, it is a good chance to have this bingo game that we always have!

Proceedings suspended from 10:29 to 10:48

CHAIR: We would like to start. We have allocated the time until 11.30 am to this particular program. Senators Fierravanti-Wells, Adams and Siewert all have some questions before 11.30 am. Senator Fierravanti-Wells, we will start with you.

Senator FIERRAVANTI-WELLS: Thank you. I will look terms of a couple of issues in relation to whole-of-portfolio funding. I will dwell more on this in terms of mental health afterwards but, in terms of the budget, do you look at what is left over in terms of a particular program in part of the process? A number of programs in your department ended on 30 June. What sort of assessment process do you go through in relation to those programs? For example, quite a number of the programs that were part of the COAG mental health announcements in 2006 end on 30 June. Can you tell me how that works? Do you look at whether there is money left over in relation to those programs in terms of determining whether they will be ended?

Ms Halton: I think we would have to take that under the relevant program.

Senator FIERRAVANTI-WELLS: Under each of the programs?

Ms Halton: Yes, because it is very hard for us to give a blanket answer. It is a case-by-case question. It depends on which context the program is in, whether it was terminating, whether it was lapsing, whether there were some other broader initiatives.

Senator FIERRAVANTI-WELLS: I will deal with that as far as mental health is concerned and a number of other areas where programs were ending. In relation to the whole of portfolio, the budget statements stated that from 1 July, 159 predominantly grant programs will be consolidated into 18 new or expanded flexible funds. What will be the impact on the individual programs? How will that work in relation to each of the programs?

Ms Halton: The answer is that the grants continue. The programs have been amalgamated into those broader funds as you have indicated, but the grants certainly continue. In fact, if they were due to expire in the next little while, they are actually going to be continued until next year. Right now we will have to consolidate program guidelines et cetera.

Senator FIERRAVANTI-WELLS: So it is an administrative function rather than a financial reallocation?

Ms Halton: Correct.

Senator FIERRAVANTI-WELLS: Will the method of assessing funding grants differ from the current system?

Ms Halton: It will be more broadly based and the minister will have to consider and then sign off guidelines across those new consolidated funds. This was the point I was making before we broke; at the moment we have individual guidelines and then accountability lines, all of which bring an administrative overhead, and what this will do is basically streamline the overhead, but there was no saving taken out of the programs themselves. It is an efficiency, streamlining mechanism; it is not a saving from the grantee's perspective. Does that make sense?

Senator FIERRAVANTI-WELLS: That is what accounts for the administrative efficiencies that are set out in Budget Paper No. 2?

Ms Halton: Correct.

Senator FIERRAVANTI-WELLS: That is the \$2 million in 2011 and the \$0.6 million, \$0.3 million and \$0.3 million over forward estimates?

Ms Halton: Yes, it is the administrative overhead.

Senator FIERRAVANTI-WELLS: There is no net reduction in funding for these programs—simply a consolidated exercise?

Ms Halton: Yes.

Senator FIERRAVANTI-WELLS: What about the public reporting mechanism of successful grant applications and how much they each receive? Will that operate through the portfolio budget statements again?

Ms Halton: Yes. Essentially there is no less transparency and there is no less obligation on us or indeed the grant recipient to report. It just means that their funding is coming out of this more broadly based bucket.

Senator FIERRAVANTI-WELLS: From time to time we see tabled in the Senate lists of funds. The difference will be the methodology?

Ms Halton: Yes, it will be a bigger list. Instead of getting lots of lists of little things you will get a smaller number of things with lots of things in them. That is the technical description, but you know what I meant.

Senator FIERRAVANTI-WELLS: I know what you mean. I might just leave it there.

Senator ADAMS: I would just like to come back to the governance arrangements for the new health system as proposed with the Independent Hospital Pricing Authority, the national performance authority and the Australian Commission on Safety and Quality in Health Care. I would really like to know practically how these three agencies are going to work together; could someone tell me that? This is getting back to my practical issues.

Mr Head: Each of them performs a unique function in the arrangements. There are some areas of common interest and we expect that, on some of those areas to do with the way information flows work et cetera, there will be a cooperative arrangement between the agencies. As part of the implementation process we are currently undertaking some of the work associated, for instance, with the IT capability that will be required to support those organisations. The relevant section of the 2010 agreement sets out, particularly in respect of the performance and accountability framework, the interaction between organisations such as the ones you have mentioned and the AIHW and the COAG Reform Council as well. For instance, there are discussions developing between us and the AIHW about the way to support the proper flow of information in the new system in order to ensure a streamlined process.

Senator ADAMS: What is concerning me is just the duplication of other agencies. Are they going to be completely in silos? Just how are they going to interact without duplicating what the others are doing?

Mr Broadhead: Essentially there are different focuses for each of the organisations. The pricing authority is really a new function in the sense that it underpins a different method of making payments for public hospital services which at the national level has not previously been used. It has been set up as an independent authority because one can expect that what it determines in terms of prices will be something that everybody has an interest in and nobody wants to see determined other than by an independent body.

The performance authority is doing something also which, with the recent exception of the MyHospitals website which sort of presages the new authority's responsibility, is reporting at the level of actual hospitals, public and private, and Medicare Locals. All previous national reporting has tended to focus on reporting at the level of states and territories. For example, the review of government service provision that is undertaken and published each year focuses on things like elective surgery, waiting times and so on, but at the level of states, so what the average performance or level of performance is in New South Wales, Victoria and so on. Similarly, the COAG Reform Council currently focuses on specific performance criteria that are set out in intergovernment agreements. The performance authority is the first time—as I say, with the possible exception of the MyHospitals website—where there will be a national authority reporting in a standard way for the public to see on service-level performance. It is a different function from what has previously been undertaken in that sense.

The safety and quality commission has a slightly different focus again, because it is particularly charged with safety and quality, which is, if you like, a very particular subset of performance. It has not just a reporting role but a capacity to engage with clinicians to look at initiative to improve safety and quality and so on. Whereas the performance authority is essentially a public reporting institution, the safety and quality commission is actually getting down into the nitty-gritty of what makes a difference to safety and quality and how to improve it as well as providing some information on it.

There is some capacity, as Mr Head has outlined, for information to be used in various contexts. One would expect that the National Health Performance Authority will include in its performance measures things that do come from the safety and quality commission about safety and quality, but it will be much broader than simply safety and quality. Similarly, one would expect in terms of financial performance and efficiency that the work of the pricing authority will inform performance indicators that the performance authority would then publish.

So there is some overlap in terms of how the performance authority will draw on the work of the other two bodies in reporting performance, but there are quite particular focuses, and a new focus in terms of the level at which performance is reported, for example, or in terms of the functions of pricing, different from what has previously been the case at the national level.

Senator ADAMS: We will get back to the local network boards and the performance authority. If one of the boards is not performing properly, does the performance authority actually go to the board first before they go to the state health on a problem? I just cannot get through my head how all of these agencies will work, when you have a complaint coming up and it is just going straight through that local network board. It does concern me that the state health authority is being left out of the loop at the start.

Ms Halton: You have pinpointed one of the issues we were discussing with Senator Fierravanti-Wells around the level of colour and movement in the negotiations at the moment. That is one of the points that is contentious, and that is one of the points that is being discussed. A proposal was on the table; that is a matter which a number of the jurisdictions have said they find problematic. We are talking to them about it. You have actually gone right to one of the penultimate issues that has to be looked at.

Mr Broadhead: The bill as originally moved in the House of Representatives does include notification of LHNs where they may be subject to a report of poor performance. The

discussion that is currently happening is about balancing the need to give such an organisation the chance to respond before any publication is made to such a potential report, while also recognising that states and territories have a role, obviously, in relation to public hospitals and their performance, and how to balance that, given that they are actually responsible as the system managers for the performance in a sense of LHNs. The discussion that is currently happening is looking at how we best balance that between the states' interest as system managers and with responsibility for performance versus ensuring that an organisation that may be the subject of a report of poor performance has the opportunity to respond. As the secretary says, that is a live issue as we speak where we are trying to tease through a sensible balance between those two.

CHAIR: Even though we have a piece of legislation that we are considering at the moment, I am allowing these questions to flow generally because so much of health reform is happening at the moment. I just wanted to put that on record. Normally we would not discuss something that is in a bill, but I made the decision when Senator Fierravanti-Wells was asking her questions; you cannot limit this discussion by putting that in. The officers well know, because they all appeared before us very recently.

Senator ADAMS: Continuing on from that, say you have a performance that is not up to scratch. Where will the Medicare Locals fit into that? Will they be informed that one of the network boards within their jurisdiction is not performing the way that they should be? I just want to get this whole thing sorted out.

Mr Broadhead: A report of poor performance ultimately would be a public document, so in a sense everybody will have the opportunity to note it. There is not, to my knowledge, any current move to have Medicare Locals advised of such a thing in advance of the actual report being made. The opportunity is for the state and/or the relevant LHN, if it is an LHN, to respond to a report not yet made. In other words, in advance of the performance authority forming a settled conclusion, it would go to the state and/or the local network to give them a chance to respond because these are things which may have context which would lead the authority to then no longer decide that there was poor performance actually that required reporting. Having gone through that process, the report would then become a matter of record, and of course Medicare Locals, to the extent that they overlapped the LHN or had an interest, would know it as much as anybody else would.

The performance authority will be producing what are called healthy community reports. These are reports for the region covered by each Medicare Local about aspects of the population's health and health needs and performance, if you like, in relation to those health needs, particularly with a focus on things that are amenable to primary care. The authority has a reporting function in relation to Medicare Locals. Its broader reporting functions may inform Medicare Locals, but only once the reports themselves become available.

Mr Head: When the performance authority produces either its healthy communities reports or its reports related to the activities of an LHN or a public hospital, it is producing those reports against the agreed performance and accountability framework that COAG will agree in the middle of the year. So, all organisations that are being assessed will understand absolutely the framework against which their performance is being assessed, and the indicators that are being used. What the secretary and Mr Broadhead have both pointed out is that what is at issue in respect of that is the consultation process on draft reports where that

assessment against the framework has indicated poor performance and how that consultation process should occur.

Senator ADAMS: Does the state authority come into this?

Mr Head: The performance and accountability framework itself will make clear the state's role as the system manager. Therefore the fact that it has responsibility for determining what rectification needs to occur to respond to poor performance is a matter for the states as system managers. The role of the performance authority is to use the agreed framework and the indicators within that framework to assess that performance and to report publicly, after it has been through a process of validating its report consulting with affected bodies. It is then for the states as system managers to determine both the actions and the time frame within which those actions are to be taken.

Senator ADAMS: Are the boundaries of the network boards and the Medicare Locals aligning? I am from Western Australia, and I know that ours are not set up yet, but are the other states actually aligning properly, specifically looking at rural and remote areas as to how they will work?

Mr Broadhead: I think the best answer to that is that there is not a complete congruence of boundaries, but there is quite a good alignment. Because they are different bodies with different particular focuses, you would not expect a one-to-one correspondence, and certainly with Victoria heading towards 80-odd LHNs, one would not expect a one-to-one correspondence. Although, even there, what is being discussed is how a collection of LHNs might map to a Medicare Local boundary. I think there is a high degree of alignment but not a complete degree of alignment.

Senator ADAMS: Coming back to the more practical issue of people who are on these Medicare Locals and the people that are on the network boards, will there be any crossover? Will there be someone from the Medicare Local on the local network board? How will the message get through to the two of them? Coming from a rural area, I am quite concerned about the size of the Medicare Locals. Having been involved in rural health services, I am very worried that they will be left out and isolated. Surely, with the composition of the local network board, there would have to be someone from the Medicare Local involved as well to try to work out where everything is going?

Mr Head: The process for establishing both Medicare Locals and LHNs does encourage some cross-membership between the governing bodies of both organisations. Ms Morris can talk about how that is anticipated in terms of Medicare Locals.

Ms Morris: With Medicare Locals, we have made it quite clear that we expect some common membership across both boards. In rural areas, there will probably be more than one person that is common to both boards. You need particular skills to staff boards. You need the right people in the job. If you get more than one person on both boards, that is not a bad thing.

Senator ADAMS: Is there a designated position for these people?

Ms Morris: Not per se. We have been explicit in the guidelines, and I am sorry that I do not have a copy of them with me. We were explicit about the range of skills needed, but left it up to applicants in their applications to say how they were going to make that work. As the secretary, Ms Halton, said earlier, we were very pleasantly surprised at the quality of the applications we received. People had put a lot of thought into it and thought seriously about

how they could make it work. There were three sorts of engagement we were asking them to have: one was with the local hospital network, so that the allocation of resources across both sectors was made in the right place for the benefit of patients; the second was engagement with primary healthcare professionals within an area; and the third was community engagement. So they were required to address all of that in their applications.

Senator ADAMS: I have a question to ask about aged-care services and Medicare Locals; can I do that here? It is on the one-stop shop. I will do that under ageing.

Senator SIEWERT: I will go back to the issue of administrative efficiencies and the new funding approach. In terms of the way you will be reporting from now on, will we still be able to track the individual programs fairly easily? For example, will the dementia initiative which is now program 4.6 be differentiated under 5.2?

Ms Halton: In terms of the grants we provide, yes. There will be reporting against individual programs, as we do now. We report against grants. We will continue to indicate what the grants are under the consolidated program.

Senator SIEWERT: But that one will be the single point of contract for health information advice and counselling?

Ms Halton: Correct.

Senator SIEWERT: And then it will be broken down to those grants?

Ms Halton: Yes. Essentially what you will see is the macro program heading, and then, as we do now, with individual grants, you will be able to see those. Obviously they will not be reported in here, but they are not in here now anyway.

Senator SIEWERT: But you will still report against them?

Ms Halton: As it will still be accountable for individual grants, correct.

Senator SIEWERT: Senator Fierravanti-Wells asked the other questions I was going to ask there. In terms of your involvement with the new not-for-profit commission and the whole new approach across government in dealing with the community sector, with respect to the program, report once, use often—and I asked PM&C the other day but I did not get a totally satisfactory answer—what consultation has there been with your agency, and how will you be participating in that process?

Ms Halton: We have been quite closely involved in those discussions. I attend the social policy committee of cabinet, so I have also been there for the discussions around these issues. You will have seen in our streamlining our administrative changes a number of things which are very congruent with that work, for example, moving to a single head of an agreement, if we can, with an organisation that would then cover a number of activities under that agreement. I suspect we may end up being further out the front of the pack on some of the streamlining type activities that are foreshadowed in that broader work than some of the others, because we have to do this now to deliver our administrative efficiencies. Mr Morris is sitting here, I suspect, because he wants to make a comment about this.

Mr Morris: Only to confirm that we are actively engaged with the whole-of-government approach to addressing the response to the Productivity Commission report.

Senator SIEWERT: I have a couple of questions following on from there. The way it seemed to be heading when I was asking PM&C is that it was more about financial. They

asked me if I was talking about the standard charter of accounts and things like that. I appreciate we want to get that better and reporting once, but you would be aware of the overburden report and a number of other reports that show many not-for-profits have multiple grants and have to report multiple times.

Ms Halton: Yes.

Senator SIEWERT: That did not seem to be giving that as much consideration as the financial reporting once, use often. When you are looking at it, is the concept for you also to minimise the number of reports and improve the quality so that it can be used multiple times?

Ms Halton: The theory is yes. One of my challenges is that the financial framework actually does drive a lot of what happens in terms of the reporting side and not just the money reporting side but the activity reporting side. In fact, I actually have a meeting with a representative of one of the large not-for-profits in my diary in, I think, early July, and this particular person and I have an agreement that we will sit down and talk about whether we can find a way to work on piloting that more streamlined activity reporting across a number of grants. I do not know how we will go with that, because actually it does require the centre of government, in terms of the reporting frameworks, to be more flexible. If you look at our portfolio, the obvious place where we have more flexibility is in things like multipurpose services, where we provide money, but it still comes from one program. I have not seen anyone across government who has cracked the money coming from several programs and then streamlining the reporting there. That is the hard part of this.

Senator SIEWERT: Exactly.

Ms Halton: That is the core of the difficult issue here. We are going to have a go at it. As you say, this is the hard part.

Senator SIEWERT: What is your time frame for making that happen?

Ms Halton: I do not know that I want to be held.

Senator SIEWERT: Does that mean as long as a piece of string?

Ms Halton: Well, as long as it takes.

CHAIR: That is not exactly imminent, but it is not by the end of the year.

Ms Halton: The answer is I do not know.

CHAIR: Hopefully responses on timing is imminent in the short—

Ms Halton: I do not know, because I do not know how long it will take.

Senator SIEWERT: We have the 2012 deadline and the 2013 deadline. I understand that that would be more the 2013 deadline?

Ms Halton: If I was required to opt for one or the other—I was going to say take a punt, but I just thought to myself I had better not say that because Senator Xenophon will be in here in two seconds flat correcting me—I would think on the balance of probability, yes, it is likely to be that later timetable, simply because this is such a difficult and intractable issue. It will require some creativity, but also I think the parliamentary bodies to whom all these reports are given also have to understand what the implications are. This is one of those where we need a kind of compact across the parliamentary world as well as the bureaucratic world if we are going to make it work.

Senator SIEWERT: Okay.

Senator FIERRAVANTI-WELLS: Can I just ask one question on the national compact, noting the comments that Ms Halton has made? In terms of the measures that the Department of Health and Ageing is implementing, are they measures peculiar to your department, or are these just measures that other departments generally are taking as well in terms of implementing the national compact between the government and the not-for-profit sector?

Ms Halton: The short answer is no, they are peculiar to us. The longer answer is in the spirit of the compact. These are not measures that someone from a central place has said, 'implement those.' We have had a look at our way of operating. We are also mindful of what is going on in the broader environment. This is something we have been trying to do anyway for a long time because, as you know, we work with a lot of community providers. They tell me regularly how burdensome this is. We are not without sympathy for this. We do not particularly want unnecessary overhead either. It is our native, local to us, part of how we do our business, but it is very much mindful of that broader reform.

Senator FIERRAVANTI-WELLS: Having rung Father Chris Riley from Youth off the Streets, I understand precisely the point. As part of the measures that DOHA are taking into it, will you be using practical examples? Are these measures that you have developed as a consequence of practical problems you have had, or will there be a whole across government strategy to which you are now contributing? Do you see my point, Ms Halton?

Ms Halton: The short answer is both. The department of finance is working on this.

Senator FIERRAVANTI-WELLS: The bean counters.

Ms Halton: They are very nice bean counters, Senator; we love them. They are working on it, because it is back to the frameworks. They draft the frameworks, they own the frameworks, and if they cannot manage to design and implement the frameworks in ways that enable us to do this, we cannot do it. They are doing macro streamlining work. We can, however, in that context do the local stuff. Because it is informed by sitting down with groups such as the NPY women's council and hearing exactly how many of their 300 grants are ours, like 200 or something, but looking at what their burden is, so our approach will be informed by that.

Senator FIERRAVANTI-WELLS: One last question on that. As part of that, obviously you have organisations that not only apply for federal grants but apply for state grants as well. Is this potentially something that will have a COAG overlay?

Ms Halton: You would like to say yes. As long as I have been working with community organisations, this has been an issue. We have been talking about the level of goodwill around this issue. It is hard enough in one department. Then you would say, okay, federally, could you do this across departments, and you would say difficulty to the degree of what have you. Then if you said, could you do it across state departments, no. I do not know in our lifetime, Senator; and then we go to local government.

Senator SIEWERT: I want to double-check, with the administrative efficiencies in the new fund approach, the way grants and things are going to be operated, as I understand it, nothing will change to the community?

Ms Halton: No, other than the streamlining.

Senator SIEWERT: But nothing will change in terms of the grants which now come under the new fund but the way that the community interacts with those is the same?

Ms Halton: Yes. We are going to look at the departmental structures that underpin those funds. One of the concerns that people express to me all the time is because their fund is quite narrow, it means there might be two people in the department working on it, and of course the two people turn over relatively regularly. One of the complaints we get from outside, and it is a legitimate complaint, is that we just create a relationship with Mary and then Mary goes off to be an acting APS6 somewhere, and we get John, and then we have to re-educate John, and then John goes off. The whole point about this is to broaden the base in the department as well, have more people with expertise across a range of areas, which means X organisation may have a relationship with Mary and John and Fred and Bill, which means that even if Mary goes off, you still have Fred and Bill. It has multiple benefits to it.

Senator SIEWERT: Thank you. I refer again to the community granting processes. We have had several discussions around, as contracts are finishing, letting community organisations know whether they have new funding, et cetera, and it is coming up to the end of the financial year; where are we up to? Overall, do you have a view across the agency of where various contracts are terminating or are due for renewal, one way or the other, on 1 July? It is coming up to the time where staff need to know whether they are going to be moving on or staying?

Ms Halton: There are two things. Firstly, for any of the programs affected by the consolidation, we have already said that we will extend anyone's grant out until 2012, because we will rewrite the guidelines across these larger programs. Secondly, we will have regular funding rounds, so that people will actually have certainty about timetables, et cetera. So anyone who is affected by that, that deadline is pushed off by definition anyway.

In terms of other programs, I am not sure whether you have a particular program in mind. Budgets have already been announced in terms of things that we are now continuing. Bowel cancer screening would be the obvious example. We now know that that money is ongoing. I am not aware that there is anybody out there who is uncertain about their future. If you have one in mind, I would like to know.

As a general point of principle, we are very mindful and in fact make the point regularly to colleagues in other departments that, for people running a community service or a health service or whatever it might be, if you are not told until May whether your money is going to continue, and your funding at best you know expires on 30 June, by the time you get the telephone call, your staff have all left. If you do not tell them really around Christmas time, good people go.

This is the other point about the terms of contracts we give people. You might have noticed that, in the reform, we are talking about having longer contracts for people. I think that is incredibly sensible. I was very concerned when we went to annual contracts some years ago, because we know that to keep quality staff in the community sector, you need to be able to say to them, 'Actually, we have a contract from government to do this activity for—insert period.' That way you have some certainty. We can offer you employment for a period, which means we can then get on and deliver a quality service.

Senator SIEWERT: As far as you are aware, all organisations that have grants that terminate on 1 July know whether they are continuing or not?

Ms Halton: That is my belief. As I said, it could be that my belief is not comprehensively founded on everything in the department, so if there is one that you become aware of, please let me know.

Senator SIEWERT: Okay. The standard practice now in the agency is that you let people know around Christmas time?

Ms Halton: That is what we endeavour to do. My point is that we advocate with people like the department of finance, because you would understand that we are not able to commit funds, which includes telling people, unless we get authority to do that. We try to ensure that, wherever we can, people are given that notice.

Senator SIEWERT: Thank you. With respect to the pay equity case, and I appreciate that it is not in the budget, so I will not ask questions like that, but what planning is the agency undertaking, depending on what happens with the pay equity case, if there is an increase in salaries that is not budgeted for? Will you be renegotiating contracts with not-for-profits in terms of their deliverables once they have to start dealing with the pay equity case?

Ms Halton: The obvious place the pay equity case affects us is aged care. It is fair to say that that is an issue for the whole of government and the whole of government has to decide how it will manage that. I do not know whether Mr Morris wants to say anything more.

Mr Morris: No, it is currently the subject of government consideration.

Senator SIEWERT: Have you done an analysis, beyond aged care, of other grants that you have with not-for-profits that will be affected by this? Has that audit been carried out?

Mr Morris: It washes across the mental health sector as well as the drug and alcohol sector, all of those sectors where we engage community sector groups to extend our services.

Senator SIEWERT: Has an audit been undertaken for exactly what grants and what organisations will be affected by a pay equity case in both the aged care and the community sector?

Mr Morris: No audit has been undertaken. That is an extremely extensive task, and it is the subject of whole of government consideration.

Ms Halton: We have a fair idea of where the effects are.

Senator SIEWERT: How did you come by that fair idea?

Mr Morris: In the case of the aged-care sector, we have the data to do modelling. In the case of the broader community sector, we do not have that data, but we have an idea of the extent of our grants, the number of organisations, and we can do an approximation.

Senator SIEWERT: You know how many people are employed by those agencies on those grants?

Mr Morris: Not precisely.

Senator SIEWERT: Even if the grants are not necessarily affected, those organisations may be, and their operations may also be affected by the pay equity case, so it will have roll-on effects on the provision of services that you fund as well. Has that been done?

Mr Morris: No precise empirical modelling has been done of the broader community sector. We are highly conscious of the extent of implications of that pay case. The empirical data is not available to do detailed modelling of the broader community sector. We have a good idea around the aged care sector because we administer it. But around the broader community sector, we have an approximate view. This is the subject of whole of government consideration as we speak, and whole of government is addressing the issue of how to grasp the financial implications of that case.

Senator SIEWERT: I suppose I have a difficulty understanding how the whole of government can come to an understanding of the impact when there has not been an audit carried out.

Ms Halton: You actually do not need to do an audit. The truth of the matter is that, given the size of this, we know how much money we give to the sectors that are affected in toto. We know that the majority of that funding goes on rents and salaries. So you can come up with an order of magnitude in these areas to give government an indication of the scale of the implication.

Senator SIEWERT: What is the scale of the implication for this agency?

Ms Halton: I do not know that we have actually got the one number. We would have to take that on notice.

Senator SIEWERT: Okay, if you could take that on notice, that would be appreciated. Thank you.

CHAIR: You will put any other questions on notice?

Senator SIEWERT: Yes.

CHAIR: We now move on to the Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare

[11:31]

CHAIR: Welcome, Mr Kalisch.

Senator FIERRAVANTI-WELLS: A report was recently released in relation to affordability of dental care. I think you are probably aware of various articles on 25 May that talk about affordability, like 'Affordability takes big bite out of dentist visits' and 'Cost main deterrent to dental care, report finds'.

Ms Halton: Was that a bad pun, Senator?

Senator FIERRAVANTI-WELLS: No. I am reading from page 8 of the *Australian*. No, I did not come up with that one.

CHAIR: If you are going to use that article, I remind you that our common practice is that you table it.

Senator FIERRAVANTI-WELLS: No, I just asked if Mr Kalisch was aware of them.

CHAIR: So you are not going to use it as part of your questioning?

Senator FIERRAVANTI-WELLS: Only if he is aware of them.

Mr Kalisch: I am aware of the reporting, but I would also note that probably over the last three months we have released about 40 reports. This is one of many. It is quite an interesting one, though.

Senator FIERRAVANTI-WELLS: In the press release that you issued you said that it uses information collected from the National Dental Telephone Interview Survey. Can you tell me roughly how many people would have been surveyed as part of this report?

Mr Kalisch: I cannot give you that exact figure today, but I can certainly take it on notice. I would also indicate that this is some research and analysis that is done for us by a dental unit that is based in Adelaide at the Adelaide university. We have a national dental research unit that we fund as one of our collaborating units, and they produce a lot of the dental information. They undertake the survey work, so I can get the further details.

Senator FIERRAVANTI-WELLS: Thank you kindly. It is clear from the reporting and from various commentary that cost of living pressures were very much an issue in relation to the high rate of cost based delay. Is that the case?

Mr Kalisch: As I recall the publication and the results, it certainly gave an indication that the costs of dental services were an impediment for some people. It did not get into the broader cost-of-living dimensions. It was a survey based on dental services.

Senator FIERRAVANTI-WELLS: As part of the question on notice, could you also give me the parameters of the questioning, so that we are not only talking about the number of people but also the general questions that were asked of them?

Mr Kalisch: Yes.

Senator BOYCE: In 2013-14 and 2014-15, you are going to pay \$76,000 to the Australian Radiation Protection and Nuclear Safety Agency.

Mr Kalisch: No.

CHAIR: What page are you on, of what?

Senator BOYCE: Page 448, of the cross portfolio measures.

Mr Kalisch: I think that refers to some of the other implications for that agency from a cross portfolio measure. It is not actually a measure that is related to the institute.

Senator BOYCE: It is not an AIHW measure?

Mr Kalisch: The AIHW is impacted slightly by that cross portfolio measure, to the extent that you see the 15, 52, 52 up the top. But there are other agencies also affected by that cross portfolio measure, and perhaps Ms Halton is best placed to answer that.

Senator BOYCE: Perhaps you could explain that to me?

Ms Halton: Essentially that is the effect on each of the agencies of the administrative efficiency measures. This one is in respect of the—

Senator BOYCE: So that has an effect on ARPANSA, not on AIHW?

Ms Halton: Correct. This is the effect on the back office, if I can put it that way, of the move to streamline administration and shared services. This is the agency-by-agency effect.

Senator BOYCE: Why does it appear under the Institute of Health and Welfare 2011-12 budget measures?

Mr Kalisch: I suspect it probably appears in every agency.

Ms Halton: It does.

Senator BOYCE: Thank you. That clears up that one. With respect to staffing levels, you anticipate losing about 40 staff, is that correct?

Mr Kalisch: That was what was in the portfolio budget statement. That was based on what we knew at the time certainly of the change to our appropriation funding and the COAG funding, but also on the basis of an estimate of our external funding. As you are aware, the institute has, over a number of years, received considerable funds through external funding, aside from our appropriation. That number of 35 FTEs was based on a very conservative estimate of our external revenue at that stage. I am happy to report that over recent weeks our position has been looking much better, and our external funding is going to be greater than we expected. So we are looking at a very modest reduction in staffing on the basis of what we know to be our agreed external funding for coming years.

Senator BOYCE: This is contracts that you have put in place recently? Are you able to tell us about them?

Mr Kalisch: That is contracts that we have bid for and been successful for, and there are a number of others that are also looking promising and others that are still to be decided. What I could get you on notice is an indication of our external funding contracts that have been successful and signed at a point in time.

Senator BOYCE: Okay, that would be good. Thank you. That would be an excellent start. Getting our definitions consistent has been an ongoing issue in this area. Do you at the institute have a definition of a hospital bed?

Mr Kalisch: I am sure we do have a definition of a hospital bed in our national minimum datasets.

Senator BOYCE: Would you be able to provide that?

Mr Kalisch: We could certainly provide that to you.

Senator BOYCE: Could you explain to me why, during a recent inquiry of this committee into the performance authority, when I asked the department that, they said they were not 100 per cent sure yet, (a) what a hospital was, or (b) what a hospital bed was?

Mr Kalisch: We certainly define a hospital as well, and we count the number of hospitals on the basis of that definition.

Senator BOYCE: You may not be able to answer this; it may be a rhetorical question. Why on earth would not the Department of Health and Ageing be using these definitions in developing the criteria and the KPIs for the performance authority?

Ms Halton: Because the counting rules used by a statistical organisation—particularly one that tries to align its counting with, in some cases, international standards—do not necessarily apply to the way you administer a system. What we define as a hospital, and what we define as a hospital bed, is informed by practice. In fact, if you look across the states and territories, it is not necessarily standard. A number of things impact on how we define and therefore fund, and what we say is and is not in and outside a hospital, which are not necessarily the same as what the counting rules are for statistical purposes.

Senator BOYCE: How will we ever end up with some sort of system which allows us to compare and contrast performance if we cannot have a system whereby our senior statistical gatherer in the area, the institute, and the department are not using the same definitions?

Ms Halton: That is a matter that needs to be resolved, which is why they did not answer the question at the time. At the end of the day, there is a longstanding practice in this country—and it goes back as long as I can remember—whereby just because there are international counting rules, it does not mean that they have applied to the administration of our health system.

Senator BOYCE: I realise that, but I would have thought that we were moving somewhat closer to standardising those definitions.

Ms Halton: Indeed. It is our fervent hope to have a standard national definition, our absolutely fervent hope. As to whether we can get the same definition as applies internationally, it is a bit like the conversation we just had about the issues around the charitable sector: there are degrees of difficulty.

Senator BOYCE: Yes. We will leave that one. Going on to yet other degrees of difficulty, does the work you are doing in e-health relate to international health classifications?

Mr Kalisch: The institute is working with a number of agencies that are looking to progress e-health. One of the main areas, I suppose, where we are looking to play a role is around making sure that clear standards are used for counting of information, and that information that comes out of the e-health arrangements available for data and statistical purposes and for research purposes so we do have a continuity of series.

Senator BOYCE: I start to get a bit of a head twirl going on when I start thinking about the idea of personally controlled electronic health records and standardised information. Could you explain how that will happen?

Mr Kalisch: I suppose it comes to the way in which the data is recorded. It is not so much the personally controlled aspect but the way in which the data is entered by those that enter the data, just to make sure they apply consistent standards.

Senator BOYCE: But individuals will be able to enter data?

Mr Kalisch: As I understand it, individuals will be able to enter some information, but I would hope that a lot of the clinical data would actually be entered by the clinicians.

Senator BOYCE: Okay. Are we hoping that every GP in Australia will standardise the way they enter information into the record?

Ms Halton: Perhaps that is a question better addressed to the department. One of the reasons why a good number of years ago Australia was one of the small number of jurisdictions that decided to buy out the College of American Pathologists on SNOMED is precisely so we do have a standard nomenclature. That is why we took that action, with that small number of countries. We said that, if we are going to have an electronic health world, we need, preferably, to have global alignment, because of the problems we have just discussed about even the counting rules around what is a hospital bed. That is exactly why we did that: so we could actually have a system that we think will be good for clinicians to use but that will also get around the rail gauge problem. In anticipation, that is exactly why we did

what we did. It is interesting, because the number of countries that have now come into that arrangement is expanding on a very regular basis.

Senator BOYCE: But we will not have any sense of how successful we have been there for 12 months or two years; is that correct?

Ms Halton: The people who can answer these questions are not actually here yet.

Senator BOYCE: I will ask these later on.

Ms Halton: The jurisdictions are starting to adopt these standards, which I think is terrific.

Senator BOYCE: Mr Kalisch, I asked a number of questions last estimates, most of them on notice, around the topic of unmet need. The answer was that we had not really gotten very good at measuring unmet need. Numerous approaches were taken to it. You are going to be continuing your work on data validation processes in homelessness. Can you tell me about how that will work? I presume that there will be a need to have some sense of unmet need.

Mr Kalisch: Perhaps I can go back to the broader issue of unmet need, because, as we explained in our response to the question on notice, there are a number of ways in which it could be approached. Probably one of the aspects that has actually been a recent development, of which I am sure you will be quite glad, is that the institute will be doing a bit more work with the jurisdictions around the definition of unmet need. We will be doing some work with the jurisdictions around remodelling the national minimum—

Senator BOYCE: The jurisdictions being the states and territories?

Mr Kalisch: Yes, and also the Commonwealth, which is involved in this—around remodelling the national minimum dataset for disability services.

Senator BOYCE: That was going to be my next area of questions.

Mr Kalisch: At the moment it is very much a collection based on the service providers, and it will be moving towards a collection that is more based on individuals. So it is better able to collect information that is relevant to the issue of unmet demand—unmet need. It really goes to the standards issue that we were raising just earlier around the need to have a better definition. In fact, we have just received a request from the Disability Policy and Research Working Group, which is a cross-government group working in the disability area, asking us to start some work on a common conceptual framework and applying and interpreting need and demand related definitions to ensure consistency across the range of data collections. That is a piece of work that we will have underway that is looking at that aspect quite clearly. We are also assisting the Commonwealth and states and territories in the work that PricewaterhouseCoopers is continuing to do on that aspect of unmet demand and unmet need. As I understand it, that is also feeding into work around the National Disability Insurance Scheme proposal. That is being used for some of the costings and other work in that area.

Senator BOYCE: You are intending to extend your data validation processes into the area of homelessness. Can you explain when you will do that and what it will involve?

Mr Kalisch: It will take place from 1 July. The data validator, which is a product that was developed in-house by the institute, is an online data validation check that goes to states and territories who supply us with data. In this case, homelessness services will also be used by non-government agencies, so non-government organisations, small service providers. What it

really does is provide them with I suppose a few online checks so that the data they supply is internally consistent. If there are X plus X equals not 2X but 30X, it will throw up an error message before they supply the data to us. They can go through the checks and balances internally before they supply the data to us.

Senator BOYCE: Will that be all non-government agencies, or a selection?

Mr Kalisch: It will apply to all of the homelessness services that provide us with data. It is predominately non-government agencies. That will apply to our new dataset, new data collection on homelessness services to apply from 1 July. Because of the way in which this can help speed up data supply and also improve the accuracy of data that comes to the institute and therefore enables us to get data out to providers and to the broader community much quicker, and also in a more reliable fashion, we are looking to apply it to other datasets across the institute's broad range of collection. As you would understand, doing some of these system changes does take time and some money, and we want to do this in a progressive way, looking at the collections where we think we will get the major gain in that area first.

Senator BOYCE: Are you responsible for compensating the non-government agencies for supplying this information, or are they just supposed to do it anyway?

Mr Kalisch: I think they do it probably on the basis of the contracts that they have with governments around providing the services.

Senator BOYCE: Although this provision is new, is it not?

Mr Kalisch: This will be a new collection, but it replaces a previous collection. It replaces a SAP collection that is currently in existence, and generally most non-government organisations who receive funding to provide services have, as part of those contracts, requirements to deliver data. Within that context, we are trying to make that as easy as possible, to make it as automated as possible. As part of that, the housing ministers advisory council has contracted us to work with an organisation called Infoxchange, who are based in Melbourne, to provide a client management system that will also enable them to better manage the clients, and have good case notes and good forwarding arrangements and a better way of their managing their own workload, as well as then delivering us the data.

Senator BOYCE: Moving on to the redevelopment of the NMDS, you said that you are looking at collecting data around individuals. How do you propose to do that? What is the current scope of the redevelopment? I suppose that would be a good place to start.

Mr Kalisch: The current scope is really changing the collection quite fundamentally, from one that is based on reporting on service providers to reporting on people receiving services. The homelessness analogy is quite a good one. We were receiving information from agencies that are providing services, but they will be providing us with information on individuals that are receiving the service rather than the agency themselves. It really is focusing the attention more onto the individual: some of their needs, what they are receiving, where they might be receiving multiple services as well. We envisage we will have a unique individual identifier, so where people are receiving—

Senator BOYCE: So service providers will still be providing this information?

Mr Kalisch: Yes. Where people are receiving information from multiple service providers, we will look to receive that in an efficient manner.

Senator BOYCE: Thank you.

Senator ADAMS: How much is allocated this year and in the out years to the AIHW for specific work on rural and remote health, and what steps has the department taken to ensure that all recurrent health expenditures can be analysed by remoteness?

Mr Kalisch: There are probably two aspects related to that question. One was in terms of the questions on notice from last time, where you asked about whether we could disentangle the amount of information or the expenditure that we used on delivering information on rural and remote aspects. In our response, I think we talked about a number of specific bulletins and research reports that we produce which had a rural and remote focus. Generally most of our bulletins, most of our reports, do have a regional and remote dimension to them in terms of reporting some information by those geographical classifications. It is difficult for us but we could, if you were to insist, do a very rough calculation on how much we would probably spend on reporting information by rural and remote, but it would not be a very reliable indicator of the actual amount we do spend. We do take it into account in our reports. We provide information, for example, on homelessness services, on drug and alcohol services, on people with disabilities receiving services and on health services that are provided by regional and remote classification. Probably the other thing—and I am not sure if you are aware of it—is that further work is under way at the moment across the national statistical service looking at a new classification of remoteness, which is looking at the ability of agencies such as ourselves and the ABS, where there are sufficient numbers of individuals in our collections, to report at a lower level of disaggregation, so at smaller levels.

Senator ADAMS: When will that happen?

Mr Kalisch: Work is underway at the moment. I think it is an ongoing task, but hopefully within the next year things will be bedded down in terms of that new classification. I can clarify that timing for you.

Senator ADAMS: Would you take on notice the amount that has been spent, even if it is roughly? It just gives me an idea to work off.

Mr Kalisch: I warn you that it will be pretty rough.

Senator ADAMS: Okay. The National Rural Health Alliance has estimated that there is a \$2.1 billion a year underspend on Medicare for PBS and non-PBS drugs and dental and allied health services in regional, remote and very remote areas, and this is based on the 2005-06 data in your report entitled *Australian health expenditure by remoteness: a comparison of remote, regional and city health expenditure*, released earlier this year. What data can the department provide to show improvement in access to health care for rural and remote Australians since that time? Do you have any more recent data than the 2005-06, which is a long time ago now?

Mr Kalisch: We will be releasing 2009-10 information on expenditure later this year. That project was a specific task that the National Rural Health Alliance contracted us to do. It was some special work that we would not otherwise have done within our existing funding. I am not aware that we have it on our work program to do any further work on that.

Senator ADAMS: 'Later this year'—will you have that report prepared by the October estimates?

Mr Kalisch: No. That will report at a fairly high level in terms of health expenditure across the country. As I envisage it, we will not be able to get into that level of disaggregation and detail that we were able to do with that specific contract. We do not envisage repeating that work unless someone will fund us to do it.

Senator ADAMS: Thank you.

Senator BOYCE: Referring back to your staffing levels, and you have told us that hopefully they will not drop, will there be any change at all in the staffing levels in your COAG groups?

Mr Kalisch: There is a bit of extra money this year and next year for the closing the data gaps work, so we will be staffing up those aspects. Probably one of the things that I should explain is that, while overall the institute staffing will not change all that much, there will be some shifts of staff working in different areas. We certainly expect that our Indigenous group is one of those that will grow over the coming year.

Senator BOYCE: Are you able to give us figures?

Mr Kalisch: Not at the moment, but I should be able to provide it on notice.

Senator BOYCE: That would be good; thank you very much. Just related to that, mention was made at a recent conference that I attended that there is no accepted definition to measure child neglect. Is your Indigenous area working on this issue at all?

Mr Kalisch: We do report on other child protection services more broadly, so it is not just an issue related to Aboriginal and Torres Strait Islanders.

Senator BOYCE: Sorry, this was at an Indigenous conference.

Mr Kalisch: We do actually have a collection that looks at providing information on out-of-home care and various other child protection services. I can provide you with some further information on that.

Senator BOYCE: The basic point being made was that, in some circumstances, general conditions may be so poor that what would be perceived as child neglect elsewhere may be seen as the norm in particular areas. It is therefore very subjective, and, without a set standard to measure child neglect, it may go unnoticed and unreported.

Mr Kalisch: I would have thought that we would have a clear standard that we would expect to have for reporting across the country, because, as in most other areas of our collections, we do have some clear definitions and standards, so that we expect to receive data from states and territory authorities in a consistent manner. I can provide you with some further information.

Senator BOYCE: If you could give me whatever you have there, that would be good. Thank you.

CHAIR: Any other questions of AIHW? If not, thank you Mr Kalisch.

[11:59]

CHAIR: We will now move to Outcome 11—Mental Health.

CHAIR: Welcome to the officers from Outcome 11.

Senator FIERRAVANTI-WELLS: On 13 April, did Minister Butler or Minister Roxon meet with Professor Pat McGorry, Professor Ian Hickie and the Prime Minister?

Ms Halton: We cannot answer that question. We are not responsible for the minister's diary.

Senator FIERRAVANTI-WELLS: Could you take that on notice as to whether there was a meeting with Professor McGorry and Professor Hickie on that day?

CHAIR: It is not a departmental issue. That would have to go to the minister direct.

Senator FIERRAVANTI-WELLS: Senator McLucas, could you kindly take that on notice? When I was in estimates with PM&C, they seemed to think that there had been a meeting but they were not sure of the date. If you could clarify that, that would be good.

Senator McLucas: I will ask both ministers if they want to answer the question.

Senator FIERRAVANTI-WELLS: If they want to answer the question?

Senator McLucas: Who people meet with is not necessarily related to the budget information.

Senator FIERRAVANTI-WELLS: I would have thought there would have been some connection.

Senator McLucas: I will ask both ministers if they want to respond.

Senator FIERRAVANTI-WELLS: Going back to the question about finances that we talked about earlier, Ms Halton, you said it was best left to the program. Can you or your financial officers help me out in relation to funding with the range of 2006-11 COAG measures that are due to end on 30 June? As part of this budget process, did you go through the process of looking at those programs? I could take you through each program, and I will if that will be necessary, but I wanted first to globally ask, in relation to those programs: did you assess which of them had program objectives that had not been met or program funding that had not been used? Was that part of the process?

Ms Harman: I will pass you to my colleague, Ms Hart, but just make an opening statement about the fact that all of those measures are ongoing. I believe that most of them have been subject to some kind of program review or process of looking at whether or not the program has been performing. We report regularly the progress against each measure, as you know, under the COAG progress reports. I will hand over to Ms Hart to take you through the detail.

Ms Hart: Just to add to what my colleague, Ms Harman, said, we have two ways that we evaluate and track the progress and performance of the COAG mental health measures as part of the National Action Plan. One you might be familiar with is that we provide for the measures that are administered within our department, within DOHA, roughly monthly progress reports which are on our website. The other main way we have of assessing the performance and tracking the achievements of the measures under that package is through annual progress reports which Ms Harman mentioned are provided to COAG on an annual basis, as they are cleared and endorsed by the RMAC, health ministers and COAG committee structure. If you like though I could take you through the measures and indicate where various evaluations are up to for each measure?

Senator FIERRAVANTI-WELLS: Yes, because in relation to those progress reports, the latest one available is September 2009, and that plots progress from 2007-08. Is that the case, Ms Hart? I would assume that others are in the pipeline but they have not been released yet?

Ms Hart: As you would appreciate, because the progress report relates to performance in a financial year, and the information that is provided is not just against a range of KPIs that are set out in the COAG framework, but also about expenditure under the program, there is a time lag between the end of the financial year and the validation, checking and then endorsement of the reports. That is the time lag to which you refer. We currently have two COAG reports on the site, and the third report which covers the period 2008-09 was completed in April 2010, was endorsed by health ministers on 23 May, and it is currently awaiting endorsement by COAG for publication.

Senator FIERRAVANTI-WELLS: If you look at those progress reports, the first report was dated February 2008. Subsequently an assessment of it was done in the *Medical Journal of Australia* in February 2009 by Professor Mendoza, Dr Rosenberg and Professor Hickie, of which you are probably aware, but I have a relatively unmarked copy here for your information. The gist of it was that only about 4.6 per cent of that money that had been allocated had actually been spent.

Ms Hart: That was the first year of the initiative—

Senator FIERRAVANTI-WELLS: I appreciate that. When you look at the next one which came out in September 2009, and I am only having a cursory look at the numbers from a Commonwealth perspective, it just looks like only about 40 per cent of the money has been spent, although there had been things in and things out. I do not criticise; I am just simply looking at it from that perspective. We then stop there, so it is very difficult to work out from that point on how much of that money had been spent. I am conscious that it was a \$1.9 billion COAG announcement, and correct me if I am wrong, of which health had about \$1.1 billion of it; is that roughly correct?

Ms Hart: I think that is roughly right.

Senator FIERRAVANTI-WELLS: My comments in relation to COAG obviously are insofar as DOHA had responsibility for the spending of that money. I am now trying to work out through the documents, and looking at some of the progress reports, how much of that money has actually been spent, bearing in mind it is 30 June, and most of those programs come to an end and some ended last year if I am not mistaken. Is it easier for you to take me through each of those programs? Is that the best way of doing it?

Ms Hart: What I was referring to before is I have detail with me of the programs that are administered in DOHA and where the evaluation is. As my colleague mentioned, funding for all the measures is ongoing. The most recently available amalgamated information which I think is what you are seeking will be in the third COAG progress report, which is shortly to go to COAG, which rounds up both Commonwealth and state spending. Because it is a very large number of measures, some 17 initiatives, I do not have information with me about expenditure under each of the programs at the moment.

Senator FIERRAVANTI-WELLS: Given what the minister announced recently, and much fanfare was made in relation to alleged spending of new money, I would have thought that that is the sort of detail that you would have at the moment. I would assume that this process of moneys in mental health would have been foremost in the minds of this section of the department in recent times.

Ms Hart: We do monitor that very closely, and one of the purposes of the annual reports is so that the community can see exactly where spending against original commitments is up to.

I can say in broad terms that in fact the projected expenditure, which will be made public in the third progress report, will exceed the original commitments. I simply do not happen to have across all 17 initiatives account of expenditure to date with me.

Senator FIERRAVANTI-WELLS: Predominately as a consequence of the better access spending that exceeded far beyond \$538 million?

Ms Hart: That is a large contributor to outlays at the Commonwealth level, that is true.

Senator FIERRAVANTI-WELLS: That report is only going to go to the end of 2009, so what happens from then?

Ms Hart: That is right. They are done annually, so there are two subsequent reports to come out, 2009-10, and 2010-11.

Senator FIERRAVANTI-WELLS: But they are nowhere on the horizon?

Ms Hart: We are in the process of putting together the next one, so that will be the fourth one, 2009-10. As you would imagine, it is a very large exercise that requires us to compile information from all jurisdictions and across a large number of Commonwealth programs. It covers the 2009-10 period as I mentioned. It is going to our mental health information strategy subcommittee which sits under the RMAC group, the mental health standing committee, on 2 and 3 June for clearance. It then goes through a process of clearance by the mental health standing committee, AHMAC and health ministers and on to COAG. So it is in preparation. That is a lengthy process of compiling, validation and putting it into a suitable report.

Senator FIERRAVANTI-WELLS: All right. If I look at the 2006-07 budget at a glance, and look at the various correspondence at that time, there were 18 measures all up, of which DOHA has involvement in 14 of them, I think you said?

Ms Hart: Twelve, I think.

Senator FIERRAVANTI-WELLS: Sorry, 12.

Ms Hart: Yes, 12 fall to us and the others are either FaHCSIA or Education.

Senator FIERRAVANTI-WELLS: Let us take, for example, the early intervention services for parents, children and young people. That ends on 30 June. Initially the spend was \$28 million allocated over five years.

Ms Hart: That program is ongoing. As I mentioned before, the measures have ongoing funding. It has also been provided with some additional funding beyond the \$28.1 million that was the original allocation in the package.

Senator FIERRAVANTI-WELLS: I have a lot of difficulty in mental health because it is all in one, and it is very difficult to follow the program spending in this area. I am forced to try to do it in this way, but I have had a lot of difficulty. I would assume that you would be able to prepare a schedule for me that looks at COAG 2006-11, what ends on 30 June and what is then continued on in another format? I notice that there are program name changes and there are obviously changes, but can you do that for me?

Ms Harman: We would be happy to take that on notice. My colleague, Ms Krestensen, can actually talk about the specific measure that you have just mentioned, including the injection of additional funds, which we are happy to do now. But we can certainly—

CHAIR: Ms Harman, you can produce a document for the committee that actually has a format of any program in the original COAG package that is in date?

Ms Harman: Yes, we can.

CHAIR: That is the question, is it not, Senator?

Senator FIERRAVANTI-WELLS: It is.

CHAIR: The original COAG commitment for programs that are ending at the end of the five years, and the format of what will be going into the next period; is that right?

Senator FIERRAVANTI-WELLS: That is right. My point in relation to funding is whether the original funding was utilised in full? I appreciate that, as at 30 June, the program ends and if you are going to continue with the program, then you will allocate other moneys towards it. It is just that when you look at the—

Ms Halton: I think we should make a distinction here between the ending of programs and programs that are ongoing. The fact that these programs were first announced in the 2006 context—

Senator FIERRAVANTI-WELLS: The funding ends.

Ms Halton: It does not actually end; it is continuing.

Senator FIERRAVANTI-WELLS: That is what it says. When you look at the 2006-07 budget papers, and you look at the sheets in relation to each of those programs, it says categorically, 'When will the initiative conclude?' It says, 'Initial funding will be provided over five years to June 2011.'

Ms Halton: Let us make a distinction here between the program where there was an appropriation made, and remembering that they always said that these would be assessed, so the appropriation was made for that period.

Senator FIERRAVANTI-WELLS: I am not saying that, Ms Halton. I just wanted to understand what happens after 30 June. For example, funding for the new early intervention services for parents, children and young people initiative ends on 30 June.

Ms Halton: No, it does not.

Senator FIERRAVANTI-WELLS: No, no, but I am asking are you going to continue the program in exactly the same vein, or is it a new iteration? Do you see what I am getting at? A new iteration with a different funding stream, or are you going to continue it as it is?

Ms Krestensen: The early intervention measure sits within the child and youth mental health area of my branch. I understand the confusion. The early intervention measure has really evolved to fund what we call the KidsMatter suite of activities, and funding for that does continue over the next five years, from 2009-10 to 2013-14, with an allocation of \$51.6 million under the original measure of the early intervention measure, which was part of the COAG package. Funding has been supplemented through the taking action package last year, which provided specific funding for KidsMatter expansion. This affects expanding the KidsMatter primary school program. That offered an additional \$18.4 million over the four-

year period. So that will supplement and be a separately accountable program which will also support and supplement the expansion of the primary school programs.

Senator FIERRAVANTI-WELLS: In the same vein as I did with the GP superclinics, I will send you a table and I would appreciate it if you could fill it in. Ms Halton, it will make it easier if I just do it that way and send you a table like we did with the GP superclinics, and if you can fill in the spaces so that we do not spend time across the table talking about what has come in and what has gone out.

CHAIR: So you have developed your own table?

Senator FIERRAVANTI-WELLS: I have. The GP superclinics table has been very successful. It has been backwards and forwards three or four times.

CHAIR: You will put that on notice, and then you will send the table?

Senator FIERRAVANTI-WELLS: Yes, I will.

CHAIR: Do you have any other specific program areas that we can follow up?

Senator FIERRAVANTI-WELLS: We are. Can I look at some of the implementation issues? It worries me that implementation has been a bit of a problem here. Let us look at last year's budget paper in relation to 2010-11, and I am looking specifically at pages 234 and 235.

CHAIR: This is the 2010 budget?

Senator FIERRAVANTI-WELLS: Yes, it is.

CHAIR: Does anyone in the department have a copy of last year's budget? Just so we are working on the same tables.

Ms Halton: Yes, I have 2010-11. What are you reading from, Senator?

Senator FIERRAVANTI-WELLS: From the departmental—

Ms Halton: I do not have that for last year.

Senator FIERRAVANTI-WELLS: It is a general question. Basically, moneys were set aside of \$25.1 million under the heading of Expanding the Early Psychosis Prevention and Intervention Centre Model. How much of that money has actually been spent?

Ms Harman: We are just trying to find the right piece of paper. To date, \$100,000 has been expended from that allocation, and that is part of the first payment under a larger contract with Orygen Youth Health to provide assistance in advising the department on the rollout of that measure. Obviously in the 2011-12 budget context, the government has made a significant commitment to expand the funding that it will invest in youth centres.

Senator FIERRAVANTI-WELLS: Have you had a conversation with the states and territories about shared funding arrangements?

Ms Harman: Yes, we have, in the context of the 2010-11 budget measure, and those have been informal negotiations at this stage, but there has been strong interest from states and territories in partnering with the Commonwealth on the EPPIC rollout.

Senator FIERRAVANTI-WELLS: Notwithstanding last year's measure, nothing happened effectively on it except for paying Professor McGorry's organisation \$100,000?

Ms Harman: We have been doing a lot of groundwork in terms of planning the rollout of the measure, and obviously now with the significant new injection of funds through this latest budget, we are ready to move very quickly to start those formal negotiations with states.

Senator FIERRAVANTI-WELLS: If you have spoken to Professor McGorry, you will know that the Parkville EPPIC costs around \$13 million a year. Even with one-on-one funding with the states, it just means one extra centre. How will that work?

Ms Harman: We have costed the measure on an increased cost per site from the 2010-11 budget measure of \$10 million per year in operational costs. That was actually based on a costing that was provided to the government by Professor McGorry. That is based on a 50-50 cost share arrangement with states and territories. We believe that \$10 million is adequate for a functioning EPPIC.

Senator FIERRAVANTI-WELLS: I do not have the page in front of me, but in this year's budget, as I understand it, you are still claiming that you will get four plus another 12 from the \$220 million in this year's budget announcements. Even if you do not allow for annual growth in costs over five years, and assuming the 12 centres operate in July 2015, and one on line every quarter and coming on line by 2016, are you not going to require substantially more than what you have budgeted for, almost \$1 million a year alone?

Ms Harman: As I said, we have costed this measure on the basis of Professor McGorry's own costings. In terms of implementation, there will be a staged approach to implementation, with basically two tranches of EPPICs coming on line, the first eight centres commencing planning in year 1, reaching full capacity in year 4, and the second tranche of centres starting development in year 2 and reaching full capacity in year 5. It is a staged implementation approach to take into account the planning that needs to go into places, and the strong connections that need to be made with the state systems.

Senator FIERRAVANTI-WELLS: You do not see any shortfall at all over the forward estimates?

Ms Harman: As I said, this has been costed on the basis of Professor McGorry's own costings, based on the services that an EPPIC model provides.

Senator FIERRAVANTI-WELLS: What about in last year's budget the flexible care packages to patients with severe mental illness? There was \$58.5 million there. Have you spent anything in relation to that? Have you not spent that money either? Can you assist me there?

Ms Krestensen: We have sought and received a proposal. The first phase of that project in this year, as the minister announced in the press release on 1 April, will be focusing on laying the groundwork and developing clinical governance arrangements and guidelines, quality assurance and that sort of thing. We have sought and are considering two proposals: one from the AGPN, the Australian General Practice Network, and one from the Australian Psychological Society for developing infrastructure and advice on the approach and the groundwork to guide the way that that measure will go forward. We are currently considering those proposals. Funding has not been outlaid yet on those proposals.

Senator FIERRAVANTI-WELLS: Apart from a small amount, you have not spent any of that money?

Ms Krestensen: No. The only other expenditure would have been the cost of consultation processes which took place earlier on this calendar year.

Senator FIERRAVANTI-WELLS: Let us go to the subacute beds. They were part of the announcement last year. Where are we at with the subacute beds? Have any of those come on line?

Ms Harman: That is a question for Outcome 13.

Senator FIERRAVANTI-WELLS: What about the headline, 'Funding announcement for one-stop shop care coordination and flexible funding for people with severe and persistent mental illness'? How will that work? That comes into this year's figures.

Ms Harman: That is a measure that provides \$333.8 million over the next five years, and over the forward estimates period, \$196.8 million. The measure will provide support to around 24,000 people with severe and persistent mental illness and complex care needs.

Senator FIERRAVANTI-WELLS: I will come to that. There is no money rolled over from last year in relation to that program?

Ms Harman: We are rolling the flexible care packages funding from 2012-13 into the severe coordination, the new measure, from 2012-13.

Senator FIERRAVANTI-WELLS: Sorry, my notes were in the wrong place. What has happened with the mental health nurse initiative program? This was one of those very good programs out of the 2006 budget. The original estimate for five years was \$191 million. I understand in the first budget of this government, under Mr Rudd, the program was cut to just under \$50 million. What has happened to that \$191 million?

Ms Harman: Unfortunately I am not able to answer that question. That is actually a measure that is part of the health workforce outcome.

Senator FIERRAVANTI-WELLS: It was not in 2006. It came under your umbrella then.

Ms Harman: The officers who manage that program are not currently here.

Senator FIERRAVANTI-WELLS: Sorry, it is under Outcome 12?

Ms Harman: My understanding is that that program is going very well and has strong growth. As I said, if you could direct specific questions under Outcome 12.

Senator FIERRAVANTI-WELLS: What also happened to the improved services initiative? I think there was \$70 million over five years in 2006. Was that money spent?

Ms Harman: I am really sorry to do this, but that is actually an Outcome 1 issue, on which I would be happy to take questions under that outcome tomorrow.

CHAIR: Ms Harman, it may be useful in terms of clarity—because I understand why they fall into other parts of the department, because it is a service delivery issue, if we could get a graphic that you design, not Senator Fierravanti-Wells—if we could have mental health and then the streams of these things that come out. It is clear that it comes into other areas.

Senator FIERRAVANTI-WELLS: Putting it all under one umbrella, it just goes round and round in circles. Maybe this is deliberately done, but it is very difficult to follow programs because it is all under one outcome.

Senator BOYCE: It is not all under one outcome.

CHAIR: My understanding is that this is a longstanding division of labour within the department. It goes back maybe as long as you, Ms Halton, but I am not sure, in terms of process. There is nothing new in the way that it works. If we could get that from you, Ms Harman? It is not on your website in terms of which part of the department looks after things that come under mental health. It would help us so that when we are preparing, we would know where to ask the questions.

Ms Harman: Of course. I think we have actually pretty much covered the ones that do not fit under our governance, to be honest. But yes, we will do that mud map.

Senator FIERRAVANTI-WELLS: Okay. Let us go to suicide prevention.

CHAIR: It is now half past 12, and I would imagine suicide prevention will be a significant area of questioning. We will stop for the lunch break until 1.30 pm and then we will come back with that area, moving straight into that. Thank you to the officers.

Committee suspended from 12:31 to 13:31

CHAIR: We will go back into questions in outcome 11—Mental health. This session is due to go through until 3.30 pm. Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS: We were talking before the break about moneys in the previous budget that have not been spent, and I wanted to talk about suicide prevention. Where are we at with the \$277 million package that was announced at the last federal election and how much of that money has been spent?

Ms Harman: Implementation of those measures is progressing well. From memory, seven of the 15 measures commenced this financial year. There is about \$9.5 million that was allocated for expenditure this financial year—and, as I said, implementation of those measures is progressing well. I will hand over to my colleague, Ms Krestensen, to talk you through the detail of that in a second. The remaining eight measures come on line this financial year. I think it is important, though, to note that, at this stage, three of the 15 measures have been rolled into the new 2011-12 budget package. They are the nationally consistent reporting measure and the annual report card on mental health and suicide prevention. That was announced originally at \$9 million over three years, starting in 2011-12. That money, over the forward estimates period and over the five-year period of the new budget package, will be rolled into the budget package and will be redirected to the new National Mental Health Commission, which will have responsibility for implementing that measure. The first of those reports is due in 2012.

The other two initiatives that will be incorporated are the non-clinical services for the mentally ill and their carers measure. That was originally announced at \$60 million over three years to 2013-14. That funding will be rolled into the new severe coordination and flexible funding for people with severe and persistent mental illness and complex care needs, so that we do not end up with lots of different buckets of money trying to achieve similar aims. So that is being consolidated in that new \$343.8 million.

Senator FIERRAVANTI-WELLS: It appears that the package was drawn up in response to the Senate inquiry on suicide. The timing was very much that; was that the case, that the package was in response to that?

Ms Harman: The government obviously took into account the findings and the recommendations of the Senate inquiry.

Senator FIERRAVANTI-WELLS: But it looks like in the last financial year you only spent \$10 million; is that correct?

Ms Harman: The allocation for this financial year, for the 2010-11 year, for that package amounted to \$9.5 million. As I say, we will hand over to Ms Krestensen to talk you through the detail of that. I just needed to point out that there are a number of measures that will not actually proceed as originally announced because they have been rolled into the new package.

Senator FIERRAVANTI-WELLS: I have noticed that there are bits and pieces that have been funded with what was the suicide money, in effect.

Ms Harman: There are three components that are being redirected into the new package.

Senator FIERRAVANTI-WELLS: Are we only talking about \$10 million of it that actually was spent?

Ms Harman: As I said, there was only an allocation of \$9.5 million for this financial year to start with.

Senator FIERRAVANTI-WELLS: At the last estimates, we talked about implementation costs for a lot of the measures that were part of that \$277 million. I will not go through it again, but the evidence from the last estimates was that there were no implementation costs. The money was there for the program, but the implementation of it would be absorbed into the department's ongoing expenses.

Ms Harman: That is correct. From memory, the secretary gave evidence of the fact that, whilst we did not receive any new departmental funding for implementation, we obviously treated this as an absolute priority; and, through our ongoing process of business improvement and creating efficiencies within the portfolio, we have obviously dedicated some resources to implementation of this package.

Senator FIERRAVANTI-WELLS: So, the bulk of that suicide money is now rolled over into the new package?

Ms Harman: Not the bulk of it. As I said, three out of those 15 measures will be.

Senator FIERRAVANTI-WELLS: Money-wise?

Ms Harman: In terms of money, if I talk about the five-year period of the 2011-12 budget package, the first redirection is to the National Mental Health Commission, and that will be for the national mental health report card. The total amount to be redirected to the commission over the forward estimates period is \$9.5 million. Over the five-year period of the new budget package, \$12.5 million will be redirected to the commission.

Senator FIERRAVANTI-WELLS: The rest of it, you say, stays in suicide?

Ms Harman: The rest of it—\$2.5 million, I think, from memory—will remain with DoHA in the coming financial year so that we can lay the groundwork to hand that project over to the commission so they can then devise the report card and publish it.

Senator FIERRAVANTI-WELLS: So the bulk of the \$277 million that was announced is just going to be—taking out these few bits and pieces that you have told me about—rolled over?

Ms Harman: That is exactly right. Those three elements will be redirected into the new measures, but the majority of it will continue as announced—and, as I said, implementation is

progressing well with those measures. We can talk you through the detail of that if that is useful.

Senator FIERRAVANTI-WELLS: I will put some detailed questions on notice in relation to it. I was interested in it because it seemed that you announced it at the election and then nothing seemed to happen and there was only a very small amount of money. I will put some detailed questions on notice.

Ms Harman: If I can just reiterate, there was \$9.5 million allocated for the 2010-11 year. The rest of the money, obviously, then was—

Senator FIERRAVANTI-WELLS: Was the rest of the money in the out years?

Ms Harman: We have made very, very good implementation progress in terms of implementing those measures that were due.

Senator FIERRAVANTI-WELLS: I might move now to the various measures in this year's budget. For other senators who may have questions, I thought I would progress through the measures starting with Better Access and hopefully as they appear in Budget Paper No. 2. I hope I do not get out of sync. I will start at page 228 of Budget Paper No. 2. I find that is a bit easier to read than the yellow book. In terms of the big picture, in 2006 when the \$1.9 billion announcement was made by the Howard government, the documentation talked about targeting people with mental illness. There was no distinction made between mild, moderate or severe; the money was set aside for 'mental illness'. What seems to be happening here—and correct me if I am wrong—is that we now seem to be shifting focus in terms of a distinction between mild and moderate and advanced and severe. Is that a deliberate shift in terms of how programs are being funded?

Ms Harman: What the government has done through its new budget package is to say that it is very keen on addressing the system's gaps that exist currently. We know from various sources, including, obviously, direct feedback from consumers themselves and the people who care for them, that the people in that severe, complex, persistent illness group are particularly disadvantaged and continue to miss out on services and fall through gaps, which is obviously why the government is expending \$343.8 million over the next five years in that new severe coordinated measure. The government has clearly made some decisions around where it wants to invest in the future, and doing better for people with severe and persistent mental illness is clearly a policy priority of the government.

I will talk about my understanding of how the Better Access measure, in particular, was designed. It was designed very much as an early intervention process to treat people with common mental disorders. By definition, that does not necessarily mean less severe, because we know anxiety and depression can be very severe. The Better Access scheme was designed with a certain number of sessions of cognitive behavioural therapy or other evidence based interventions, and we know that those have clinical veracity for people with more common disorders. So that kind of intervention is not necessarily going to work for a person with a very severe form of mental illness. As I said, I think the design of the Better Access was definitely for people with common disorders.

Ms Halton: I might make a comment about this one. The process leading into that COAG agreement and the discussions with the states responded to a lot of the issues that were raised with governments about what the challenges were in mental health. A common complaint at

that particular point was, as Ms Harman has mentioned, some of those high prevalence issues and also the need for states and territories to do work on the acute end. So, essentially, the package that was agreed by COAG at that point had these two large tranches to it. The first was what the states and territories were meant to do on their services, which went to the more acute end of the system; and the second was in relation to access in the community for people with anxiety and depression. Essentially, that was the package that was agreed to, in which there was a significant Commonwealth investment, which is the one that you have referred to.

Senator FIERRAVANTI-WELLS: I cannot put my hands on the document at the moment, but, as I understood it, you were not just treating mild disorders; there were a whole list of aspects covered which did not look very mild and moderate to me.

Ms Halton: No, but let us be clear that the issue that was raised from the Commonwealth's perspective was that, through the structure of the benefits arrangements, people who needed care and assistance in the community could be assisted—particularly with anxiety and depression, which can range from mild to quite severe, as we have just acknowledged—and that that was a part of the way our health system at large did not work very well, in addition to the bits that did not work very well in respect of state and territory traditional responsibilities. So you had a number of consistent complaints, and the package that was agreed at that point was designed to respond to that broadly framed set of contentions.

You have raised the point about why is it we are now talking about specifics, about people with more severe illness and so on. The answer is, as the Better Access evaluation shows, that it is dealing quite well with a number of the objectives that it had. But, rightly, people in the community—and they are very prominent and they are very eloquent—have raised where the gaps (and I think this is the point that has just been raised) in the system remain and where the system can be improved in order to provide a better suite of services to meet that full range of needs. In some cases, that means we need to target and that is what we are doing.

Senator FIERRAVANTI-WELLS: One shift also in this budget seems to be that you are directing funding away from the fee-for-service provision by individual health professionals such as GPs, and basically prioritising instead multidisciplinary services provided by community health, the Medicare Locals and other non-government organisations which primarily will be funded through block grants. That seems to be very much a deliberate shift.

Ms Halton: Again, let us remind ourselves that, for example, the Better Access program will continue to grow. It is true that moneys are directed in this budget to a number of areas which look objectively at what has not attracted money because of the approach to financing—areas which are areas of need. The evaluation shows us that, and we all know that there are certain weak spots in the system, particularly in respect of rural and remote, Indigenous clients and so on. So, much as we have done with the broader health system, sometimes what you need to do is find an intervention that will actually focus the investment—so put an investment in an area which will not otherwise attract it if you use the existing vehicles.

Senator FIERRAVANTI-WELLS: I will take them separately but, under Better Access, there is the \$174.6 million which is now being taken out of allied health treatment services and the \$405 million that is being taken out of GP services. What I would like to do is look at some figures here. Looking at the allied health treatment sessions, you have got over 18,000

allied mental health professionals registered with Medicare; is that the case? I was looking at what I think, Ms Hart, is one of those progress reports that you referred to earlier.

Ms Hart: I have possibly the more up-to-date figure as at 30 April for the number of providers registered with Medicare to provide Better Access. That is a total of 19,400 allied mental health professionals.

Senator FIERRAVANTI-WELLS: You have probably got the number of GPs that are registered as well. Your most recent one, the February progress report, had it at 26,000.

Ms Hart: I have 27,000 as at the end of December.

Senator FIERRAVANTI-WELLS: Looking at the allied mental health professionals, mild and moderate are now only able to get six plus four sessions—before they could get six plus six plus six. So, in effect, are we going to see half the services delivered? I am trying to get a handle on the number of services that will be reduced and I just have not been able to find that. I would like your assistance because I am getting copious correspondence from affected practitioners who are giving me a lot of information and telling me about insufficient treatment and all sorts of things that are going to result from this, but I would like to hear from you if I can.

Ms Hart: Yes. I think the important point about the work that was done under the evaluation in following through a sample size of consumers and looking at how the program served them was that, when the program was devised in 2006, there was a limit put on the number of allied health services. As with most programs, over time we look at the evidence for whether or not the parameters of that program need to be modified or finessed. The evaluation was able to show us that the bulk of people who were using the allied health services under the program were using far, far fewer than the maximum limit, whether that was 12, which was the ordinary amount of services, or whether it took into account exceptional circumstances where a further six could be added on to the 12. We know that the average number of services received was five and we also know that almost three-quarters of people only needed between one and six services a year. With these changes, approximately 87 per cent—the majority of users—will be unaffected.

Senator FIERRAVANTI-WELLS: I will take you now to that evaluation. First of all, I would like to ask you some questions in relation to the tender process for the evaluation. Who sat on the panel that formulated the tender documents to undertake the Better Access evaluation?

Ms Hart: I may just need to check with some of my staff. I was not around at the time. The arrangements for tendering were formulated under the guidance of the previous first assistant secretary, Rosemary Calder, and my understanding was that that was developed over a period of several months—about a year and a half. We will have that for you before the end of the outcome, though. We will just check that.

Senator FIERRAVANTI-WELLS: I have some detailed questions and I would like to know about the tender process, so I will ask you if, before the end of the session, you can have the relevant officer assist. Who decided who would sit on the panel that would formulate the tender documents for the evaluation?

CHAIR: It would seem to me that the officer could not answer the previous question, and she may need to get further briefing on the whole thing.

Senator FIERRAVANTI-WELLS: No, she is going to. I assume somebody is listening to this.

CHAIR: Do you want to do that twice or move on to another area and then come back to this before the end of our session? It is up to you.

Ms Halton: Because this was a while ago and there has been a change in staff, I do not think we are going to be able to answer this. I think we will have to take it on notice, because we will have to dig out the files to have a look.

CHAIR: Do you want to go ahead and put them on notice in that way?

Ms Halton: Or do you want to tell us now and we will see whether we can answer them?

Senator FIERRAVANTI-WELLS: Was this also the same panel who decided which provider was awarded the contract to carry out the evaluation? I am very interested in going back to the tender process to set up this evaluation because I believe there were some deficiencies in relation to it and I would like to pursue those issues.

Ms Halton: I think we have been asked these questions at estimates before. I think, whatever the theory is around this, this has surfaced before, because we have had this set of questions before.

Senator FIERRAVANTI-WELLS: The Better Access evaluation? The documents were only—

Ms Halton: This is ringing a bell, but whether or not we have got someone who can deal with it now—

Senator FIERRAVANTI-WELLS: How much did the Better Access evaluation cost? I think it was about a million dollars; is that correct?

Ms Hart: That is correct. I think just over a million was put aside for it. I will just double-check that for you. I believe we will need to put the question about the approach to the evaluation on notice. It had a number of components and there would have been individual tender and procurement exercises for each of those components, so that is quite a lot of detail I need to find out for you.

Senator FIERRAVANTI-WELLS: In so doing, did you seek any advice in terms of best practice standards that you would need to insert into those tenders to get a proper evaluation?

Ms Hart: I guess there are two parts to your question. One is to go back to the original framework for the Better Access program evaluation and look at what the key questions were about the program, and that was to look at whether or not the program was successful in improving access for the client group we are concerned with—people with mild to moderate common disorders. There were a range of other questions that related to access by underrepresented groups—affordability and distribution of services—so the tenders were designed to address the specific components of the original evaluation framework, and then there were individual projects within those. Because it covers such a large expanse of information and data, there were individual projects conducted to address each of the areas.

Senator FIERRAVANTI-WELLS: I am also getting to that point. This is a program that spends about \$10 million a week and you spent a million dollars on an evaluation. My concern is that, for something that important—because ultimately you have used it to take almost \$600 million out of the particular program—for a million dollars, looking at the big

picture and given what you have spent, potentially, on other comparable evaluations, it does not seem to be a very adequate framework for doing an evaluation that has now led to this particular set of decisions.

Ms Hart: Could I just correct my earlier answer? One of the officers has just pointed out that we had a budget expenditure of \$1.98 million, GST inclusive, so it was closer to \$2 million. I think the other issue you are raising, though, is about the comprehensiveness of the evaluation, and so that was the budget. But the design of the evaluation was done with extensive consideration of the original policy parameters around the design of the program and what needed to be addressed in order to determine whether or not it was effective. We did have an expert group appointed, a reference group who had expertise ranging from service delivery through to health economics, and they gave advice on the evaluation components delivered about the comprehensiveness of the evaluation and the adequacy of the sample sizes and methodology.

Senator FIERRAVANTI-WELLS: If my memory serves me correctly, the tender that was put up was in very generic terms, and, if my recollection also serves me correctly, various organisations tendered, some more comprehensively than others. It is my understanding that you did not go with as comprehensive an evaluation as perhaps you could have, with the benefit of hindsight.

Ms Harman: If I could take that one, I think my colleague has given evidence to the fact that we understand this is one of the most comprehensive program evaluations taken. The budget was just under \$2 million. The proper and usual procurement processes for tenders of this magnitude and complexity were taken within the department. We are very happy to take further detailed questions on notice and get back to you. The other point I would just like to make, though, just picking up on a comment that you made earlier around using the evidence from the evaluation to inform the changes that have been announced in this current budget, is: yes, of course the government took into consideration the findings of the Better Access evaluation, but it also took into consideration a range of other data sources and consultative and feedback mechanisms. Clearly, the government has taken a decision using a range of inputs and evidence, and has said very clearly that the changes to the Better Access that it will be making reflect the need to ensure that investments are appropriately targeted to those most in need.

One thing that the valuation did show us very clearly about Better Access is that those most in need, in a sense, continue to miss out: two-thirds of the people receiving Better Access services live in capital cities; the use of Better Access is about 10 per cent lower for people living in the most socioeconomically disadvantaged areas; and in 2009 the richest 20 per cent of Australians received two and a half times the number of Better Access services, or three times the value of Better Access rebates, compared to the poorest quintile. So the government has taken a decision to rebalance its investment and double the investment in—

Senator FIERRAVANTI-WELLS: I appreciate all that. There were two million people who were assisted under this evaluation and you surveyed 1,350 customers. On my calculation, that is 0.07 per cent. That is a minute sample. Did you get any advice as to what would be an effective sample for this evaluation in order to achieve a statistically and clinically significant result? Two million people were assisted, and yet you chose 1,350 consumers.

Ms Hart: We certainly took extensive advice from some very prominent researchers in the field. I mentioned earlier we had a technical advisory group—an expert reference group—who gave us advice throughout the evaluation. That included very prominent mental health researchers, such as Professor Gavin Andrews. It also included expertise on the health economics side, and we asked them repeatedly about the appropriateness of the sample sizes for this survey and particularly the number of consumers, as you mentioned, who were part of component A. We were given their technical advice and close consideration that this was an appropriate sample size.; the power of the sample size was sufficient to draw conclusions.

Ms Halton: If I could add to that, statistically people will tell you that a sample size of over 1,000, if it is appropriately stratified in terms of the sampling methodology, has the power to tell you an awful lot about the population concerned. If I can just go on to make the point that I think, in terms of value for money, people would be rightly concerned. Two million dollars is a lot of money to have spent on this evaluation—this is not a small amount of money; this is a lot of money—and that was done in order to make sure that the study was robust and representative. The process which the officers have been outlining, which goes to the level of technical and content oversight and scrutiny, has been, certainly in my experience, right up there amongst the best that we have done.

Senator FIERRAVANTI-WELLS: The reason I raised that is that the evaluation has been criticised in various quarters, including by the Mental Health Council of Australia, so I am not the only one. If the Mental Health Council of Australia is critical of the very small sample size that you used, then I would have thought that my questions are fully justified in terms of asking them. Who determined which consumers would be surveyed in this program and how were those surveyed consumers chosen?

Ms Hart: Once we determined the sample size for the consumer recruitment in component A of the evaluation, we then had a procedure where individuals were selected according to a protocol. I am just double-checking, but from memory there was a protocol that said from a certain date the next five consumers were identified as being within the study. This was done to ensure, as closely as possible, that they were randomly selected. I am aware that there has been some criticism that there was some skew in the way consumers were selected, with providers selecting consumers who were likely to show uncharacteristic improvement under the program. That is why they were done in that sequential fashion according to an agreed protocol. Once again, we received expert advice from our technical steering committee on that.

Senator FIERRAVANTI-WELLS: My concern was that the very providers who were providing the services were the ones that were selectively choosing. You have said that it is according to a protocol, but that has still left options for the providers to choose the people.

Ms Hart: If the protocol was adhered to then it did not leave discretion about selection. It said that the next five people that came through the provider's door would need to be included in our survey from this date. It is as close as we can possibly get to a random selection.

Senator FIERRAVANTI-WELLS: I know, but clearly as part of the process, you are not able to do that. You have asked for that to happen, but you have no way of ensuring that is exactly what has happened, other than from the word of the provider themselves.

Ms Hart: No, we do not, but we asked all the professionals who were involved in the survey to ensure that there was a very clear understanding about the protocol amongst their members.

Senator FIERRAVANTI-WELLS: We had 1,350 consumers. Were they different providers? From what you have said, they chose five so that means that you have about 200 providers.

Ms Hart: Component A had a total of 299 providers who selected and recruited the consumers.

Senator FIERRAVANTI-WELLS: So you have approximately 18,000 providers and only 200 of them were able to—

Ms Hart: It is closer to 300.

Senator FIERRAVANTI-WELLS: So they were only drawn from 300 providers out of 18,000 or thereabouts?

Ms Hart: Once again, that was based on technical advice about adequacy and power of sample size.

Senator FIERRAVANTI-WELLS: That was the reason why I asked you about the technical advice in the first place, where that came from and whether they were the same people who decided both sides of the process. That is why I am interested in understanding how that process occurred. With regard to the launching of the program, you said earlier about the evaluation being measured against the original objectives of the Better Access program. One of those was to ensure collaboration. Going back to when the program was launched in May 2006 the then health minister, Tony Abbott, said:

It will encourage team based mental health care in the community with psychologists working alongside GPs, psychiatrists, mental health nurses and other allied mental health professionals.

Collaborative care was one of the explicit founding objectives. Where, in the evaluation, will I find the information on the success or otherwise of the collaborative services that are being provided by occupational therapists, social workers and psychologists?

Ms Hart: The brief overview of the evidence that demonstrates the outcomes around multidisciplinary collaboration between mental health care providers is in the summative evaluation and final report, the overview of which is on page 11. I am also looking at the more detailed chapter that provides the analysis of the evidence against multidisciplinary collaboration, which is on page 43 of that report. They provide an assessment of the data that was collected. Component E looked at the effectiveness of the Mental Health Professionals Network, which is another body that has been funded by the department to promote multidisciplinary collaborative care. I think the crucial analysis from the evaluation is extracted in the summative evaluation at those two parts.

Senator FIERRAVANTI-WELLS: What therapies are being provided for the 16 million mental health sessions under the program? Is it non-specific counselling or was there evidence in the evaluation of evidence based care such as cognitive behavioural therapy?

Ms Hart: That was an explicit question for the evaluation to determine what services were being provided. In component B of the analysis we took information about the type of care

that was provided, which is outlined on page 107 of the report. It asked providers to have a look at the services and report on the type of services that were provided under the program.

Senator FIERRAVANTI-WELLS: Did you say 107?

Ms Hart: It is on page 108 of the component B report.

Senator FIERRAVANTI-WELLS: I do not have that one with me. What page did you say?

Ms Hart: It is on page 108 and continues on from there. The majority of the services were cognitive behavioural therapy and associated services. It is not a program that is supposed to provide general counselling services. One of the important evaluation questions was: are the providers giving and are the consumers receiving evidence based care for these disorders?

Senator FIERRAVANTI-WELLS: So it was just in generic terms; it did not go into the actual therapies?

Ms Hart: No. I believe they did. I would need to pull out an appendix from a report.

Senator FIERRAVANTI-WELLS: I am happy for you to take that on notice.

Ms Hart: Yes. We asked specifically about the therapies that were provided, so we have that information.

Senator FIERRAVANTI-WELLS: Obviously you drew the conclusion from the Better Access program, subject to Ms Harman's comments that there were other factors, that you needed to change the rebates and the number of psychology sessions. How do you plan to monitor the impact on the quality of care available to people as a result of these changes? Are you going to be monitoring and how will that occur?

Ms Hart: At this stage we will look at the continuance of standard data that is collected, which ranges across a number of demographic and affordability dimensions. Data collected routinely by the Medicare benefits division provides us with information on use across a number of characteristics. We will need to look at considerations around the quality of care. Obviously with an extensive evaluation having just been completed, we assume that has identified the major issues in the program.

Senator FIERRAVANTI-WELLS: Will that monitoring also include people who now get access compared to those who got it in the past? You cannot just take that sort of money out of the program and not expect there to be less assistance available.

Mr Bartlett: The medical benefits data will essentially enable that sort of assessment to be done about the numbers of people accessing it; whether or not people are accessing things for the first time and continue to access it, and the volume of services that are provided.

Senator FIERRAVANTI-WELLS: On that point, just taking one of your answers to a question on notice, E11-243—

Ms Hart: Just while we are going to that, if you do not mind I would hark back to your earlier question about the type of services and the information. Component A of the evaluation, pages 25 to 26, provides some more information on the types of therapies delivered by providers.

Senator FIERRAVANTI-WELLS: Thank you. This question goes to the overall proportion of new customers to repeat customers. The answer indicates that in 2008 68 per

cent of Better Access clients were new customers and in 2009 this percentage had dropped to 57 per cent. What is this suggesting? Is it the case that short, sharp interventions are being used more to provide ongoing and continual mental health treatment to the same clients?

Ms Hart: The data shows that there was a very big need for the program when it was introduced. That was the first time that there was Commonwealth subsidisation of allied health services. We know from the 2007 survey of common mental disorders that there were low treatment rates in this group. We know from the analysis done as part of the Better Access evaluation that we have been quite successful over that period in increasing the treatment rate for this group. I think that demonstrates the number of people who needed services. There was unmet need, the program was introduced, people are accessing it and that is leading to an overall increase in the treated population rate.

Senator FIERRAVANTI-WELLS: So what was short, sharp assistance for a set period of time now seems to be more continual mental health assistance?

Ms Harman: Ms Hart was trying to convey that when Better Access was first introduced it was a completely untapped market. Better Access went in there and did a fantastic job in reaching out to people for the first time. Obviously that rate of first-time users has declined as the program has grown with increased access. As the secretary mentioned earlier, Better Access has a very strong rate of growth and we expect it will continue to grow.

Senator FIERRAVANTI-WELLS: It has grown because more people are using it to treat ongoing mental health issues.

Ms Harman: The data shows us that a number of those are still new users, so it is increasing access to services, which is its obvious intent.

Senator FIERRAVANTI-WELLS: I will put more questions on notice in relation to that because I want to move on to other parts of the budget.

Senator BOYCE: There has been a large number of complaints about the changes to the Better Access system that have come through to my office and I am sure everyone else's. How many has the department received?

Ms Harman: We would have to take that on notice.

Senator BOYCE: Have you received complaints about changes to the Better Access program?

Ms Hart: We have received some complaints and inquiries, but I do not know off the top of my head what that number is.

Senator BOYCE: Are ministerials on the issue sent through to the department to deal with?

Ms Hart: They may well be at the moment. We are three weeks after the budget so I am not sure how many of those we have received.

Senator BOYCE: On notice, could you give us both those figures?

Senator FIERRAVANTI-WELLS: Yes, you could. While you are at it, I would assume that the letter that the AMA has written to all members of parliament must, at the very least, have hit the desk of the minister. Has there been any response to that? I have not come across any formal response from the minister yet?

Ms Hart: I do not believe so. I think that is under consideration by the minister.

Senator FIERRAVANTI-WELLS: These things are coming in fast. As Senator Boyce said, she is getting correspondence. As I have been sitting here I am getting more and more correspondence in relation to it.

Ms Halton: That is a matter for the minister. We cannot answer that.

Senator FIERRAVANTI-WELLS: I appreciate that. The point is that this correspondence is showing some issues. I have an example of one that I received today which is very critical of what has happened, but also basically talks about the number of treatments for common psychological ailments which they have set out. It is obviously far in excess of what the system will now be providing. Suffice to say, the criticism of the government falls into three categories: firstly, the issues about the treatment; secondly, the fact that you did not consult in relation to it; and thirdly, the distinction that is now being made between mild, moderate and severe where you effectively say that you will only worry about the more severe and forget the mild and moderate. That is putting it in a nutshell in terms of the gist of the correspondence that I am receiving. On the point of consultation, did you consult before you embarked on this, or was this like the occupational therapists and the social workers where you just made the announcement and then had to deal with it afterwards?

Ms Harman: This was clearly a decision taken by the government in the budget context.

Senator FIERRAVANTI-WELLS: Minister, you have taken a third of the money out of this program. Surely it would have been at least respectful to the industry and the practitioners to at least undertake some consultation.

Ms Halton: I need to correct one thing. We have not taken a third of this program out. I understood that is what you said, but it is not a third. That is not right.

Senator FIERRAVANTI-WELLS: Over the time you have taken out \$580 million.

Ms Halton: On the forwards with a projected spend of \$4 billion.

Senator FIERRAVANTI-WELLS: When the evaluation was released the minister put out a press release and said that over the period of time this program has spent \$1.45 billion treating two million people. I am trying to keep it simple. You are now taking out of this \$580 million over the five-year period, and that is about a third.

Ms Halton: No. The program is now budgeted to spend about \$4 billion over five years.

Senator BOYCE: Is that the Better Access program?

Ms Halton: Yes. It is \$4 billion, so a saving of \$500 million over the period is not a third. So if it were \$4.5 billion with \$500,000, then that is not a third.

Senator FIERRAVANTI-WELLS: Where is the \$4 billion?

Ms Harman: There are references to the \$4 billion in the minister's budget statements and it is also in the document produced by the Treasury.

Senator FIERRAVANTI-WELLS: Is that in terms of the services that are projected over the five years?

Ms Harman: That is right. The projected spend in Better Access is over \$4 billion for the next five years.

Senator BOYCE: In mental health services?

Ms Harman: No.

Ms Halton: In the Better Access program. This program will still be growing. It will not reduce; it will continue to grow. That is the point that we have been making quite loudly.

Senator BOYCE: But not in the next budget period.

Ms Halton: Yes.

Ms Huxtable: Not as quickly.

Ms Halton: Not as quickly, but it continues to grow. It does not decline.

Senator BOYCE: Continuing on, could you give me, on notice, the numbers of organisations and individuals who have written to the minister and the department regarding the changes in this program? Certainly from the information that I have received from the United General Practice Australia, the AMA, the college and so on, it would not suggest that they are as comfortable with the increases in this area as in others. You would also be aware that there has been quite a lot of criticism of the new spending on early intervention and headspace type programs. In my view it is not justified. There is a sense that there is competition being set up between young mental health funding and existing mental health packages. Does the perspective that has been developed here, where funding is being cut to Better Access, assist in that sort of conversation within the mental health industry?

Ms Halton: You are asking the officers to give you an opinion which I am not going to permit them to do. It would not be appropriate. I would reiterate that Better Access continues to grow. To the extent that people externally are making a series of comments—and I understand why some of those comments have been made—I would reiterate that Better Access continues to grow. Four billion dollars in anyone's money is a lot of money. In addition to that, we are investing in areas, as has been said by the officers, that are gaps. At the end of the day we have an obligation to make sure that the package of service that is provided is well balanced and founded on the evidence. I understand that some people are upset about some parts of this; we all understand that, but if you look at the balance across this package, I think it is reasonable.

Senator BOYCE: You said you understand why some people are upset. Could you explain what you meant?

Ms Halton: It is because people do not like change. Notwithstanding the fact that we have done an incredibly thorough evaluation, as soon as you change something some people get upset. That is the way of the world.

Senator FIERRAVANTI-WELLS: You could have consulted with them.

Ms Halton: The bottom line is that significant numbers of people were party to these evaluations. Everyone knew an evaluation was being undertaken. As the officers have already said, there were a number of parties who were party to advising on and being talked to as part of the process.

Senator FIERRAVANTI-WELLS: When the government announced the cutting of Medicare rebates for occupational therapists and social workers there was a hoo-ha about it and then Minister Roxon was forced to back down and change her stance in relation to that. I would have thought that the lesson would have been learnt there because there has now been a decision made and one would have thought that you would have consulted at least.

Ms Halton: No. I would point you to the fact that Minister Butler had a number of meetings with an expert working group, of which I was unofficially a member. I sat next to him during those consultations where he talked to people broadly across the sector about what would comprise a package which was balanced and that dealt with the range of issues that people were telling us needed to be addressed. He did that with quite an open mind about what the options would be. He talked to a number of those people on occasions other than just in that context. A number of those individuals provided evidence and written input, so there was a very extensive process of discussion.

Senator SIEWERT: Was the advice from the expert panel that the number of sessions should be cut?

Ms Halton: Specifically, no.

Senator SIEWERT: So that was not discussed?

Ms Halton: There was a discussion about the balance across Better Access and so on, the various elements and where those balances were.

Senator BOYCE: As to where the money went, whether it went to early intervention, Better Access or whatever?

Ms Halton: It was about the need to have investments across the range and the fact that prior to the budget package what we saw, in terms of where all the investments were, was not as balanced as people in that group thought it might be.

Senator FIERRAVANTI-WELLS: Which panel was it? Senator Siewert asked you about your expert panel? Who are we talking about? There are lots of experts running around.

Ms Halton: It is the expert working group convened by Minister Butler.

Senator FIERRAVANTI-WELLS: Is it the one where he is the chair of the independent expert group?

Ms Halton: No. Let us not confuse evaluations—

Senator FIERRAVANTI-WELLS: You have your National Mental Health Council. Who are we talking about?

Ms Halton: We are talking about the expert working group convened by Minister Butler to advise him on the mental health package as part of the budget. That expert group comprised Professor Pat McGorry, Professor Ian Hickie, Mr Toby Hall, Professor Frank Oberklaid, Mr Anthony Falker, Monsignor David Cappo, Dr Christine McAuliffe, Dr Christine Bennett, Ms Sally Sinclair, Ms Janet Maher, Dr Pat Dudgeon and Professor Lyn Littlefield. I was party to that process. That group met on a number of occasions to discuss the mental health package of which this element was one component, and indeed the review of Better Access was discussed at one of those meetings.

Senator FIERRAVANTI-WELLS: Without mentioning names, there are people in that committee where any decision in relation to cutting back Better Access will have a direct implication in terms of funding that is taken out of one. When you are robbing Peter to pay Paul, if you have Paul as part of your advisory body, potentially there could be a conflict of interest. That is certainly one of the issues.

Ms Halton: You have both Peter and Paul represented here, if we wish to get into metaphors.

Senator FIERRAVANTI-WELLS: There are issues that have been raised with myself and my colleagues. Did you have proper conflict-of-interest parameters in place in relation to this decision?

Ms Halton: Everyone here declared their conflict of interest. Let us be very clear. Mental health is not a large community. Everyone, in some way, is conflicted because everyone is involved in the delivery of service. All of these people are passionate advocates, and good on them, because they care about the delivery of service. What we did and what the minister did with this process was actually try to get a balanced view about how you deliver a balanced package to meet mental health needs, and the important thing that came out of this was an acknowledgement that mental health is not just a health issue. Mental health is an employment issue, a housing issue, an issue of income, an issue of social justice and I could go on. The balance of the package did not just go across our portfolio, it went across FaHCSIA and DEEWR. The whole point about this process was to ask what we needed to do to address the issues and needs of people with mental illness. You have rightly pointed to one part of this decision in toto that some people are not happy with, and I have said to you that I understand that and I do.

Senator FIERRAVANTI-WELLS: I would have thought that we had also learnt from the 2006 package. The 2006 package had 18 components to it which went across DOHA, DEEWR, FaHCSIA and a whole range of other departments. I think we heard evidence before that much of what is in this package is simply just a repackaging of previous programs.

Ms Halton: No, we did not hear evidence to that effect. I have to say that is not the evidence. What you heard in evidence was that a number of those elements are continued. We had a discussion about whether they were stopped and then recontinued. They are continued. That is appropriate because they work well and they are popular. You would continue them and we have done so. This package includes a number of significant new elements and yes, in one respect, some funding has been redirected. I have explained that I understand why people have a view about that and some are not happy about it, but to suggest that there was an absence of, firstly, a thorough review in respect of that particular program, I do not accept as a contention. Secondly, there was extensive dialogue and discussion with the sector before the package was formed.

Senator FIERRAVANTI-WELLS: It is very clear from the reactions afterwards that the key players who have reacted quite violently in relation to the cuts, certainly from their public comments, do not appear to have been consulted with. You have obviously got this little group which had a series of interests but here we are talking about the college of GPs, the AMA and those people who are the coalface of delivery of these services. It is very clear that such a large measure and the cut to those programs were not directly discussed with them as the most directly affected parties.

Ms Halton: Apart from the fact that I have to take some issue with the use of the 'violent' because I have not seen any violent reactions—

Senator FIERRAVANTI-WELLS: Strident. I withdraw 'violent' and I replace it with 'strident'.

Ms Halton: 'Strident' I would agree with; 'violent' I do not. The truth of the matter is that sometimes, no, governments do not consult about the precise detail of a particular budget

measure. That is not exactly new to this government. But in terms of the broad parameters the point I am making is that there was an awful lot of discussion.

Senator FIERRAVANTI-WELLS: Now that it has come out and you have seen some of the more strident comments, what is the government going to do about it? Is it just simply going to ignore that criticism or are you going to enter into some sort of discussion or consider the views of the psychologists, the psychiatrists, the general practitioners, the college of GPs and the range of other people who have been critical of this measure? Is there going to be at least some consultation with them or has the decision been made and you really do not care what they think now?

Senator McLucas: Of course we care what they think.

Senator FIERRAVANTI-WELLS: I am just asking.

Senator McLucas: They are essential players in the array of services that we provide. But as I think all of the officers at the table have explained to you, this is a balanced approach ensuring that we get the best outcome for people with mental illness across the country. There is a whole range of reasons why we have had to reallocate the money that was previously allocated through the Better Access program so that we get much more targeted services. We know from the evaluation that the Better Access program really was not getting those hard-to-access people, people with mental illness in remote locations from communities that are not well connected into the private medical sector. We know that we can support more younger people through the Headspace programs. We know we are doing really well throughout the country.

When you have got an allocation of money that you want to get the best value from you have to make tough decisions, and that is what our government has done.

Senator FIERRAVANTI-WELLS: I appreciate that.

Senator McLucas: We recognise that there are some in the mental health sector who would prefer not to change the number of appointments that you can receive under the Better Access program. We know that. However, our job is to give the best services to people with mental health in the country that we possibly can.

Senator FIERRAVANTI-WELLS: I will leave it at this point. You have the providers of those services. You have got a range of professors and other experts here and then you have got these 26,000 plus 18,000, 19,000 sitting over here providing these services day to day. It is all very well to consult on this point but what about the 40,000 sitting on this side of the equation who are now jumping up and down because they are at the coalface delivering services? When somebody comes along to their surgery, or whatever, and they say, 'No, I cannot get a rebate anymore.' They are told, 'No, you cannot get a rebate anymore.' That suggests you have not thought this thing through, just like you did not think it through with social workers and occupational therapists—

Senator McLucas: Sorry, I would completely refute that assertion. This package has had an enormous amount of effort put into it, including from a range of experts in the mental health area. We are obliged to receive their advice. I think from the commentary that I have seen that this package has been extremely well received across the sector. Certainly there is a group of people who would prefer there be no change to the Better Access program. However, the evidence would suggest that a reallocation—and all of that money is being

reallocated into mental health; we are not losing a cent of it—will ensure that we will get better outcomes for people with mental illness in Australia.

Senator BOYCE: You mentioned the expenditure in 2011-12 as not rising as much as expected. Could you just tell me what the net increase is in real terms?

Ms Huxtable: I think I was referring to over the forward estimates period and that the rate of growth of the program would be slower than would otherwise be expected because there is a saving being taken out. I do not believe I made a specific reference to 2011-12. I think the officer from Medicare benefits division who appears to be fleeing the table—no, he has fled the table.

Ms Hart: We can calculate that for you. In broad terms expenditure to date under the program is \$1.9 billion and as we previously discussed the program will rise to \$4 billion, so we can get someone to—

Senator BOYCE: On an annual basis, please? Could you calculate year by year and in real terms, please?

Senator SIEWERT: I would like to clarify some issues around the sessions. We are not moving from 12 to 10; as I understand it it is 18 to 10 because you are not going to have the possibility anymore of having that other additional session, are you?

Ms Hart: The new arrangements mean that the maximum entitlement to services will be 10 in a calendar year. Previously the usual course of entitlement encompassed up to 12 sessions and there was a very small group for whom exceptional circumstances could be made out who could receive a further six. This is in addition to 10 group sessions.

Senator SIEWERT: From now on the maximum you are able to get is 10?

Ms Hart: That is correct.

Senator SIEWERT: When you had to take into account the exceptional circumstances to take it to 18, as you have just said that was a fairly small number of people. Could you tell us, first, how many—and if you have already told us that I will find it. I apologise if I have asked something again. Secondly, what is the process then to move from your six sessions to 10? You have your six sessions and you can have another four; what is the process for getting that other four?

Ms Hart: If I answer your second question first, the process for the additional four sessions has not changed. The point was that after six sessions there was a need for some sort of review mechanism to see whether clinical symptoms and functioning have changed. That will be preserved so the patient can then have a consultation or have a discussion with their service provider to see whether additional sessions are required and that can be provided.

Senator SIEWERT: Is there a different process at the current time between 12 and 18? It is not going to be that process. It will be the process between the six and the—

Ms Hart: That is correct. The exceptional circumstances requirements do not come in after six sessions. It will just be the normal course of a review at six and a consideration by the patient and their provider when additional sessions up to four are required.

Senator SIEWERT: Do you have to take on notice that figure from the 12 to the 18?

Ms Hart: I have a percentage figure. I may just need to take that on notice to calculate. As I said, the majority of patients, just under 87 per cent, will be unaffected by the change and there are around 13 per cent of patients who will be affected by the changes.

Senator SIEWERT: I have got this fact sheet. That is not how I understood it. This was the difference between one and 10, 87 per cent, so I was asking for between 12 and 18.

Ms Hart: I would need to take that on notice and just do that calculation.

Senator SIEWERT: Those are the ones that relate to exceptional circumstances?

Ms Hart: Yes.

Senator SIEWERT: If you could take that on notice it would be appreciated. There is a list on this fact sheet about where people go to if they can no longer get the additional services. Did you do any consultation with the states about those people now being able to access state services?

Ms Hart: There has been discussion with my state and territory counterparts through the vehicle of the Mental Health Standing Committee about the need to consider whether or not they are suitable clients for state and territory services. As we also point out in that, if they are people who are experiencing more complex and persistent conditions they could also access up to 50 subsidised consultant psychiatry services a year.

Senator SIEWERT: If they are going into state or territory services will they have to join the waiting list or will they go straight into services?

Ms Hart: It depends. There is probably no simple answer to that. It depends very much on their clinical need. The state and territory services make an assessment of all new clients, new patients, presenting to their service to determine their level of mental illness, their need and the services available.

Senator FIERRAVANTI-WELLS: In terms of the GP services, we now have these two tiers of standard and higher rebate. You told me before at the end of December there were about 27,000 GPs. How many of those GPs have mental health special training?

Ms Hart: Those are numbers that we update monthly through the GP mental health standards collaboration and it has been growing very rapidly. I believe at last count approximately it is just under 17,000 GPs had completed mental health skills training. It is a reasonably short course that is available online and face to face for GPs and it has been taken up with great zeal.

Senator SIEWERT: In relation to the changes in the GP payments, I understand there was a time and motion study done in terms of the way it was calculated, how much time it has actually taken for the plans; is that correct?

Mr Bartlett: BEACH is a University of Sydney entity that does a range of surveys of GPs. It looks at items and length of time spent on items. It has done work on mental health plans.

Senator SIEWERT: Did it look at this specific program?

Mr Bartlett: That is correct.

Senator SIEWERT: When was that?

Mr Bartlett: It has provided a range of data from between 2006 and 2010. As I understand it, there are 574 different responses.

Senator SIEWERT: The Medicare benefit structure will change to \$67.65 for both items 2712 and 2713; is that correct?

Ms Harman: That is correct. Those are the two review items.

Senator SIEWERT: Will that be for the review process and the others will apply for the preparation?

Ms Harman: For the professional preparation of the treatment plan, yes.

Senator SIEWERT: Previously it was \$163; is that correct?

Mr Bartlett: The plan preparation was \$163.35.

Ms Harman: That is obviously an untimed item.

Senator SIEWERT: I understand that. The maximum now will be \$126.43 if you have done the training and the plan takes 40 minutes; is that correct?

Mr Bartlett: If the plan takes 40 or more minutes to prepare.

Senator FIERRAVANTI-WELLS: Some of the funds that applied to flexible care packages are being redirected from that provision in last year's budget funding changes to the Better Access program which I think relate to the occupational therapist and social workers that we were talking about. Page 213 of the blue book—let us go back to colouring books—has the cut last year and then it has been reinstated; is that the way it works?

Ms Harman: This is just confirming the government's decision, yes, to overturn that decision.

Senator FIERRAVANTI-WELLS: Some of the funds that were going to be applied to flexible care packages last year were redirected under last year's budget?

Ms Harman: The decision of the government that last year—

Senator FIERRAVANTI-WELLS: As I understood it, that \$52.6 million was taken out of last year's budget and redirected to flexible care packages in last year's budget.

Ms Harman: That is correct.

Senator FIERRAVANTI-WELLS: Now that you have reinstated it, what about the flexible care packages? Does that mean that they are \$52.6 million short?

Ms Harman: No. At the time the government took the decision to reverse its decision to remove OTs and social workers from eligibility for Better Access services, the government also confirmed that it had found those funds from elsewhere so that funding—

Senator FIERRAVANTI-WELLS: On page 230 you have got \$549 million for the care and flexible fund for people with severe and persistent mental illness. It says that the remaining \$200 million is to be met through a consolidation of existing elements. Where is the allocation of that \$200 million?

Ms Harman: It is \$206 million. It is just over \$206 million—

Senator FIERRAVANTI-WELLS: It is \$206.1 million, yes.

Ms Harman: That is derived from redirecting three allocations—

Senator FIERRAVANTI-WELLS: Where is that allocated?

Ms Harman: I will just run through it, if that is okay.

Senator FIERRAVANTI-WELLS: Yes.

Ms Harman: The first of those is redirecting four years of funding over that five-year period from the original flexible care packages measure, so from 2012-13 that money will go forward and be rolled into the new coordinated and flexible funding for people with severe and persistent mental illness. The second offset is the element that I was talking about earlier. It is the originally announced \$60 million from the—

Senator FIERRAVANTI-WELLS: The suicide packages, yes.

Ms Harman: suicide package. Over the five-year period of the new budget package that will amount to \$100 million that will go towards contributing to that \$549.8 million. The third element is the more community based psychiatrist measure again under the taking action to tackle suicide measure which was originally announced from memory at \$22.5 million over three years. The offset amount over the five-year period of the new budget package is \$37.67 million, so that amounts to about \$206 million that will be used to take the amount to be invested in the coordinated care measure to \$549.8 million.

Senator FIERRAVANTI-WELLS: The net of spend here for severe and persistent mental illness is \$343.8 million?

Ms Harman: That is correct.

Senator FIERRAVANTI-WELLS: It will aim to assist approximately 24,000 people.

Ms Harman: That is correct.

Senator FIERRAVANTI-WELLS: Will some of these people include those people who are coming out of Better Access? Did I read correctly that they are to—

Ms Harman: The 24,000 people come from a group that is estimated to comprise about 60,000 people. If you look at the triangle of severity of mental illness there, the group that is really at the top of the triangle in terms of complexity of need and severity of illness, these are people who require a range of clinical and non-clinical services. They suffer from an extended cycle of readmission to hospital and the intent of this measure is really to stop the cycle of not knowing where to go in the system. Money will be invested for regionally based organisations to become a single point of contact for the individuals and their families, providing a single navigation and referral point. We will be providing a national consistent assessment framework that will cover the full range of services that individuals in this cohort need, ranging from housing, employment support through to clinical and social support services.

These organisations in regions will be providing care facilitation and assessment using the national consistent assessment framework. They will then work with all the range of providers that are identified as meeting the person's needs. For example, our Day-to-Day Living program, FaHCSIA's PHaMs program, state services. Then we will actually come up with a multiagency care plan to put care around that individual's needs. Then the role of the organisation and the regional basis going forward will be to actually connect those services and make sure that they are actually realising the services that have been identified in the individual's care plan. It is about gluing the services together and providing that single point of contact and facilitation for an individual.

Senator FIERRAVANTI-WELLS: If you put together the various statements that have been made, you are talking about a multidisciplinary care plan, more services and comprehensive care and support. That seems to be the case. Let me take that \$348.3 million and you are talking about 24,000 over five years. When you work it out that is about \$2,800 per person per year. Is that your calculation?

Ms Harman: We are aware that that was a calculation that was published by Professor Rosenberg recently. We understand that Professor Rosenberg has calculated that amount by dividing the amount of people by the amount of funding available. The amount of funding available to a person will depend on their needs. The purpose of the flexible fund will actually be to plug gaps that currently exist, it is not to replace current investment in services that are either provided by the Commonwealth or the states. It is to actually plug the gap. The amount that will be available per person will to some extent depend on the individual's own personal needs. With the implementation of this measure the amount will actually be more than that \$2,800.

Senator FIERRAVANTI-WELLS: Are you saying that that is in addition to, for example, any service that they may receive at a state hospital or in addition to other supports that they may receive.

Ms Harman: That is exactly right.

Senator FIERRAVANTI-WELLS: Have you worked out in terms of all the various packages that could be available to that person with severe mental illness a figure as to roughly how much that is going to be worth to them?

Ms Harman: We have looked at the package as a whole because obviously the package as a whole has significant new investment for PHaMs for example, the Personal Helpers and Mentors program, and a significant new investment for the Day-to-Day Living program. These are the kinds of services that will actually contribute to that wrap-around care. Then through this budget measure we have gathered together several funding sources, a significant new injection of \$343.8 million, and used a component of that to help plug service gaps.

Senator FIERRAVANTI-WELLS: Do I understand in a nutshell that all those extra moneys to those programs are basically directed towards people with severe mental illness?

Ms Harman: That is exactly right. It is very, very clear in the program guidelines that PHaMs and Day-to-Day Living are targeted for people with severe and persistent mental illness.

Senator FIERRAVANTI-WELLS: When you take that into account, is it perhaps another couple of thousand dollars per person?

Ms Harman: In terms of PHaMs you would have to direct that to FaHCSIA.

Senator FIERRAVANTI-WELLS: In addition to this \$343.8 million, can you take on notice what you estimate to be the average 'package' amount for a person with severe and persistent mental illness, taking into account those other parameters? Mr Singh says you cannot do that.

Ms Harman: I think that the point of this measure is that it is about gluing the service together around an individual's needs, so you need to go through the process of actually assessing the individual's needs. They might not need the full gamut of services. They might

just need a little bit of assistance with housing; they might need the full complement of services. It is very difficult to estimate on a per capital basis or a per head basis the amount of money that will be allocated for each individual. It has got to be within a range. It has got to be a process based on an individual's needs, going through a proper clinical and non-clinical assessment of those needs which again is a significant component of this new measure. We will actually have the framework to do that.

Senator FIERRAVANTI-WELLS: When you consider that the average cost a night for a mentally ill person to stay in a public hospital would be about \$900 or \$1,000, when you put it into that sort of context we are really not talking about a lot of money.

Ms Harman: The point is that we are not seeking to replace—

Senator FIERRAVANTI-WELLS: I appreciate that but I am trying to get a handle on this. You are saying to me, yes, there is a significant amount of money. I am trying to get a handle on what that average could be for those 24,000 people. You have told me that a component of that is \$2,865 per person. I am sorry, Dr Rosenberg has worked out that that is an average amount and that is a starting point. I am trying to get to the figure that you are saying would the average figure that a person with severe and persistent mental illness could have per annum, or he or she could avail themselves of in a given year? I am trying to get to that figure, which is obviously more than \$2,865 but how much more is not clear from what you have said and that is what I am trying to get to the bottom of.

Ms Halton: We will consciously resist giving that kind of figure for the very reason that it misleads. It is a bit like community aged care packages or all these other things that we do that are packaged around the individual. As soon as you start using a dollar figure people say, 'I am entitled to that much.'

Senator FIERRAVANTI-WELLS: I am trying to get an average to get a handle. Ms Harman is trying to make out—not make out. Let me retract that. I just want to get a handle on what that range of potential value is beyond \$2,800. That is all I am trying to get to. If Ms Harman cannot answer it, that is fine; I accept that. If it cannot be calculated, I accept that. I am just asking can it be calculated? If it can be calculated, can I get assistance in relation to having it calculated?

I will put the questions on notice in relation to Medicare Locals. I now want to move, if I may, to EPPIC. We heard evidence this morning in relation to those figures. Obviously they are conditional on the states providing the funds. What happens if the states do not provide the funds, if they are not prepared to match the funds?

Ms Harman: I think the first thing to say is that the states have committed through the fourth National Mental Health Plan to implement cost-effective early psychosis services. As I indicated in evidence earlier, our discussions with states and territories to date have been very positive in terms of their interest in partnering with the Commonwealth on EPPICs. We are asking for a fifty-fifty cost contribution from the states and territories and we are very hopeful to achieve that. Should the states not be willing to proceed then the Commonwealth has the option to proceed to fund early psychosis, or EPPICs, in its own right; it would obviously be a smaller number but wholly Commonwealth funded. We are very hopeful that will not eventuate. As I said, there are very positive signs from states and territories about wanting to partner with us, but that is an option.

Senator FIERRAVANTI-WELLS: But you have only just started your discussions, notwithstanding that the moneys were previously—

Ms Harman: Exactly.

Senator BOYCE: What about the funds in the 2010-11 budget? How many did you end up with then?

Senator FIERRAVANTI-WELLS: None.

Ms Harman: We were in the stages of informal negotiations with states and territories. That measure has now been rolled into this latest budget paper. We have a bigger amount of money—

Senator BOYCE: Have all of those discussions have been going for 12 months now?

Ms Harman: As I said earlier, we have been doing a lot of the early planning for the measure so we have engaged Orygen Youth Health to work with us advising us on how we approach this and what constitutes an EPPIC brand, if you like, and what are the absolute must-haves in terms of an EPPIC centre—

Senator BOYCE: Has any state or territory said they want a partner on EPPICs?

Ms Krestensen: Yes, I think they have all expressed a strong interest in working with us on this and in talking more to us. We have written to them once—

Senator BOYCE: Sorry, I am having trouble hearing you.

Ms Krestensen: All the states and territories have indicated very strong interest in working with us on this. As far as I am aware, all of the states and territories are interested in putting forward proposals. Of course, the discussions started before the budget. We have had further discussions after the budget, and I think their response has been very positive to the greater amount of money. I am not aware of any states and territories that are not interested in working with us on this measure.

Senator BOYCE: Thank you.

Senator FIERRAVANTI-WELLS: In relation to EPPICs, what is the criteria for setting them up? We went through the GP superclinics and the whole issue about criteria. In terms of location and governance frameworks, have all of those issues been worked out, say, where they are going to be located?

Ms Harman: In terms of EPPICs?

Senator FIERRAVANTI-WELLS: Yes.

Ms Harman: Clearly that is something that needs to be discussed with the states and territories, because one of the things that needs to be determined is that EPPICs will have the biggest benefit if they are located in areas where there is a high incidence of youth mental health problems, but there are also other considerations like really sound existing state infrastructure and capability, including subacute, in-patient beds and other backup services.

Senator BOYCE: Are you saying that you would be looking for new areas to service?

Ms Harman: We need to work through with the states where we can place EPPICs so they can have the biggest bang for the buck in terms of service reach and population reach. The EPPICs provide the out-of-hospital care and wraparound holistic support to the individual and their family. It needs to have strong links to acute services.

Senator BOYCE: For example, how is that going to work for remote Indigenous communities that do not have large populations or large areas of reach?

Ms Harman: Like many intensive acute and community based services that are specialist, we would not be able to build an EPPIC in a remote community. There would have to be some kind of service by which people could go to an EPPIC or be referred to an EPPIC.

Senator BOYCE: Is that one of the most acute sectors for severe mental illness?

Ms Krestensen: Ms Harman's answer is correct. There are only going to be 16 services funded through this measure. The intent in promoting the EPPIC model is also to build the knowledge base, which is then going to flow on to other youth mental health services and conceivably services providing services to Indigenous people in other remote areas. There is going to be a flow of information and expertise through these centres, which will be set up as being a centre of excellence as well as being a centre where people can receive services. I am very confident there will be a flow on of information and support from these services.

Senator FIERRAVANTI-WELLS: I wanted to ask questions in three different areas and I am going to use my remaining time to cover those areas.

CHAIR: You have 10 minutes.

Senator FIERRAVANTI-WELLS: Can you explain to me why you are not setting up the National Mental Health Commission as a statutory authority? Senator Evans was a bit hard pressed the other evening at estimates to find a comparable entity to what this is going to be. Can you tell me why it is not being set up as a statutory authority?

Ms Halton: I am assuming that you know that it is not being set up in this portfolio.

Senator FIERRAVANTI-WELLS: I am. When I went to PM&C they told me to come and talk to you. I have gone through this with PM&C repeatedly.

Senator BOYCE: Why on earth is it in PM&C?

Senator FIERRAVANTI-WELLS: It is not a statutory authority. It is set up as an executive agency. I will put some questions on notice about this. From the literature that I have read over the last 10 years about a National Mental Health Commission this is certainly not what the sector had been asking for. My question is: why is it being set up as an executive agency in Prime Minister and Cabinet as opposed to a statutory authority with a degree of independence?

Ms Halton: It is not a portfolio agency, be it executive or statutory, in my portfolio. I can explain to you why it is set up in PM&C. That is detail to which I am privy. It is perfectly clear that is because mental health is seen as a whole-of-government issue and in fact to put it in health would be to downgrade the significance of the other areas. As it is an agency set up in the Prime Minister's portfolio, I cannot answer questions on it.

Senator FIERRAVANTI-WELLS: I will remind Mr Rimmer next time. Ms Halton, I go through this all the time.

Ms Halton: Next time Mr Rimmer will be in another portfolio, so you can ask him those sorts of questions and express frustration with PM&C. He may sympathise with you at that point.

Senator FIERRAVANTI-WELLS: Thank you for sympathising with me, but it is of no use to me at this point. I would like to ask some questions on headspace. In the 2010-11

budget you announced the expansion of 30 new headspace sites. Additional money was provided to the National Youth Mental Health Foundation for existing headspace sites and to fund new sites. Headspace would have further sites expanded over four years. Are the 30 new headspace announced in this budget in addition to the 30 announced last year? Is it the case that you have the existing 30 plus the 30 new ones?

Ms Harman: There were 30 announced in the 2010-11 budget and a further 30 in this budget, taking a total number of headspaces around the country by 2014-15 to 90.

Senator FIERRAVANTI-WELLS: You have only determined the first 10?

Ms Harman: The locations and the lead agencies for the first 10 have been announced. They are services that are being established right now and will begin to open their doors and provide services by December this year.

Senator FIERRAVANTI-WELLS: We only have a few that have actually opened.

Ms Harman: As I said, the lead agencies for those first 10 were announced by Minister Butler on 14 April this year. Those organisations are now in the planning phase. We know from rolling out the first 30 headspace that it does take some time to get these services established and then to provide services to young people. That is no different from the way the measure has rolled out previously.

Senator FIERRAVANTI-WELLS: I would like to ask some questions in relation to a headspace in Western Sydney. When it was opened by the minister on 11 November it was originally opened Monday to Friday 9 to 5, and now it is only opened Monday to Thursday, so it would seem that a headspace that is just barely six months on is already needing to cut back its hours. Can you have a look at that one for me and in relation to the ones that are already operational can you tell me whether they have had to cut back services?

Ms Harman: From memory, I think you asked a question on notice on this matter.

Senator FIERRAVANTI-WELLS: I may have, but I have lost track.

Ms Harman: From memory, we indicated the operating hours. The Commonwealth's role is to provide the funding and oversee the program and its performance.

Senator FIERRAVANTI-WELLS: The day-to-day?

Ms Harman: It is up to the headspace company to work with the lead agencies on the operating hours of each headspace site. We will go away and take another look at that.

Senator FIERRAVANTI-WELLS: In relation to statistics, how many clients have been forced to pay out-of-pocket or gap payments due to underfunding of services? From the document I cannot ascertain what the funding is for each of those headspace sites. Could you take on notice the funding for each of those headspace sites?

Ms Krestensen: Yes. I can add that, roughly speaking, the previous level of funding for each site was an average of \$500,000. The new measure increases the number of sites up to 90 but also brings the average site cost up to about \$842,000, which is the amount that headspace advised the government it needed at an average level to be able to be fully sustainable and operational. We anticipate there will be a range in the sites. There will be big sites and smaller sites around that average cost, but moving to that level of funding is almost certain to address the problems you are alluding to from the past, where we have not been able to sustain full levels of operation in smaller sites.

Senator FIERRAVANTI-WELLS: Can I also have a look at the selection criteria being used to select the existing headspace sites. Can you advise whether that criteria will vary for the new sites?

Ms Krestensen: Do you want those criteria now?

Senator FIERRAVANTI-WELLS: Yes, but I am happy for you to take them on notice and provide them to me. Are they long?

Ms Krestensen: I have them here and I can read them out.

Senator FIERRAVANTI-WELLS: All right.

Ms Krestensen: Under the selection criteria priority will be given to areas that have a significant and growing youth population, experience known socioeconomic disadvantage, have experienced indicators of social distress in relation to youth mental health—for example, incidents of youth suicide, imprisonment or homelessness—have sufficient local capacity and infrastructure to support integration and possible co-location of support, including physical health, mental health, alcohol and other drugs, and social vocational support, and finally will be supported by existing local service providers and community organisations.

Senator FIERRAVANTI-WELLS: I have one last set of questions on culturally and linguistically diverse mental health services. Ms Halton, did I understand your comments earlier that those organisations that were having their funding for next year have been notified?

Ms Halton: No, that was a question about grants.

Senator FIERRAVANTI-WELLS: In relation to any cuts to CALO services and funding for Multicultural Mental Health Australia, it appears that their funding is going to be—correct me if I am wrong—taken away from them and another provider taking over the funding. Is that the situation?

Ms Krestensen: That is not the situation. The government and the department remain committed to funding the Multicultural Mental Health project. It is a project, not an organisation. It has been funded for a number of years and auspiced through the Western Sydney Local Health Network. As with all good procurement processes, from time to time we need to review our procurement and open up tender arrangements to invite—

Senator FIERRAVANTI-WELLS: So, there will be a tender?

Ms Krestensen: There has been an ITA, an invitation to apply, and that is still open and underway. We have not identified a successful or unsuccessful applicant for that, but as a courtesy we have kept all the applicants apprised of where we are up to in the process. We are at the stage of negotiating with a preferred applicant. We are certainly committed to continuing funding for this particular project. There is no suggestion that we are going to be reducing funding for that project.

Senator FIERRAVANTI-WELLS: Obviously there are not too many organisations that deliver this sort of service. Is the objective to mainstream these services or keep them with a more specific culturally and linguistically diverse provider?

Ms Krestensen: As I said, it is currently auspiced by the Western Sydney Local Health Network. It is not a service in terms of traditional mental health services. The project provides policy advice to governments, both Commonwealth and states and territories. It provides

support in terms of advice to providers about how to appropriately support people from core backgrounds in mental health service provision, and it promotes the concept of early intervention. It tries to drive a partnership between the mental health sector and the culturally and linguistically diverse sector. There is a range of organisations across Australia that have a very strong interest in transcultural mental health. This is an area where we have actively promoted a collaborative approach across the sector. The criteria for the ITA will ensure that whoever is the successful applicant will have a very strong understanding of the sector and strong experience within the multicultural sector.

Senator FIERRAVANTI-WELLS: So, the tender is to deliver the same service?

Ms Krestensen: The invitation to apply is a funding process and not a procurement process. It is to deliver the same objectives around policy advice, supporting better treatment from service providers and the sorts of things I have described. It has reviewed the requirements in the light of the current expanding and very busy mental health sector and included, for example, reference to working closely with primary care providers as well as state and territory providers. It is very much about continuing that role in collaboration and policy advice to governments.

Senator FIERRAVANTI-WELLS: I will put the rest of my questions on notice.

CHAIR: Senator Siewert, we will go through until 25 to or until you finish your questions.

Senator SIEWERT: Senator Fierravanti-Wells was touching on a topic that I was going to raise, so I have one more question to add to that series of questions. Have the current providers of services been evaluated prior to the release of the next round of tenders?

Ms Krestensen: There has been a series of reviews of the current project to help inform and advise us on where to go next.

Senator SIEWERT: There have been some reviews?

Ms Krestensen: There have been some internal reviews; that is correct.

Senator SIEWERT: Internal reviews of the programs or of the work of the current providers?

Ms Krestensen: Just to be clear, are you asking me whether we have reviewed multicultural service delivery or the multicultural project?

Senator SIEWERT: The delivery and services.

Ms Krestensen: We have not reviewed delivery of multicultural services, but we have kept a close eye on the project. We have looked to the project also to give us advice about how delivery of multicultural mental health services are progressing and invited input through their collaborative networks to get that sort of advice back to governments.

Senator SIEWERT: Have the providers who are currently providing the services undergone an evaluation?

Ms Krestensen: No. There has been an external review that was undertaken of the project and we have also undertaken a financial review of the project over recent times. Those two reviews have been undertaken to identify what has been working well, what needs to be tightened up, and also to help inform the department in terms of the future shape of that particular project.

Senator SIEWERT: Have they been released publicly?

Ms Krestensen: No, they have not been publicly released, because they have been informing in part the process we are going through at the moment.

Senator SIEWERT: Thank you. I am aware of time so we might move on. I might have some other questions on notice. I would like to ask about child health checks.

Senator FIERRAVANTI-WELLS: I was going to that.

Senator SIEWERT: I am conscious that I may have to put some questions on notice. There now seems to be two child health checks. There is the four-year-old child health check and now there is the three-year-old child health checks. Can you take me through how these two processes are going to interact? Does one replace the other or do we have two?

Mr Singh: They will interact in the sense that the four-year-old check will be amended to produce the three-year-old check. It will be amended to include issues around emotional and social development, and then the age of the check will be brought forward to three years old.

Senator SIEWERT: So, we no longer have four-year-old health checks?

Mr Singh: That is right.

Senator SIEWERT: So, the legislation that is currently before the parliament is out of date before we even deal with it?

Mr Singh: No. The revised health check will not commence until 2012-13.

Senator SIEWERT: And then we will amend the current legislation?

Mr Singh: That is right.

Senator SIEWERT: I am glad that is clear. It is not going to be a universal health check, is it? It is voluntary other than if you want the family supplement?

Mr Singh: That is correct.

Senator SIEWERT: So, if you are getting a family supplement it is going to be compulsory?

Mr Singh: My understanding of the policy is that people who wish to have their family tax benefit annual supplement, who have a child in the relevant age group, need to do a health check, but it does not necessarily have to be one of the health checks on Medicare. Checks provided within the state and territory systems are also acceptable.

Senator SIEWERT: That legislation will be amended to three years?

Mr Singh: That is right, yes.

Senator SIEWERT: Can you tell me the evidence base that is being used to compare the three-year and the four-year?

Mr Singh: We have basically taken advice from a range of experts, including leading professionals in their field, such as Professor Frank Oberklaid, who was mentioned earlier as one of the experts advising Minister Butler. He has basically advised us that by the time a child reaches four years of age it can be too late to address things like conduct disorder, particularly if effects are compounded by environmental disadvantage, and that there are in fact reliable points of intervention for screening and so on at earlier than four years of age. Three years of age is the earliest stage for which assessment instruments can be considered to

be valid, and obviously early intervention makes a significant difference. The general ethos is, given that it is effective to intervene at an earlier age, let's bring forward the age to let that happen.

Senator SIEWERT: How does a family engage in terms of being aware that the three-year health checks are available?

Mr Singh: We will convene an expert group in child health in this coming year who will be advising on the exact nature of the assessments and the instruments that would be included.

Senator SIEWERT: So, you have not determined any of that yet?

Mr Singh: That is correct.

Senator SIEWERT: When is that coming on stream?

Mr Singh: It is the year after, 2012-13.

Senator SIEWERT: Is there going to be broader consultation from the advisory group that you are establishing?

Mr Singh: I imagine that the group would want to undertake some sort of consultation, but those details we will be thinking through as part of detailed implementation.

Ms Harman: The other important task that the expert group will be charged with is to actually map existing services so we get a sense of where they are and where children and their families can be referred to.

Senator SIEWERT: I will probably put some more questions on notice. I have a couple of other areas and I apologise for racing through this. I wanted to go to the eHealth elements of the new package. Before I go to the new initiative, I would like to go to the beyondblue men's health campaign. Have you given any thought as to how much of that will be specifically targeted at young men?

Ms Krestensen: We have entered into contract with beyondblue for that component of the Taking Action package, and we are aware that young men is an area of interest/focus of beyondblue. I cannot quantify in terms of the amount of that particular piece of work being directed to that group, but they are very mindful that that is a particular target group they need to work towards, as well as of course concern continuing around middle aged men, who are the group at highest risk of suicide.

Senator SIEWERT: I think we understand the issues around middle aged men and the fact that we need to target messages there. I understand from some of the research that is occurring now that younger men need specifically different messages and do not pick up on the targets for middle aged men. That messaging needs to be very different. How much of that money have you agreed with beyondblue will be targeted to specifically young men?

Ms Krestensen: We would have to take that particular question on notice. I am very happy to look into that for you.

Senator SIEWERT: Now that you have entered into a contract with them, do you still engage in discussions on how that will be rolled out?

Ms Krestensen: Do we engage with beyondblue?

Senator SIEWERT: About how that measure will be rolled out?

Ms Krestensen: Absolutely. We have a fairly detailed contract with them for that particular component, which requires regular communication and correspondence.

Senator SIEWERT: Can you take on notice whether there is a percentage set aside for young men?

Ms Krestensen: Certainly.

Senator SIEWERT: I would like to go on to the broader eHealth initiative now, as part of the package. What is the intention of rolling that out? Have you identified potential partners or are you going to be identifying potential partners?

Ms Krestensen: This funding is really a tip of iceberg funding in the sense that the money announced through the budget, which was \$11.1 million over four years and \$14.4 over five years, was designed to glue together other existing investment in eMental health. A particularly important part of that overall picture is the National Health Call Centre Network, which has already received funding for mental health enhancement from the Commonwealth. There have been discussions under way for some time about the use of that money, in part, going towards construction of the basic infrastructure for a portal. The intent would be to optimally use that funding and to use that as the base to develop specifications with input from the sector on how to go forward with the components of the measure.

The measure itself was designed to promote easier access by bringing together all the various bits and pieces that we fund and that others fund that are credible eHealth interventions to expand the virtual clinic element of our central strategy by expanding online therapies and to develop a central support service that would support all of the above. The intent is to use the portal construction through the National Health Call Centre Network and build upon that by linking in our existing and continuing investment in telephone and web based measures and also to optimally use the investment from the Taking Action package in a virtual clinic to construct a whole strategy, so to speak.

Senator SIEWERT: You mentioned central services. Who would be providing those central services?

Ms Krestensen: The approach to market has not yet been worked out for that element. We could go to tender, but there will certainly be a process to work out who will be the provider of that central support service, and we also need to work out what process we will be using to identify who will be the operator of the virtual clinic, which is a key component of that measure as well.

Senator SIEWERT: So, the actual process of establishing it has not been finalised yet?

Ms Krestensen: That is correct. We need to get the whole strategy together and then progress the parts. The one part which is very well progressed is the advice on construction of the portal itself.

Senator SIEWERT: Did you say that has progressed?

Ms Krestensen: Yes.

Senator SIEWERT: Who is doing that?

Ms Krestensen: That is the National Health Call Centre Network through the funding which the Commonwealth has already provided to them for mental health enhancement. The

specifications of how to do that will very much be drawn from the telephone and web based experts, with whom we work regularly in this space.

Senator SIEWERT: In terms of existing eHealth providers—and this committee has heard from a number of them through our various inquiries—will they be engaged in discussion about how to roll this out?

Ms Krestensen: Absolutely. They could try very hard to get away from us, but they would not be able to. We will be engaging them very much in the process of developing specifications of the various components. We plan to be revisiting the telephone and web based advisory group that we have and strengthening that as being an ongoing advisory structure to shape this whole proposal.

Senator SIEWERT: So, enhancing that then becomes the advisory body for the whole imitative?

Ms Krestensen: That is correct.

Senator SIEWERT: Is it \$14.4 million over five years?

Ms Krestensen: Yes.

Senator SIEWERT: You mentioned the previous figure, which I missed.

Ms Krestensen: It is \$11.1 million over four years.

Senator SIEWERT: It is so much per year loaded upfront presumably, while you construct the web portal and so on. Is that correct?

Ms Krestensen: I can get the year-by-year funding if you are interested.

Ms Harman: In 2011-12 it is \$1.9 million; in 2012-13, \$2.9 million; in 2013-14, \$2.9 million; and in 2014-15, it is \$3.3 million. In the fifth year, it is \$3.3 million.

Senator SIEWERT: Is the funding allocation designed as the service ramps up?

Ms Harman: As Ms Krestensen said, with a lot of the infrastructure and establishment of the portal—we have made great strides on that. This is about rolling out these other two measures in terms of the new funding, going to market and then obviously having the time to establish the governance arrangements and the actual infrastructure to support the virtual clinic and the central support service. There is a gradual ramping up.

Senator SIEWERT: I am conscious of time. I would like to spend my last couple of minutes on Indigenous mental health. Would you like me to ask that on Friday? Would it be easier to ask about that on Friday?

Ms Harman: That would be preferable.

Senator SIEWERT: I will do that on Friday. That will buy me a bit more time here.

CHAIR: And maybe on Friday.

Senator SIEWERT: Should I ask questions specifically about the money that has been brought forward out of the National Suicide Prevention program to the Kimberley on Friday?

Ms Harman: That would be fantastic.

Senator SIEWERT: How is the rollout of the rest of the package progressing in terms of the hotline? Are each of the initiatives now underway or the planning for them? I realise it does not get underway until July. Is the planning for all of those initiatives underway?

Ms Krestensen: We are actually—

Senator SIEWERT: This is the standard suicide package, sorry.

Ms Krestensen: Yes, we are pleased with the progress across the board on that package. There has been progress against each of the measures. As Ms Harman explained earlier, there is only funding on I think it is seven of the measures this year and eight commence next year, but there has been planning against all of them. There has been particularly strong progress in terms of the services for men, as we were talking about before, and in terms of the ATAPS psychology services. Even though the funding starts next year, we are very well advanced in terms of talking to the sector and developing an approach for taking that funding through divisions next year.

In terms of the crisis lines, there has been significant progress which we have then supported through our colleagues in the Department of Broadband, Communications and the Digital Economy. In progressing the concept of free calls to Lifeline's crisis line, both Vodaphone and Telstra have committed to provide free calls by mobile phone to Lifeline's crisis line, which is an extraordinarily important breakthrough as part of that measure.

Senator SIEWERT: That is Vodaphone and Telstra, did you say?

Ms Krestensen: Vodaphone and Telstra; that is right.

Senator SIEWERT: What about Optus?

Ms Krestensen: We have had no progress with Optus that I can report on to date. My apologies to Optus if there is progress I do not know about.

Ms Halton: No pressure on Optus at this point.

Ms Krestensen: But our colleagues at broadband are progressing those discussions with assistance from my staff and with Lifeline. The way this works is that we will be getting some funding through Lifeline to partially offset the cost to the phone companies of setting up those new arrangements.

Senator SIEWERT: How long is it before that is likely to come to fruition?

Ms Krestensen: It is expected to be in place by July 2011. We are hoping it will be ready to roll very soon. That has been exciting progress. It has of course been progressed in terms of the Suicide Hot Spots funding in terms of the funding for The Gap this year. Discussions are to take place over the coming months to start to plan where those other sites might be. There have also been discussions with headspace and Principals Australia about how we take forward the schools outreach suicide prevention project. That is being developed as a hand-in-glove project to complement the MindMatters school based program. There is good progress across-the-board at a particularly busy time. But we are very pleased with how much we have been able to progress this year, noting that the bulk of the funding really starts to kick in next year.

Senator SIEWERT: As to LGBT funding—you were just waiting for that, weren't you?

Ms Harman: As I think we gave evidence at the last hearing, we have provided \$139,876 GST inclusive this financial year for a project for the alliance to strengthen their networks and linkages between the LGBTI sector and other suicide prevention programs and projects. That is being funded through the Taking Action to Tackle Suicide package. We have also provided some core funding to the alliance for this financial year of \$60,390, and that is in contract, as I

understand it, to support the operations of the alliance this financial year. Funding past this financial year is under very active consideration.

Senator SIEWERT: When is it likely that that will be?

Ms Harman: I am not able to provide you with an exact date at this stage. As I said, it is under active consideration.

Senator SIEWERT: Before this next financial year starts?

Ms Harman: I would hope so.

CHAIR: I thank the officers from mental health. There will be quite a few questions on notice for you as usual.

Proceedings suspended from 15:36 to 15:51

Senator ADAMS: The network of one-stop shops across Australia was to be established at a cost of \$37 million. It was to start on 1 July 2011 with a one-stop shop in every region supported by telephone and web based systems. Is that going to go on or will the government's single phone number for consumer and carers take its place?

Ms C Smith: In early April Minister Butler announced the phased implementation of the one-stop shop measure, the single phone number that you refer to, and the improved web presence, which will be available from 1 July, is the first step in that process. The government was very mindful of the need for both people delivering aged care services and for those receiving them to have assurances about continuity of service delivery and the need to move in a careful and phased way from where we are today to where we want to be in the future.

Senator ADAMS: Regarding the new front end, which will have strong links, one again, with the local hospital networks and Medicare Locals, how is that all going to work together? The government will continue to support access to information through the aged care information line and the aged care website, but just where does all that fit in?

Ms C Smith: We have been working with our colleagues in the primary and ambulatory care division as we implement each of our measures, because it is really important that both health reform measures are complementary to each other. Medicare Locals are going to be focusing on population and service planning while the new front end of aged care has more of a focus on providing information assessment and access to services for individuals. They have slightly different roles, but it is really important that they provide a complementary service. As a first step, during the 2011-12 period, we are going to be working with a small number of the first 15 Medicare Locals to get an understanding of the best way to connect the two services, and that reflects the feedback that we have received about the need to ensure that aged care and primary healthcare systems are working in an integrated way to meet need.

Senator ADAMS: As far as multipurpose services and the aged care component of those is concerned, how do they fit into the Medicare Locals and the provision of aged care?

Ms C Smith: I think that is probably a question for primary care, but certainly multipurpose services would be one of the services that is relevant in the local region. As part of the service planning that Medicare Locals will need to do they will need to understand both the residential aged care services and the multipurpose health services that are available in that region. There is also the new regional health agency, which I think will also have a role in that regard.

Ms Halton: Can you give us a bit more of an indication of what your particular interest is? As you know, multipurpose services are an absolutely crucial element to the delivery of services—

Senator ADAMS: I certainly do know. That is why I am posing the question.

Ms Halton: Indeed, and we know how big a supporter you have been of them over the years. Essentially the way we see this working is we need to get a much better handle on all of the services that are delivering basically out-of-hospital care in a community, and so they will have to have an eye to what is going on with aged care as well as what is going on in the more traditional primary care world. Because MPSs straddle those domains, there will have to be a very close working relationship. You can assume that is our intention. I was just wondering whether there was anything else you were trying to elicit.

Senator ADAMS: No, I am just making sure that those small communities which I have been going on about local, local, local—

Ms Halton: Yes.

Senator ADAMS: I am coming right from the grassroots and the really local issues and with the very small health services or hospitals—of course most of them are—they have multipurpose services, especially in Western Australia. I am really worried about the size of the Medicare Locals in that the primary healthcare for these small communities and the aged services which are absolutely essential are not forgotten. That is why I am raising—

Ms Halton: No, they will not be. I absolutely promise you they will not be. They are very high on our agenda.

Senator ADAMS: They are very important. The incentives that have previously been paid to health professionals, general practice and allied health to provide care in residential aged care facilities I understand are going to be transferred to Medicare Locals. I am having problems with the budget papers, so I am not clear as to whether these incentives will still be there for health professions and, once again, coming back to the smaller communities how the Medicare Locals would deal with it. This is in aged care.

Ms C Smith: Those initiatives are actually administered by the primary care division. I am sorry, I think that would have to be something for them later in the afternoon or tomorrow.

Senator FIERRAVANTI-WELLS: Can I start with the savings measure across the department that we talked about earlier? Will there be any changes in relation to Outcome 4 in terms of staffing and savings across-the-board?

Ms Halton: Yes.

Senator FIERRAVANTI-WELLS: Does that include potential staff losses in aged care?

Ms Halton: Certainly all parts of the department are affected by the streamlining changes and the efficiency measures. That means everyone is affected. There is certainly also program consolidation work that affects this program so, yes.

Senator FIERRAVANTI-WELLS: In view of the Productivity Commission bringing down its report—we know when that is coming and then of course there will be a period of work for the department in relation to formulating the government's response—will that effect the timing of the government's response?

Ms Halton: No.

Senator FIERRAVANTI-WELLS: Assuming the Productivity Commission will deliver on time, what does the government envisage will be the time frame for its response, bearing in mind I note the sitting day requirement, but that is not always an indicator.

Ms Halton: I think that is a question for the parliamentary secretary, to be honest with you. I cannot commit the government—they have said they will respond in a timely fashion—

Senator FIERRAVANTI-WELLS: Senator McLucas?

Senator McLucas: It will go to our minister, and as I understand it he has indicated that we will respond within the designated time.

Senator FIERRAVANTI-WELLS: In the sitting period? Okay. I would like to ask some questions in relation to the GPs in aged care. In the last budget I think there was that measure of trying to—

Ms Huxtable: I think you might be asking in the wrong outcome. I think it is in Outcome 5.

Senator FIERRAVANTI-WELLS: Are we back to that again? So, this is in my GP outcome?

Ms Huxtable: Yes, if it is about the aged services.

Senator FIERRAVANTI-WELLS: Yes, it is. That is primary care. The February heads of agreement confirmed that the Commonwealth will take full responsibility for aged care policy. I assume discussions are continuing with Western Australia and Victoria about the transfer of HACC services; is that the case?

Ms C Smith: Yes, that is correct. There is a commitment from the heads of agreement that there would be a discussion about a potential change in roles and responsibilities and those discussions are underway.

Senator FIERRAVANTI-WELLS: Whereas under Mark 1 there was a defined timetable, we are now talking about three years for aged care pursuant to the heads of agreement 61 to 63. It says, 'The proposed agreement will be delivered'—

Ms Huxtable: I may be corrected, but I do not believe that the timetable actually changed. I believe the timetable for the transfer of HACC services has not changed.

Senator FIERRAVANTI-WELLS: The transfer of HACC happened at the same time that other reforms—

Ms C Smith: There was an acknowledgment from all parties to the heads of agreement that aged care and mental health would be areas of reform during the next three years. The existing commitments that participating states had made in terms of the transfer of responsibility for the HACC program continue. So that is 1 July 2011 in terms of funding and policy responsibility, and 1 July 2012 for operational responsibility. Then for Victoria and WA the heads of agreement outlined that there would be a discussion about a potential change in roles and responsibilities.

Senator BOYCE: I think I have got the right people at the table, so I will ask my question now. The budget papers state that we are going to have savings of \$211.7 million over five years because of the lower costs of delivering care in the home. For the record, could you give me the elements that are going to contribute to those savings and the savings from each of those elements. I got that wrong, obviously.

Ms C Smith: This was a measure that was actually announced as part of the portfolio additional estimates back in February and it was a reflection of outcomes from the ACAR process last year.

Senator BOYCE: This is about the rebalance according to the current budget papers.

Ms C Smith: It is a temporary change in the planning ratio to reflect that there were more community care places rolled out last ACAR instead of residential care places, and it reflects the fact that it is slightly cheaper to roll out community care, because it does not have the accommodation component.

Senator BOYCE: Yes, but who is going to be providing what and what are the savings in each area, related to the fact that you are increasing some programs but decreasing the high-care programs?

Ms Halton: It is hard to put it in those terms, because essentially it is a temporary change to the ratio. It is quite complex in terms of the way the formulas work, because it is to do with when the beds are going to come on and a whole series of other things. We work on the basis of a cost per residential care place as against, in this case, the cost per community care place. Because of this temporary change it then is reflected in the relative share of the estimates of how much is there for community care places against how much is there for residential care places. So the number of places has moved from one place to the other place, but there is a consequential. You cannot say this organisation will have less and this organisation will have more; it does not quite work like that.

Senator SIEWERT: The bottom line—

Senator BOYCE: Where do you get \$211.7 million from?

Senator SIEWERT: What happens to the \$211.7 million?

Senator BOYCE: How did you arrive at that figure?

Prof. Cullen: The cost is the cost of a policy change. The policy change is as follows.

Senator SIEWERT: Sorry to stop you; we are short of time. We get that. I want to know where the \$211 million goes. Does it go back into aged care spending later on or is it lost to the portfolio?

Ms Halton: It is actually a technical change. We would regard this as being a technical estimates variation, to be quite honest with you, because the way our money is derived is from a formula and it is a consequence of a place. For example, if a place is slow coming on, we do not get that money back to spend elsewhere. Because they are standing appropriations, it is the places that drive, according to this formula, the aggregate that we get appropriated. We move the places from one place to the other, and we then drive that side of the equation, we compare the difference, which is \$211 million, and that is a save. But, no, it does not come back in somewhere else.

Senator BOYCE: What are the actual figures for high-care residential and at home? What are the figures that you use there?

Ms C Smith: As in the ratio that we are operating under?

Senator BOYCE: Yes.

Ms Halton: Do you mean the cost or the ratio?

Senator BOYCE: The cost and the ratio.

Prof. Cullen: We will have to take the cost on notice.

Senator BOYCE: But that is where you got your \$211 million from, is it not?

Prof. Cullen: It is.

Ms C Smith: It is a fairly complex model, though.

Senator BOYCE: That is fine, if you could take that on notice. And the ratio?

Prof. Cullen: As I started to explain, the ratio is 113 overall. The ratio is that there will be 48 high-care places and 65 low-care places. Those two ratios are unchanged by this policy. There is another ratio, which is that over the long term there will be 88 residential and 25 community. In the short term that has changed to 86 and 27. The first two ratios are unchanged; the only ratio which has changed is the residential community split.

Senator BOYCE: So the \$211.7 million is derived from the change from 88 to 86 and 25 to 27 over five years?

Prof. Cullen: That is correct.

Senator BOYCE: Thank you. And, yes, if you would take those other questions on notice.

Senator SIEWERT: Before you move on, I actually did have a question about the HACC issue, going exactly to the issue that you just raised, Ms Smith, in terms of consultation with WA and Victoria. There was a conversation held in the planning options committee hearing around where we were up to with the HACC reform, and you said WA had gone off to do some consultation. I inquired in Western Australia about consultation and it does not seem to have got very far. I am just wondering whether you have had an update since I have had an update from WA in terms of where they are up to with the new heads of agreement or the new COAG agreement.

Ms C Smith: I certainly know that WA is doing a fair bit of consideration within government about its position. I am not sure the degree to which they are talking to the sector. We were at a forum—

Senator SIEWERT: I have a question from the parliament in WA. They said, 'The stakeholders are yet to be determined.' So they have not even got as far as doing that yet.

Ms C Smith: We are certainly going over to WA in a couple of weeks, I believe, and there are discussions with stakeholders as part of that visit.

Senator SIEWERT: I am aware of the time, so I do not want to take us back through again the rollout process, but given that WA is now so far behind in that consultation process how does that then relate to the reform process that you have just been through but that we also went through at a hearing in March?

Ms C Smith: I certainly could not pre-empt in any way the outcome of discussions at a COAG level, but I think that if Victoria and WA were to come onboard then there would have to be a separate discussion about the time lines that might apply to them.

Senator SIEWERT: At the moment, in that case, does that mean that in WA and Victoria the current situation prevails basically until further notice?

Ms C Smith: Business as usual will apply in those jurisdictions until their government makes a decision otherwise.

Ms Huxtable: Between us and them, certainly.

Senator SIEWERT: Yes, and I understand what you are saying in terms of internally, but this was as of only two weeks ago. They had not even determined which stakeholders to talk to. I think at that hearing the process was that WA said they would go away and undertake consultation. It has not happened yet. I do appreciate, without slagging off WA too much, that they have just been through the budget stuff and they are doing a whole lot in the not-for-profit sector. So I am not slagging them off, I am just asking what that means in terms of where you are up to in rolling out the reforms.

Ms C Smith: I think there was also a really good opportunity at the beginning of April at the Home and Community Care conference. We had HACC providers from all over the country, including Victoria and WA, and on the third day there were quite a number of sessions about the reform process, including quite detailed discussions about the HACC issues. We certainly got good engagement from stakeholders at that service provider level during that process. So that is another opportunity for people that they have had recently.

Senator SIEWERT: Thank you. I am done.

Senator FIERRAVANTI-WELLS: Just in relation to that, the policy and funding responsibility for aged care is expected to be budget neutral. Is that still the situation? Yes. Has the mechanism to achieve this been finalised?

Ms C Smith: That is still under consideration.

Senator FIERRAVANTI-WELLS: Do we have a time line in relation to that?

Ms Balmanno: It would actually be a question for Treasury as to the mechanism for budget neutrality.

Senator FIERRAVANTI-WELLS: Are they the ones that will be working out the mechanism?

Ms Balmanno: Yes, the Commonwealth Treasury is negotiating with state and territory treasuries on the appropriate mechanism.

Senator FIERRAVANTI-WELLS: Can I just ask about the one-stop shops? They are not going to be implemented as originally envisaged—is that the case, Ms Smith?

Ms C Smith: Minister Butler has announced that they will be implemented in a phased way and that it will start with a single phone number and enhancements to the website.

Senator FIERRAVANTI-WELLS: That is developing a new front end for the system?

Ms C Smith: I think what has been really clear during the consultation process is that we have had really good validation from stakeholders about all the different elements of what is required to improve service in this area. Information provision is clearly an important part of that. There is also the work that we need to do in terms of needs identification and assessment—both the preliminary assessment and then the more comprehensive assessment—and then the work that we can do to better link consumers to services. The other clear message that has come from the consultation process is that we have quite a complex system of service delivery at the moment with existing relationships and networks, and we need to

proceed carefully to move from where we are now to where we want to be. We will start focusing on the information provision in the first instance.

Senator FIERRAVANTI-WELLS: There was \$20 million allocated in last year's budget. If this is not going ahead for the one-stop shops, what is happening with that allocation? Has it been reallocated somewhere else?

Ms C Smith: That \$20 million was for an ICT system to support all the very important interactions that need to occur between all the different entities. We needed an IT system to enable that to happen most effectively. That money has been rephased.

Senator FIERRAVANTI-WELLS: It will just be spent in the future when you have worked out what you are actually going to do?

Ms C Smith: It will be spent in future when we get to the next phase.

Senator FIERRAVANTI-WELLS: At the moment it is just a telephone number. How does that work? That is all very well for people that speak English, but what about culturally diverse communities? We have an increasing number—it is about 25 per cent now. Have you built into that provisions for people who do not speak English?

Ms C Smith: We have been doing quite a lot of consultation in that area, and I might ask Ms Mackey to explain.

Ms Mackey: In the first instance, with the new number, it will divert geographically to the Commonwealth Respite and Carelink Centres. There are all of the existing support mechanisms for people that find it difficult either to understand English or maybe even to use a phone number; they will still be able to use all of those supports that are already in place. We are certainly, as Ms Smith has talked about, in terms of the phasing for the new front end working closely with a range of stakeholders as well, including those representing CALD communities, to make sure we get the right approaches in place for the future to meet their needs.

Senator FIERRAVANTI-WELLS: Can you take on notice a bit more detail about that, particularly in relation to the CALD communities. In relation to another round of zero-interest loans being conducted, have you done an evaluation on how the process has gone thus far, Ms Smith? I have not been able to actually work out how many new beds this whole process has actually resulted in.

Ms C Smith: My colleague Ms Robertson has that.

Ms Robertson: Bear with me for a moment while I find the numbers I have on that.

Senator FIERRAVANTI-WELLS: I know this was one of Ms Podesta's favourites. I just wanted to remember her, Ms Halton.

Ms Halton: Actually I will share with you, while someone is flicking pages, that there has been an active conversation on this. You might recall that at last estimates we all discovered that Ms Podesta was watching. She is a very unwell human being.

Senator FIFIELD: It sounds like she is watching from on high.

Ms Halton: No.

Senator FIFIELD: I assume that is not the case.

Ms Halton: No. She has been counselled about this behaviour.

Senator FIERRAVANTI-WELLS: Has she?

Ms Halton: As none of us has actually received a text from her today, we are actually moderately confident it may have worked.

Senator FIERRAVANTI-WELLS: In case she is watching, she is being missed.

Ms Halton: She is gardening, smelling the flowers—doing something.

Senator FIERRAVANTI-WELLS: No offence, Ms Smith.

Ms C Smith: No, but we did wonder whether you needed to set up Estimates Anonymous or something for people who cannot give up their addiction.

Senator FIERRAVANTI-WELLS: I know. It is a bit like Ms Brown, formerly of my office, now in Europe; she is probably watching.

Ms Halton: They are sad people.

Ms Robertson: Some of them need to get a life.

Ms Robertson: I have found those figures for you. In round 1 we had a total of 40 offers for 1,348 residential aged care places.

Senator FIERRAVANTI-WELLS: They are still in the process of being—

Ms Robertson: Some of them are going—

Senator FIERRAVANTI-WELLS: Can you take on notice for me—I am conscious of time—where they are, please.

Ms Robertson: I can tell you that at 5 May we had 16 providers who had completed their projects and brought online an additional 247 residential aged care places into areas of high need.

Senator FIERRAVANTI-WELLS: Can you just take on notice where those places are.

Ms Robertson: Certainly.

Senator FIERRAVANTI-WELLS: The regions.

Ms Robertson: The planning regions within the states?

Senator SIEWERT: Yes, please.

Ms Robertson: Certainly.

Senator FIERRAVANTI-WELLS: In relation to the Productivity Commission, what steps are you taking in preparation for the final report? Ms Smith, obviously you have received a draft report.

Ms C Smith: The draft report was publicly received. The department made a submission to that process, which is up on the Productivity Commission's website. We have had meetings with the Productivity Commission and we have had meetings with relevant stakeholder groups as part of our informing ourselves as to the extent of reaction to the draft, and obviously we are waiting with bated breath for the final.

Senator FIERRAVANTI-WELLS: Tell me: has the department received complaints or have concerns been raised with the department in relation to recommendations in the draft report, including the more contentious issue of counting the family home in a person's capacity just to pay some of the care costs?

Ms C Smith: I certainly do not think you would regard feedback on a draft report as complaints. I think the Productivity Commission—

Senator FIERRAVANTI-WELLS: Perhaps I can rephrase my question.

Ms C Smith: Actually not much, no.

Senator FIERRAVANTI-WELLS: ‘Contact’ to the department in relation to any of the more contentious elements?

Ms Halton: In fact, much less than I anticipated, if I am going to be quite honest with you.

Ms C Smith: I think the Productivity Commission has also had a very extensive process for people to feed their views through to them—public hearings, submissions and so on. It has been relatively quiet.

Ms Halton: As I said, it is quieter than I thought.

Senator FIERRAVANTI-WELLS: I am conscious of time. I am just going to go through the ones that I have. As to the consumer directed care packages that were announced in the 2010-11 budget, I understand that 500 packages were allocated. How many of those are operational?

Ms Mackey: They are fluctuating. We are monitoring them as part of the evaluation, but we are not monitoring them on a weekly or a monthly basis.

Senator FIERRAVANTI-WELLS: Just as a ballpark, how many are operational?

Ms Mackey: I would have to take that on notice. We are certainly aware from feedback from providers that there has been a high level of demand and interest in the packages, with people looking at the website to check the service providers who have those places and indicating their interest before the packages were even ready to be operational.

Senator FIERRAVANTI-WELLS: Has there been some evaluation process?

Ms Mackey: There is an evaluation process underway by KPMG.

Ms C Smith: We also have the second round of places that were advertised in mid-March, and applications closed on 21 April and we are in the process of assessing them.

Senator FIERRAVANTI-WELLS: I am happy for that evaluation process to be taken on notice. I will put the rest of my questions on notice, because I am conscious of time.

Senator BOYCE: In relation to the quite strange little announcement all by itself in the budget of about \$4.4 million for an aged care accommodation facility at Hughenden, will this come out of existing capital programs?

Ms C Smith: No, it will not.

Senator BOYCE: So it is new money?

Ms Halton: Yes.

Senator BOYCE: From? Just new money? Okay. How did this come to be? Why Hughenden? What other areas were assessed as potentially requiring a new aged care facility and being put in the budget?

Ms Halton: In fact, I was actually telling Senator McLucas that Hughenden has been on the radar in terms of an aged care facility. I can remember the day when I first had it raised

with me. I went back to work after having child No. 2. As he is about to turn 18, I can tell you quite confidently when this was first raised with me. This was a decision—

Senator BOYCE: Would you be able to give me a list of the need for aged care facilities throughout Australia that have been raised with you in the last 12 years, say?

Ms Halton: No.

Senator BOYCE: You are not suggesting this is the only one?

Ms Halton: No, but I cannot sit and—

Senator FIERRAVANTI-WELLS: Would that not require a list?

Ms Halton: No, we were talking about this particular facility.

Senator BOYCE: Who is the approved provider for this facility?

Ms C Smith: It is actually a different model from that. The concept of approved provider refers to a service funded under the Aged Care Act.

Senator BOYCE: Perhaps you can explain this aged care accommodation facility to me, then. Will it have beds or not?

Ms Halton: Approved beds, no.

Ms C Smith: It will comprise self-contained rental units and some community facilities co-located on one site.

Senator BOYCE: So what will the ownership structure be, then, or the service provision structure? Will they rent them from the council or from who/what?

Ms C Smith: I would have to take that level of detail on notice.

Senator BOYCE: But, if this is a whole new model, do you not know what the whole new model is?

Ms C Smith: This is going to be a collaborative model between the local council and the local community. The exact governance structure to support that I would have to take on notice.

Senator BOYCE: You can take the services that will be provided there and whether there will be beds there on notice and tell me.

Ms C Smith: We can certainly provide you more detail on notice. As I said before, this is a combination of self-contained rental units, a communal dining room, a recreational area, a respite care suite, and some office facilities that enable the congregation of both accommodation and services in a remote area.

Senator BOYCE: What will the total cost of the project be?

Ms C Smith: The government contribution is \$4.4 million, but I believe the community will also be contributing towards this as well.

Senator BOYCE: The council, the community or both?

Ms C Smith: I believe both the council and the local community.

Senator BOYCE: Where would I find the total figure for the cost of this?

Ms C Smith: We believe it is a total figure of approximately \$5 million.

Senator BOYCE: So they are going to put in \$600,000?

Ms C Smith: That is my current information.

Senator BOYCE: That will include a new building and everything else?

Ms C Smith: Yes.

Senator BOYCE: Are you aware of the ordinary annual services report from the secretariat of community affairs on your budget? No. The secretariat of community affairs has produced the ordinary annual services report, which was sent through to us last Friday from the community affairs department. It looks at what may perhaps be errors.

Senator McLucas: Is that a state department?

Senator BOYCE: Sorry. It was sent through about the departments that are covered by the committee on community affairs.

Senator FIERRAVANTI-WELLS: Ordinary annual services budget estimates.

Senator BOYCE: I specifically made an inquiry on Friday afternoon and was told that it had been provided in the past to the Clerk of the Senate but it was now provided to the committee.

CHAIR: I am unaware of this document.

Senator BOYCE: I asked if it was a document that needed to be approved by the committee before it could be referred to and was told no.

CHAIR: Keep on with your question until we hear what it is.

Senator BOYCE: Within this report the community affairs committee secretariat has come to the view that the \$4.4 million for an aged care accommodation facility in Hughenden may well be misplaced and should, in fact, be listed elsewhere and that whilst it forms part of program 4.7 in your table 1.3.1, page 38, the individual program expenses for it are not listed individually as you would expect under table 4.30 on page 203.

Ms Halton: On page 203 of what?

Senator BOYCE: Of your PBS—table 4.30.

Ms Halton: Page what?

Senator BOYCE: Page 203 of the DOHA PBS, table 4.30. It states, ‘The new measure forms part of program 4.7,’ but the program expenses for 4.7 are not listed individually as one might expect they would be in table 4.30.

Ms Halton: It is capital funding. Apart from the fact that I have not seen the document to which you refer and I am unaware of some committee’s consideration of the issue, I do not believe we have appeared in front of any such committee and provided any kind of evidence, so I am unclear as to the basis of this conclusion. I could go on, but at the end of the day this is capital funding for a flexible service. It is not generally our habit to put things in the wrong program.

Senator BOYCE: I would hope not, and that is the reason for asking the question.

Ms Halton: Exactly, yes.

Senator BOYCE: Could you perhaps take the question on notice and confirm what you have just said?

Ms Halton: I would be happy to say on the record that it is my understanding that the expenditure is correctly classified, but without seeing the document to which you have referred—

Senator BOYCE: Absolutely. I agree that you probably need to see the document. I specifically made this inquiry on Friday afternoon, and I would hope that we can make it available to the department.

Senator FIFIELD: I think the matter might go to an ongoing dispute between the House and the Senate as to where particular things should be allocated. I could be wrong, but I think it goes back to something called the Compact of 1965—but anyway.

Senator FIERRAVANTI-WELLS: I think there is a discrepancy on page 212 of the blue book and page 203 of the yellow book. I am sorry; that is putting it in a simple way.

Senator BOYCE: That is the suggestion and it is only a suggestion.

Senator FIERRAVANTI-WELLS: Page 212 of Budget Paper No. 2 refers to—

Senator BOYCE: I did not want to take hours here. Can we just follow this up on notice. As I said, it is simply a suggestion; it is not a definitive view that there is an error here. I would ask you to look at it. It did particularly come to my attention because it seemed a bit odd that we had one little aged care accommodation facility getting its own little mention in the budget.

Senator FIERRAVANTI-WELLS: While we are at it we might put on notice—

Senator BOYCE: It is in the electorate of Kennedy, as I understand it.

Ms Halton: I guess what Senator Fifield is helpfully suggesting is that this goes to some outstanding issue between the House of Representatives and the Senate. Rule No. 1, as any public servant knows, is never get in between the House and the Senate, because that is not a smart place to be. We will have to take some advice on what that issue is, because I certainly do not know. Whether there is anything I can say to you on notice about that, I think it would be—

Senator BOYCE: Perhaps you could tell me on notice.

Ms Halton: Yes, I could.

Senator BOYCE: Then I will ask at the next estimates.

Senator SIEWERT: Can I go to the issue of young people in nursing homes? Is this coming year, 2011-12, the final year of the program? That is correct, is it not?

Senator McLucas: The allocation from the Commonwealth is ongoing but it has been rolled into the National Disability Agreement. That amount of funds will continue to be delivered to the states and territories in the National Disability Agreement.

Senator SIEWERT: At the same level?

Senator McLucas: With indexation.

Senator SIEWERT: Has an evaluation been done of the first part of the program?

Prof. Cullen: This program is administered by the department of families, not by this department. So we cannot answer questions about it.

Senator SIEWERT: I do have questions for you, because you obviously interact with that program. Bearing in mind that you have not done the evaluation, are you aware whether there is an evaluation and have you participated in it?

Prof. Cullen: My understanding is that there are annual reports published about that program prepared by the states and territories. I have discussions with FaCHSIA every now and again about the program, but in essence the program is managed out of there. We manage the aged-care homes.

Senator SIEWERT: In that case, let me be more specific. Have you done an evaluation or looked at what impact the number of young people in nursing homes has on the provision of aged care—say, bed blockages, and the provision of different care for younger people in aged care? Have you done any of that work looking into where the program goes to in the future?

Ms C Smith: We are certainly very mindful of the issues faced by younger people in residential aged care and have lots of discussions with our colleagues in FaCHSIA addressing the policy question, which is that people should be placed in the setting that is most appropriate to their need. For many younger people with a disability residential aged care is not their preferred setting. In terms of a formal modelling process, perhaps my colleague Dr Cullen might be able to assist.

Prof. Cullen: All I can tell you is that the number of young people as a proportion of all residents—in other words, the amount of space young people are taking up—is going down. In 2001-02 they made up 0.6 per cent of all residents and in 2009-10 they made up 0.4 per cent of all residents. So there was a 33 per cent drop-off in terms of their impact on the entire system.

Senator SIEWERT: I am not trying to be pedantic in this question, but are you talking about the group that is covered under the Young People in Nursing Homes program or are you talking generally about people under the age of 65?

Prof. Cullen: The figures I just gave you were for those under 50.

Senator SIEWERT: Under 50?

Prof. Cullen: Yes. People under 65 made up 3.9 per cent in 2001-02 and make up 3.6 per cent now, in 2009-10. There is no flag that attaches to a resident which says that they are or are not eligible for this program. My understanding is that eligibility is essentially age based.

Senator SIEWERT: There are some provisions around who is included in the cohort of people, as I understand it, for the program. That is why I was asking that question. In terms of any particular changes to the program and its ongoing funding, have you been engaged in any discussions with FaCHSIA about that?

Ms C Smith: It has certainly come up in discussions we have been having with FaCHSIA about a range of issues, particularly the interface between aged care and disability. But it has not come up as an issue of any contention. They just explained how it would work in the future.

Senator SIEWERT: Thank you. I might have some questions on notice once I talk to FaCHSIA about that. Turning to ACFI, you might remember we have had previous

discussions about different assessment tools. If I recall correctly, we had a discussion around different assessment tools that people had been using for people under 65.

Prof. Cullen: I know we have an age based assessment tool instead of the ACFI—

Senator SIEWERT: The discussion was around ageing with a disability and the fact that people were saying that early onset ageing was not being picked up in the current assessment process. As I recall, we had a discussion and the point was made that there was in fact a number of assessment tools where this could be picked up. I have subsequently been told that in fact those other tools are not being used, which is why I am asking the question.

Ms C Smith: I think this question came up in the separate inquiry that was done in relation to people who are ageing with a disability. My recollection is that it was more around the tools used by an ACAP as opposed to the ACFI tools.

Prof. Cullen: We have just completed the review of the ACFI, and this issue was not raised in any submission to that, but I have heard the issue raised in ACAP-land, so my colleague can assist.

Ms C Smith: We might have Ms Mackey come to the table and she can talk about what is happening in terms of assessment tools under the Aged Care Assessment Program, because I think that is where the issue came up in our previous discussion.

Ms Mackey: We have been progressing with putting in place a more consistent assessment tool across the Aged Care Assessment Program. At the moment an array of assessment tools is used. We have been working very closely with aged-care assessments teams and the clinical reference group to look at what tools would cover off the broad range of triggers and conditions that they wanted to encompass in a comprehensive assessment. There are three core assessment tools that are now being progressed. The first is around cognition and it is the standardised mini mental state examination. The second is around activities of daily living, where we are looking at the modified Barthel index. The third is around instrumental activities of daily living, where we have OARS IADL items. They are being put together as a toolkit. The clinical reference group actually met last week to consider that toolkit and we are now in the process of developing an education pack for aged-care assessment teams. There is no age delineation in terms of those tools. I can provide more information in terms of what those tools go to which demonstrate that it is on the basis of the person's individual capacity as to whether they have a disability or whether it is through the frailties of ageing.

Senator SIEWERT: That would be appreciated. I have had several instances now where people have got back to me and said their loved one has not been assessed—that they basically will not be assessed using a tool because they have a disability and they are ageing prematurely. Does that mean it is actually the ACAT teams that are not using the tools appropriately?

Ms Mackey: At the moment ACAT teams use a range of tools, and that is not prescribed in terms of the way that program operates. Each state has developed its own set of tools that it uses. Sometimes that is right down to a team level.

Senator SIEWERT: I thought under the new process there was a push to have everybody using this. I am not wrong there, am I?

Ms Mackey: Absolutely not.

Ms C Smith: That is an important part of what we are doing to improve the consistency in terms of the ACAT program.

Ms Mackey: And that is exactly what this toolkit is all about.

Senator SIEWERT: While that was being delivered and the proposal was out there, the consistent tools were not available?

Ms C Smith: At the moment there may be individual ACATs who have assessed people and caused the concern that you are talking about, but we are in a change process and we are confident that the new tools used consistently will improve that assessment process. Next time the clinical reference group meets specifically, we can discuss with them some of those concerns and see what their professional opinion is.

Senator SIEWERT: That would be appreciated; thank you. I have some data questions around packages for each of the states that I am going to put on notice. I want to find out the number of allocated operational packages for each of the states under each of the categories, but I will put that on notice. My other question is: when is the next ACAR round?

Ms C Smith: Planning for that is underway and we expect decisions to be announced soon.

Senator SIEWERT: Is 'soon' before the length of time that is shorter than last year's?

Ms Halton: It is imminent.

Ms C Smith: We have already had meetings of the ACPACs, and we have also been consulting with the sector.

Senator SIEWERT: Lastly, in terms of extra services, do I understand correctly that consideration is being given to going back to extra services on a state based level rather than a regional level?

Ms C Smith: The requirement that applies to ESS is at a state level. We then give consideration to what that looks like at a regional level, because as you would be aware there are some regions that can cope with a higher level of extra service than others and still not unreasonably impede access. As part of our planning for ACAR we are looking at the area of ESS.

Senator SIEWERT: Does that mean you may be going back, focussing on the regions and applying the state level, 15 per cent, again?

Ms Halton: We are looking at how it is administered. The truth of the matter is it applies at a state level. There have been some—

Senator SIEWERT: I understand that but, as you know, it has caused problems in Western Australia because of the way—

Ms Halton: It has, yes.

Senator SIEWERT: it has been applied, which is why I am asking the question.

Ms Halton: We are looking at that.

Senator FIFIELD: The portfolio budget statement on page 188 states that the department with FaCHSIA will continue with the development of the national carer strategy and reporting against the carers recognition legislation. I assume FaCHSIA is the lead department there or is it a shared responsibility?

Ms C Smith: It is a shared—

Senator FIFIELD: On the strategy and reporting against the carer recognition legislation?

Ms C Smith: It is a shared process and we have been working very closely with our colleagues from FaCHSIA on that one.

Ms Mackey: In terms of the legislation, all Commonwealth agencies are required to report against that, not just FaCHSIA and DOHA.

Senator FIFIELD: Has that reporting actually occurred? I know it is intended that the reporting against that is in the annual reports, but is it released in any other form prior to that?

Ms Mackey: The first reporting cycle will be in the next financial year and we are currently working, as are a number of other Commonwealth agencies, with FaCHSIA to finalise the guidelines to support agencies to report under that new legislation.

Senator FIFIELD: Each Commonwealth department agency has to report against that, and so DOHA will do that as any other department would, but is there any broader role that DOHA has in the reporting across government with FaCHSIA or is it really basically that each department and agency does their own report against the legislation?

Ms Mackey: FaCHSIA have certainly been taking somewhat of a lead. I am sure they can provide additional information, because they have taken responsibility for drafting the guidelines to support agencies.

Senator FIFIELD: What is the break-up in the responsibilities between FaCHSIA and DOHA in the development of the carer strategy?

Ms Mackey: It is very much a shared activity and has been for more than 12 months now. There is shared drafting. We have co-convened all of the consultations. We have met with stakeholders together. We have certainly done this in a very collaborative way.

Senator FIFIELD: Could you take on notice and table the stakeholder engagement that there has been?

Ms Mackey: Certainly.

Senator FIFIELD: Is the national carer strategy still due to be delivered by the end of 2011? Is that still the time frame you are working to?

Ms Mackey: I think Minister Macklin has actually indicated that will be mid-2011.

Senator FIFIELD: Did I say 2011?

Ms Mackey: I think you might have said 'the end'.

Senator FIFIELD: I said 'by the end of 2011'. So 2011 is obviously by the end of 2011. Will there be a draft for the strategy released for consultation prior to—

Ms C Smith: There has been extensive consultation done as part of the development of the program.

Senator FIFIELD: I am sorry. I meant: will there be a draft release prior to conclusion of the consultation?

Ms C Smith: I think that is a matter for the government.

Ms Halton: The minister will have to make a decision on that.

Senator FIFIELD: I just thought they may have already.

Ms Halton: Not that we are aware of.

Senator McLucas: There is a consultation paper you may be aware of.

Senator FIFIELD: The issues paper?

Senator McLucas: The issues paper; that is right.

Senator FIFIELD: At the last estimates I raised the issue of those holders of Department of Veterans' Affairs pensioner concession cards who had missed out on the continence aids program, which the department said they were rectifying. Has that been completely sorted now?

Ms C Smith: That has. All the clients who were affected by that issue have received their payments.

Senator FIFIELD: I think the National Continence Management Strategy has been moved into a new fund—a new pot of money—which is the same pot that the CAPS program is drawn from. Is that right?

Ms C Smith: As part of the program consolidation process we have the Aged Care Service Improvement and Healthy Ageing Grants Fund. As part of that the National Continence Program has been transferred into that new fund. The CAPS program is separate.

Senator FIFIELD: It will remain separate?

Ms C Smith: Yes.

Senator FIFIELD: Could you take on notice how many current recipients there are of the CAPS program?

Ms C Smith: There are about 80,000, but we will certainly take the precise number on notice for you.

Senator FIFIELD: How many complaints have been received by the department each month since February? Could you advise the nature of those complaints or issues raised?

Ms Halton: In respect of that program?

Senator FIFIELD: In respect of the CAPS program, yes. Is there any review planned at the moment of what I will just call the new scheme?

Ms C Smith: We are certainly looking at it as a post-implementation process of evaluation. I think that is something that we are just starting to get underway as well at the moment.

Senator FIFIELD: Have there been any deletions or changes in service providers? I know it is an open scheme now and so over time there may be service providers who come and go. Have there been any changes since February?

Ms C Smith: We do not have a list of providers in this program anymore, because obviously the client gets the money now and they can really go to whoever they see as appropriate. We do not keep a master list of who is providing products in this area.

Senator FIFIELD: Is there any accreditation that the department does of any sort in relation to—

Ms C Smith: No.

Senator FIFIELD: I just thought there may be in terms of some of these providers actually giving advice to the users of the products?

Ms C Smith: We have the existing mechanisms for consumers to get advice through the helpline part of the website. That is a source of professional advice about the sorts of products people should be using. They also have the mechanisms through their GP and so on.

Senator FIFIELD: Could you take on notice how many calls the helpline has received each month since it was established and also a breakdown, if you have it, of the issues raised? There might be particular categories that the issues are put into.

Ms C Smith: We will try to get as much information for you as we can. I am just not sure of the level to which we can go down, but we will see what we can do.

Senator FIFIELD: Also as part of that answer could you provide the nature of the details which the department collects from the calls to the helpline?

Ms C Smith: Yes.

Senator FURNER: I wanted some questions answered in respect of the Aged Care Education and Training Incentive Program. Some of these may need to be taken on notice. I wanted some feedback in respect of the \$60 million budget that was allocated for that particular program as to how much of that has been paid out and what the uptake has been of the courses. I understand there are three streams. There is the basic aged-care worker, the registered nurse and enrolled nurse. Is that correct?

Ms Nicholls: As you said, there are three levels. The first level relates to VET training. That is certificate-level training for personal care workers. The second level relates to enrolled nurse training and the third level relates to undergraduate training.

Senator FURNER: Are you able to provide the outcomes in terms of those three streams as to where the uptake has been, what has been paid out in terms of not necessarily the first or the second payments but the overall payment, and also the general feedback you are receiving as a response to that particular program from the aged care facilities?

Ms Nicholls: I will take all the numbers on notice, if I may, because we do not have the breakdown. But the general feedback so far has been positive.

Senator FURNER: So it is meeting its objectives in terms of training people in those particular areas?

Ms Nicholls: Yes.

[16:57]

CHAIR: That completes the questions in outcome 4. I thank officers from that outcome. We will now move to outcome 10, health system capacity and quality. I am going to try to move through outcome by outcome and see how we go. We are going to move to outcome 10.1, which is chronic disease. Senator Boyce, you said you had at least one question in this area.

Senator BOYCE: I have questions relating to the inquiry the Department of Health and Ageing had done by, I understand, McGrath Nichol to look into the investment behaviour of Diabetes Australia.

Ms Halton: I think we said we were going to do that under outcome 2; did we not?

Senator BOYCE: Okay, well, that is my 'chronic' question.

CHAIR: If we have no questions on chronic disease, then we will move on to 10.2, which is e-health implementation. Is this the place to call NEHTA?

Ms Halton: I am sorry, yes. I beg your pardon, not chronic disease?

CHAIR: No, we have established that no-one is uncomfortable with chronic disease. We are moving straight into—

Ms Halton: You might want to rephrase that.

CHAIR: No, I am leaving it. We are moving to 10.2, which is e-health, and I call the officers from NEHTA.

Senator BOYCE: Thank you very much, Mr Fleming, for being here.

Mr Fleming: It is a pleasure.

Senator BOYCE: We have discussed at a number of estimates how good it would be to have the opportunity to speak to NEHTA, and it is delightful that you are here.

Ms Halton: Don't give him a false sense of security.

Senator BOYCE: Beg your pardon?

Ms Halton: 'It is delightful that you are here' implies a false sense of security. I am saying don't give him a false sense of security.

Senator BOYCE: I am not, I hope. I am pleased that you are here. I wanted to start out by looking at the report on your conference that you had in, I think, November-December, which was published in 2011.

Ms Halton: That was our conference, not his conference.

Senator BOYCE: It is a very long report; isn't it?

Ms Halton: Is this the report of the conference which was our conference, just so that we can be clear what we are talking about? NEHTA did not organise the e-health conference, if that is the one you are talking about; we did.

Senator BOYCE: Is this NEHTA's report or the department's report? That is probably one of the first things we should clear up.

Mr Fleming: I believe that was a department report rather than a NEHTA report.

Senator BOYCE: The key barriers and constraints to the implementation of the PCEHR system included tight implementation time frames, the maturity of what was already happening in technology in the sector, the quality of health information assets, a scarcity of appropriately skilled workers, the existing culture, mindsets and attitudes, and funding in investment for the operation of e-health. There was also uncertainty regarding medical legal responsibilities and risks, and the complexity of the stakeholder landscape. All of this was said in November-December last year and yet we are looking at a 1 July 2012 implementation time frame. Can you make those two statements stand together? How is it that even in a report where you talk about the implementation time frame being extremely tight and acting as a constraint to what could be practically delivered—

Ms Huxtable: We will leave that sort of question for the department. That is in relation to the investment in the Personally Controlled Electronic Health Record.

Senator BOYCE: That is what I just said.

Ms Huxtable: That is Commonwealth funding. NEHTA is under the sourcing strategy for that project operating as our managing agent, but it is under a contractual arrangement to the Commonwealth. The report itself is in respect of a conference which was a critical element of the first phase of the stakeholder engagement strategy. NEHTA worked with us in the preparation for that conference and in fact was responsible—

Senator BOYCE: I know all of that.

Ms Huxtable: I am just trying to give the context for that.

Senator BOYCE: I preface this question by saying in that case I will direct this question to the department. Your report states that the implementation time frame for 1 July 2012 is extremely tight and will act as a constraint to what can be practically delivered and yet you are continuing to say that you will deliver. What will be delivered by July 2012?

Ms Huxtable: It is clear from the minister's statements that the intention is from July 2012 people will have a capacity to register for a Personally Controlled Electronic Health Record system.

Senator BOYCE: They have that now.

Ms Huxtable: No. There is no capacity to register now. That is not correct.

Senator BOYCE: You can have an IHA now if you want one.

Ms Huxtable: The IHI is an important foundation element of having a personally controlled electronic health record system. It is a necessary precondition, but in itself it is not the electronic health record system. It has been clear from the beginning that the timing is tight. We have a two-year period to be able to create that capability to register, to work through the way in which the PCEHR itself is constructed and establish what information would be available on the PCEHR. There is a Concept of Operations, which I am sure you would have seen, that has been released and goes into much more detail around those elements. The consultation process finishes at the end of this month—tomorrow—in respect of the ConOps. There will also be a legislative issues paper which will be released quite soon that will go into the regulatory elements of the PCEHR. Some of the issues that were raised in what you read a moment ago are issues that have been revisited both in the ConOps and in the legislative issues paper.

Senator BOYCE: Revisited in the ConOps by doing what?

Ms Huxtable: The ConOps went to a much greater level of detail in terms of how the PCEHR would be constructed.

Senator BOYCE: Was it basically decided to do less?

Ms Huxtable: No, I do not believe so. In addition, there is another document that is very close to being finalised, which provides yet another layer of detail in terms of the design elements. The reality is that, yes, this is a complex body of work. It has a strong technical element to it.

Senator BOYCE: I do not think anyone is disputing whether it is a complex body of work. It is just that we are continually given deadlines which, in the end, are not realistic or deliver something other than what people understood they would deliver.

Ms Huxtable: I can assure you that everyone in our organisation, in NEHTA and the states and territories are working to achieve the deliverable that has been announced by government. The reality is, yes, it is complex and has a number of streams, including a technical stream, but also a change and adoption stream. We are also doing the work on lead implementation sites. There have been 12 of those announced to date.

Senator BOYCE: I know that. I am going to get around to those. I would like to go back to the ConOps. I must admit that I had great difficulty trying to get on to the website to work out how to leave a comment. You are sent from one website to another and then to another. How many comments or submissions have you received?

Ms Huxtable: I would have to get an officer to respond to that question. I am sorry, I do not know that level of detail.

Senator BOYCE: Mr Fleming might know.

Mr Fleming: No, I do not. The comments close tomorrow.

Ms Granger: We have received 11 submissions so far, approximately 2,000 downloads of the document and 3,000 views online. That is approximate, but I can find out the exact figures if you would like.

Ms Huxtable: We are also undertaking bilateral discussions with some of the key stakeholders in regard to the Concept of Operations. I have personally been involved in several of those and I know the officers—

Senator BOYCE: Which stakeholders are they?

Ms Huxtable: I have personally met with the AMA and the Pharmacy Guild. The officers have met with others as well.

Ms Granger: There are 16 in all.

Senator BOYCE: Is that around the Concept of Operations?

Ms Huxtable: That is correct.

Ms Granger: I have an updated figure as of today of views online of the ConOps, which is at 5,000, and downloads are at 4,000.

Senator BOYCE: Why is there such a discrepancy between the number of downloads and views and the number of submissions?

Ms Granger: The submissions do not close until tomorrow.

Ms Huxtable: That is not unusual.

Senator BOYCE: Are you expecting 1,000 or so tomorrow?

Ms Granger: I doubt that we would get 1,000 submissions. In our consultations people have been quite positive.

Ms Huxtable: It is not unusual to get submissions right on the due date.

Senator BOYCE: I realise that, but to have 5,000 downloads and to only have 11 submissions seems light on, even if there are 24 hours to go.

Ms Huxtable: There have been many avenues for consultation and discussion around this document. Many interested parties have been involved in our conference and also in the consultations that have been occurring under the auspices of NEHTA. Mr Fleming may have

more information, but there has been a very large number of roundtables and discussions, so I think it is a heavily consulted document.

Senator BOYCE: Will you be publishing these submissions?

Ms Granger: We are asking for permission to publish them.

Senator BOYCE: From?

Ms Granger: From the people who submit them. We will also publish a summary as well. If people are happy for us to publish them then we will.

Senator BOYCE: Have you asked them already?

Ms Granger: We are asking that as part of the submission process.

Senator BOYCE: When would they be published? You would already know which ones you can publish out of the ones that you have.

Ms Granger: Yes. We are thinking by the end of June.

Senator BOYCE: That will probably cover off on ConOps for now. Mr Fleming, we were told that 2009 was going to be the year of delivery for NEHTA. Can you tell me what was delivered?

Mr Fleming: Certainly. The HI service, as you would be aware, has been built and is available.

Senator BOYCE: We are talking 2009. Are you talking about your whole strategic plan from 2009 to 2012?

Mr Fleming: Yes.

Senator BOYCE: Perhaps you could give me a year for when you have done these things?

Mr Fleming: If it is all right with you, we can take it on notice to provide the individual years. Subsequent to making a statement on the year of delivery, the HI service was built and we are going through a process of implementation. Tasmania went live earlier this month with implementation to the acute care sector, where they are updating the HI system within their database as patients admit into acute. That is flowing through to work we are doing with other jurisdictions. Indeed, in the private sector, through wave one and two, once again, the HI system and that NEHTA stack will be implemented. In addition to the HI system there was a lot of work done around standards and secure messaging standards. We went through a process with key stakeholders, including the software industry, and it has been lodged as a technical document before Standards Australia. There are a number of other standards around discharge, referral and medication management. The AMT system, which is part of SNOMED, has now gone live in two hospitals in Victoria.

Senator BOYCE: Which ones are they?

Mr Fleming: Australian Medicines Terminology has gone live in Box Hill Hospital, down in Victoria, and the eye and ear hospital. That will now flow through as part of the Victorian rollout of their smart health system into each of their hospitals over time. AMT takes effect from both PBS and TGA. It has the full set of medicines that are available. It is quite key in terms of achieving quality of care around medication.

Senator BOYCE: Not Medicare, though?

Mr Fleming: No. They are some of the key activities in that area. There has also been a lot of work around the National Product Catalogue. We have been working in particular with Western Australia to introduce the National Product Catalogue. It currently has 130,000 items in there.

Senator BOYCE: What is a product in your terms?

Mr Fleming: Any product that is used within the medical environment would fit into that.

Ms Halton: Swabs, devices or items that you would purchase.

Senator BOYCE: Consumer and professional items?

Mr Fleming: Absolutely.

Ms Halton: That is correct. Everything from a trolley to an ear bud.

Mr Fleming: They are some of the major highlights, but I can take it on notice to provide a list by year.

Senator BOYCE: Yes. My question, though, related to the fact that 2009 was going to be the year of delivery. Did it get started in 2009, in your view?

Mr Fleming: Certainly part of that process was changing the culture of NEHTA to be very delivery orientated. We maintain that delivery orientation, but very much also with a focus on what we are doing around implementation—so continuing on delivery, but the implementation of these systems throughout the health system.

Senator BOYCE: Where are you up to in that sense? Your three-year plan went out to the end of 2012. Where would you say you are in terms of your strategic plan?

Mr Fleming: The three-year plan goes out to where our funding ceases. So, it is COAG and PCEHR funding. It finishes in the middle of June 2012. The plan goes out to there. We are on track with that. Each one of those components is tracking to its critical path.

Senator BOYCE: At the last estimates the department had assessed and accepted progress reports from NEHTA on 52 deliverables. I do not want you to tell me what they are now. You may have told me about some of them already, but could you provide on notice to me the reports on those 52 deliverables?

Mr Fleming: The answer is, yes, but it is 2,000 pages.

Ms Halton: We gave you the list of the documents on notice, but the documents equate to 2,000 pages.

Senator BOYCE: I would like to see them. I thought about that for a minute before I said yes. What is your expected spend on consultants for the year ending 2011?

Mr Fleming: The current spend, as at the end of April, on consultants was \$39,714,000, which comprised \$16 million for Medicare and \$8 million for IBM for the work they are doing with us on NASH. I will have to take the forecast on notice, but that is the spend through to the end of April.

Senator BOYCE: That is fine, thank you. It looks as though this amount has increased every year since 2006. Can you explain why?

Mr Fleming: On consultants?

Senator BOYCE: Yes.

Mr Fleming: NEHTA is the National e-Health Transition Authority. Our job is clearly to implement a series of agreed objectives. As part of that process we use external parties wherever we believe they will add significant value, whether it be in terms of delivering on time, within time frames and quality. We certainly use a number of external companies to do those activities.

Senator BOYCE: As you mentioned before, your funding goes through to the end of 2012. I must admit I have great difficulty getting my head around the idea of an organisation that is functioning now, and I presume will continue to function, but does not know where their funding will be after 30 June 2012. When will you know what the government's decision will be in that area?

Mr Fleming: We are putting together the details for the next COAG business case.

Senator BOYCE: When will that be presented?

Mr Fleming: It will be presented to our board within the next two months, but I cannot give you an answer on the process post that.

Senator BOYCE: I realise that. Does the fact that you really are not certain about your future affect staff retention at all?

Mr Fleming: The reality is that most of our staff understand that we have a job to do for the long term and are aware of that, but it is fair to say that those sorts of things would be a consideration.

Senator BOYCE: Are you short staffed at the present time? Do you have positions that are vacant?

Mr Fleming: We do.

Senator BOYCE: How many?

Mr Fleming: I can take that on notice.

Senator BOYCE: As a rough proportion is it one per cent or 20 per cent?

Mr Fleming: It would probably be in the order of about 20, but that is an approximation.

Senator BOYCE: Twenty staff?

Mr Fleming: Yes, 20 staff. However, I would like to point out that PCEHR is a relatively new program so, as you would expect, we are ramping up staff numbers to accommodate that.

Senator BOYCE: As this report has pointed out, there is a shortage of sufficiently skilled staff and if I were to apply for a job there, presuming I had the skills, I would have no idea whether my career was going to last 12 months or five years. Surely that would affect your ability to recruit staff.

Mr Fleming: It has not to date. In terms of what we are trying to do, our objectives are well articulated. Our staff and people looking at this regard it as a very exciting opportunity.

Senator BOYCE: On notice, can you give me a quarterly figure of staff vacancies since 2006 at NEHTA as a percentage of the workforce at the time?

Mr Fleming: We will give you what we can. We may not be able to go back to 2006.

Senator BOYCE: Perhaps the last two years or whatever is convenient.

Ms Halton: Mr Fleming should do what he reasonably can without directing resources, because I suspect that it will be hard to recreate.

Senator BOYCE: We are only talking about a five-year history and I did not realise that would be a difficult question. If it is, then it is whatever is conveniently available. How long would a job vacancy last, on average, at NEHTA?

Mr Fleming: I would have to take that on notice. It would depend on the type of role we were discussing.

Senator BOYCE: Perhaps the shortest to the longest.

Ms Halton: Something which does not require people to get out every record and start calculating things but gives you a feel would be what we should be providing.

Senator BOYCE: I referred to the department's report of their inquiry. You would be very well aware of this report. It is full of comments like stakeholders indicated that it 'should' be possible to do something by date X and it 'may' be realistic and so on. What is your view of this report and the attitudes taken?

Ms Halton: I have to say that I will advise Mr Fleming that he is not to give you an opinion. You just asked him for an opinion.

Senator BOYCE: He runs an independent authority that is supposed to be implementing e-health.

Ms Halton: The protocol in this committee and every committee is that you do not ask people for opinions.

CHAIR: It is a standard process.

Senator BOYCE: Do you think it will be possible to implement all of the current e-health projects by 1 July 2012?

CHAIR: I am wondering about the first three words in that question.

Senator BOYCE: Will it be possible to implement all of the current plans/projects under e-health that are currently there by July 2012?

Mr Fleming: All of our projects are tracking to their critical path. All activities that we expect to be delivered at certain times are being delivered within those time frames.

Ms Halton: Mr Fleming doesn't use public service speak, does he? Well done.

Senator BOYCE: The question related to July 2012. Is that the case?

Mr Fleming: Yes.

Senator BOYCE: 'Critical paths' means that it will all happen in 2012?

Mr Fleming: All activities to date are tracking to their critical path, and all staff are absolutely committed to doing that.

Senator BOYCE: In 2008 Deloitte came up with an e-health strategy that recommended decommissioning NEHTA and replacing it with a stronger governance body. Are you aware of that report?

Mr Fleming: I am, yes.

Senator BOYCE: What response did NEHTA have to that report?

Mr Fleming: This was slightly before my time. A series of actions was taken.

Senator BOYCE: I have some questions on governance, so that is where we are heading.

Mr Fleming: There was a series of actions taken at the time which included introducing an external chair and another independent director. They were key actions taken as part of that process.

Senator BOYCE: Are you aware of the US Veterans' Affairs Department's Blue Button?

Mr Fleming: Absolutely.

Senator BOYCE: Can you tell us about Blue Button?

Mr Fleming: Only at a high level.

Senator BOYCE: That is all I wanted.

Mr Fleming: It is a system that has just been introduced for veterans to effectively access their electronic health record. I believe the uptake of that process has been extremely quick, but I do not have the actual figures in front of me.

Senator BOYCE: I understand it was 100,000 veterans in the first 45 days.

Mr Fleming: Yes.

Senator BOYCE: The reason I asked that is what are the learnings for NEHTA out of that in terms of the personally controlled e-health record?

Mr Fleming: Change management is by far and away the most complex of the activities in front of us. The technology pales into significance in terms of the activities here. The department is appointing an independent party to assist with change management. They are the things that will be looked at. We are continuing to look at international trends and the learnings from those. We will be ensuring that the systems that are built have the propensity to expand to handle volumes.

Senator BOYCE: Is stakeholder engagement not one of the areas that should be beefed up in terms of learning from the Blue Button program?

Mr Fleming: Stakeholder engagement is an area that we are constantly working on, as you would expect. Among other things NEHTA has a group called the SRF, Stakeholder Reference Forum, which consists of a large number of key stakeholders.

Senator BOYCE: How long has it included consumers?

Mr Fleming: Since the day the SRF first started.

Senator BOYCE: Which was?

Mr Fleming: At least three years ago now.

Senator BOYCE: That does not gel with the consumers and healthcare people complaining about their lack of involvement less than six months ago. How do you square those two?

Mr Fleming: Stakeholder involvement is very significant when you think of the fact that this touches every consumer and clinician in one way or another. There are over 800,000 people that work in the medical environment here. It is complex. There are many groups involved here. Part of the process is that the individuals that sit on the SRF go back into their own groups. In terms of the consumer involvement, we are looking for ways that we can increase that, and it is expected that the change management partner will assist in that process.

Senator BOYCE: Can you explain in a bit more detail what you are doing for change management, since we are talking about beefing this up?

Mr Fleming: There was a tender issued for a change management partner.

Senator BOYCE: Is this the IBM one?

Mr Fleming: No. There is a series of tenders at the moment. Change management is one of those. The evaluation has been completed and I believe that is going through the final stages now.

Ms Halton: That is something that you have to ask us about.

Senator BOYCE: DOHA did an evaluation of the tender. DOHA is letting the tender. Is that right?

Ms Halton: We are letting a number of tenders. There is a distinction between the work that is done by NEHTA on the contract to us as part of the electronic health record and the work that we are letting to other parties as part of the tender process.

Senator BOYCE: Who is overseeing the change management program?

Ms Huxtable: The tenderer.

Senator BOYCE: You are overseeing it?

Ms Huxtable: The change and adoption partner tender process is almost complete. The evaluation of the tenders has been conducted by the department and with NEHTA involved in the evaluation process, but we will enter contractual arrangements with the change and adoption partner when they are appointed.

Senator BOYCE: How will that group interact or how will the successful tenderer interact with NEHTA?

Ms Huxtable: We work very closely with NEHTA in regard to all these matters. We want to leverage the opportunities that there are already in NEHTA through their various clinical reference groups and so on. We will continue to work closely with them with the change and adoption partner. The change and adoption partner becomes another resource that can focus very much on individual sectoral readiness on the engagement process with consumers and the like as we get closer to the point of implementation. One of the things to be aware of is that while there has been a lot of consultation occurring already around technical and other issues, as we discussed earlier, as we move more into a level of public engagement we want to time that correctly. We do not want to begin that too early before there is a PCEHR available to people. That effort is focused very much on the wave sites, and then as we get towards 1 July it will change in its nature from a more technical discussion through to a more public discussion.

Senator BOYCE: When you get closer to July?

Ms Huxtable: July of next year. The nature of the engagement changes as you move closer to an implementation point.

Senator BOYCE: Absolutely.

Ms Huxtable: I do not think I am saying anything too radical in that regard. The change and adoption partner will be with us through that process.

Senator BOYCE: When will you be announcing that tender?

Ms Huxtable: It will be quite soon—imminent.

Senator BOYCE: Is that weeks or days? Is it this financial year?

Ms Huxtable: I could not say. I do not think there has been a decision taken as yet as to when an announcement will be made, but I expect it will be very shortly.

Senator BOYCE: I have a department question that relates to NEHTA. Mr Fleming, you have an ongoing court case involving a DIAD patient.

Mr Fleming: Yes.

Senator BOYCE: We have been told by the department that no questions can be answered on that because of legal and professional privilege, but can you tell me how much NEHTA has spent on the case?

Mr Fleming: Can I take that on notice?

Senator BOYCE: Is that because you do not know the figure?

Mr Fleming: I do not have the figure in front of me.

Senator BOYCE: Whose funds is NEHTA using to pursue this case?

Mr Fleming: It is being funded through the COAG funding.

Senator BOYCE: So, it is funded by your regular funding from COAG?

Mr Fleming: Yes.

Senator BOYCE: The other legal case was around legal professional privilege. Again, I understood that the case related to alleged theft of IP. Is that case still proceeding?

Mr Fleming: The DIAD that you mentioned as the first case is one and the same. It is one issue. There is only one legal issue.

Senator BOYCE: Chair, I have more questions.

CHAIR: I will let you go through to quarter to without pulling you up and we will see how you are going then.

Senator BOYCE: I would now like to go to the personally controlled electronic health records and where we are heading with those. I attended a palliative care conference last week and there was some confusion about what was going to be initially in a PCEHR. I know what the Concept of Operation says, but it is even a bit fuzzy in terms of whether pathology, imaging and so forth are included. Could you tell me what we are planning to put in it?

Ms Huxtable: The Concept of Operations goes through the various elements that would be incorporated into a PCEHR.

Senator BOYCE: Or could be?

Ms Huxtable: Would be. The contention is when. Some sectors are more ready—for example, the health summary review. There is already a RACGP health summary review that is being trialled in the wave sites. There is a level of readiness in some regard. In pathology—and I am not necessarily across all the technical detail with that element—there is work that needs to be done to get that sector to a greater state of readiness. The business case that underpinned the funding of the PCEHR always recognised that there would be a number of release stages. Our aim is to get as much information into the record from 1 July as possible, but there will continue to be both—

Senator BOYCE: If there is additional government funding for it there will be.

Ms Huxtable: Correct.

Senator BOYCE: We do not know that yet.

Ms Huxtable: There will be additional information but also a greater quality of information as time goes by.

Senator BOYCE: One of the other questions that is constantly raised here is the fact that there is currently no funding to incentivise GPs and others to transfer data into a PCEHR rather than use the system that they currently have. I know there have been PIP payments around e-health, but they are not related to the PCEHR. Could you explain how you are intending to incentivise or encourage frontline carers, health professionals, to use the system?

Ms Huxtable: The wave sites are an important part of understanding what the lessons are in terms of how information can be incorporated into the PCEHR, both in terms of the opportunities and barriers that there may be to that. You are right; there has been a significant investment over time in terms of getting up the level of computerisation in general practice. That has been highly successful. There is now a very high level of computerisation. One of the other things to recognise is that the intention is for the practice management systems to be structured in a way that enables information to be provided to the PCEHR. One of the areas to test is what is involved in the process of uplifting information, in this case, from a general practice or existing practice management information system to the record itself. These are the sorts of issues that need to be worked through both in the wave sites and as we work through the concept of operations. Some of it goes to the precise design and what role nominated providers may have, which is talked about in the ConOps in terms of probably a general practitioner having a role to create a PCEHR on someone's behalf. There are a number of issues that still need to be worked through in consultation and we will continue to work with various sectors in that regard.

Senator BOYCE: Mr Fleming, would you have a notional cost for a PIP?

Mr Fleming: No.

Senator BOYCE: Would that be something the department would do? Are the current people involved in wave 1 receiving an incentive? I realise you are using this to test, but how are you incentivising? What assumptions have you made about incentives within the wave 1 trials?

Ms Huxtable: I cannot say that I know the answer to that. I could take it on notice or perhaps one of the officers could answer. The reality is that there is variation across the various wave 1 sites.

Senator BOYCE: Mr Fleming, I am not at all sure that I understand the question of source systems. Could you please tell me how you are going to use IBM, I take it, to turn source systems into a generalised NEHTA system? I can see from the back that I got that completely wrong.

Mr Fleming: Yes.

Senator BOYCE: Can you enlighten me?

Mr Fleming: IBM is working very specifically on a program called NASH, the National Authentication Services for Health.

Senator BOYCE: Which will be part of the IHI and the PCEHR.

Mr Fleming: It is a foundation program. What it means is that when someone in the medical community has a transaction there would be a way of authenticating that they are the correct person. That is where IBM fits into that question.

Senator BOYCE: I understand the source systems are how we are going to get a multiplicity of programs to speak to each other.

Mr Fleming: If I understand the question—as part of wave 1 we have a vendor panel. The vendor panel consists of GP desktop systems. We are working with them to implement the series of NEHTA specifications. That includes a HR system, discharge referral, secure messaging and indeed working with that NASH environment. That is on the GP desktop side. The wave 1 sites are in Hunter in New South Wales; Melbourne down in Victoria and GP Partners in Brisbane. With the three state governments we are putting in place an agreement where they will be amending their systems—at the acute care sector level—so that they can talk to that GP level. For example, where a GP practice software system will implement the ability to take a NEHTA compliant discharge the state government will be amending their systems to be able to send a NEHTA compliant discharge. It is part of an overall process that fits in with what we are doing at wave 1 and wave 2 sites.

Senator BOYCE: Are these being done to a standard that you have developed or an international standard?

Mr Fleming: They start with international standards. We have a process of looking at the international standards, then decomposing down into the Australian standards and, if need be, amending and going through the Standards Australia process to do that.

Senator BOYCE: Have you undertaken a risk assessment of that process?

Mr Fleming: Of the standards process?

Senator BOYCE: Of the source systems process.

Mr Fleming: We have detailed risk registers for our program that lists out the various risk and mitigating actions to address that. Yes, we have risk assessments.

Senator BOYCE: You have done a risk assessment?

Mr Fleming: Absolutely, yes.

Senator BOYCE: Has NEHTA done that risk assessment or are you asking those people to self-report on the risks?

Mr Fleming: No. We have a risk group that looks at risk and does that in conjunction with all of our key stakeholders. It takes information risks that are identified in areas such as Concept of Operations and flows that through. There is also a NEHTA board subcommittee that reviews all of our risk and the actions being taken.

Senator BOYCE: Let us get on to risk assessment in the last couple of minutes that I have. Has a risk assessment been done on Individual Health Identifiers? I asked this question and received an answer that told me there had not been a risk assessment of the HI system done, but I was looking specifically at individual health identifiers. Has there been a risk assessment of that process?

Mr Fleming: We have had a risk assessment of the HI system for a number of years as we have gone through various stages. Clearly the initial focus was on the development and the issues applied there. The development is done. The focus is very much around the implementation and what we need to do there.

Senator BOYCE: I understand PCEHRs are going to be operating using cloud computing. Is that correct? Is that your intention?

Mr Fleming: The reality of the PCEHR is that we use web-type technology. The intent is not to have a central database but a series of repositories that are available, which is distinct from cloud.

Senator BOYCE: Can you explain the difference?

Ms Halton: Just for general interest so everyone can understand.

Senator BOYCE: What are the repositories that you mean by that?

Mr Fleming: Firstly, there might be multiple electronic health records around the country. If I use myself as an example—and I do travel a bit—the reality is that my health record will be stored in various places around the country, just because of the amount of travel I do.

Senator BOYCE: Absolutely.

Mr Fleming: Within that context my record will basically contain my identifier. The context of the system is that we will have an indexing service and attached to the indexing service there will be a summary health profile for Peter Fleming, but within the indexing service we will know where to go out and get more detailed information from the various repositories that exist around the country as required by the clinician and for me as a patient for what I might need to know.

Ms Halton: That is distinct from cloud computing because?

Mr Fleming: I do not want to go into cloud computing.

Senator BOYCE: I do not think that we need to talk about cloud computing. When you say repositories, do you mean places where you have had a health service?

Mr Fleming: Yes. I can give a very specific example. At the end of last year I had a knee reconstruction. As part of that there was an MRI taken of me, which was done at The Avenue in Melbourne. That would be a repository that could be accessed with the right negotiation.

Senator BOYCE: Will we end up with something like 80,000 repositories?

Mr Fleming: No, not at all. There is a process for what a repository needs to be in order to be compliant with the PCEHR system. There are a few levels of compliance required, but the reality is that there will be a number of repositories around the country. It is nothing like 80,000 at a guess.

Senator BOYCE: Last time I asked how many organisations would have a health care identifier and the answer that came back on notice was about 80,000, in which case there is a potential for 80,000 repositories.

Ms Halton: We think that would be very unlikely. The reality is they will have to meet certain conditions to be a repository. It may be the case with a large radiology provider, but the greater likelihood is that they will send that radiology to your GP or your specialist. It is

more likely to be a GP and it is more likely that it will be stored there. You have to meet certain requirements to actually operate a repository.

Senator BOYCE: The clinician will be the gatekeeper of that, so to speak. Is that correct?

Mr Fleming: No, the patient will be the gatekeeper. It will be my personally controlled electronic health record.

Senator BOYCE: I realise that. If every time I have an X-ray, for example, I have to say, 'Are you a repository?' or 'Can you send this to someone who is a repository?', will that mean in the end that the GPs will be the ones who will control the information?

Mr Fleming: No. The intention here is to have automated processes in place so that it does not need that manual intervention.

Senator BOYCE: I must admit that I am more puzzled than I was before we started. I will consider this issue and put some more on notice. Are we confident that these repositories are being accredited and to what?

Mr Fleming: There is a number of components there. Firstly, we have established a thing called CCA, certification, compliance and accreditation, which we are using NEHTA to help deliver. There is a series of requirements that must be met, starting with the HI system, for utilisation of these systems.

Senator BOYCE: I will stop there.

CHAIR: There being no further questions on e-Health, I thank NEHTA. Are there any questions on 10.3, Health Information?

Senator FIERRAVANTI-WELLS: Are we going to 6.15 for this whole section?

CHAIR: Outcome 10 finishes at 6.15. I know that you have about 10 minutes on infrastructure, so I was building that in.

Senator FIERRAVANTI-WELLS: I have realised that I have two things on infrastructure.

CHAIR: Senator Siewert, do you have any questions on any of these issues?

Senator SIEWERT: I do not. I have some questions on midwives.

CHAIR: Ms Halton, there are some questions on midwives which I do not think is in this area.

Senator SIEWERT: I have questions on collaborative arrangements and so on. Where do I ask those questions?

Ms Halton: We normally do it under Outcome 5.

CHAIR: That is tomorrow. Midwives are Outcome 5.

Senator BOYCE: I have questions for 10.5.

CHAIR: I have you down there.

Senator SIEWERT: So it is e-primary care.

Ms Halton: It either sits under access for medical services or primary care. They normally come to each other's items so it depends on where we pick it up. The relevant people will probably be here.

CHAIR: Senator Adams has a couple of questions in 10.3. Are there any questions in 10.4; International Policy Engagement?

Senator ADAMS: I will put one on notice.

CHAIR: Senator Boyce, do you have any questions for 10.5, Palliative Care?

Senator BOYCE: I have about five minutes worth.

CHAIR: Does anyone else have palliative care questions?

Senator ADAMS: I have, but I will put them on notice. I would rather do 10.1, which I missed out on before.

CHAIR: There is nothing for 10.6, which is Research Capacity, and not the National Health and Medical Research Council? We will then go on to Health Infrastructure.

Senator ADAMS: I have one question on that.

CHAIR: Senator Adams, you have a choice. You can either do health information with the ones that you have or you can go back and do your Chronic Disease, because we are feeling generous and the officers have not gone yet.

Senator ADAMS: Have the HHF people gone?

Ms Halton: HHF is here.

CHAIR: We will put 10.3 on notice.

Ms Halton: Do you want to do HHF now?

Senator ADAMS: Yes.

Senator FIERRAVANTI-WELLS: My questions are for HHF.

CHAIR: We will go back to HHF.

Ms Halton: What are we doing now?

Senator BOYCE: Is it Chronic Disease?

CHAIR: Yes.

Senator ADAMS: I would like to ask about Chronic Disease.

Ms Halton: Chronic Disease usually means the policy people as against HHF.

CHAIR: We have questions for HHF. Senator Adams.

Senator ADAMS: I note that you are supporting the early detection of breast cancer by funding the national rollout of digital mammography. I would like to know about that for BreastScreen Australia. It states here that in 2011-12 states and territories will be supported to transition from analogue to digital mammography technology. Can you give me a report on where it is up to and, specifically, I would like to ask a question on the fact that Norfolk Island may be coming in under the Medicare system and the tax system. At the moment they do not have any access to breast screening, so would there be any way, under HHF, that they would be able to be part of that rollout or would they have their access from Queensland Health?

Mr Thomann: Just taking the second part of your question first, in relation to Norfolk Island, that is a broader issue for consideration in terms of assistance, and my colleagues in the Portfolio Strategies Division can handle that. We can come back to the first part of your question after Mr Morris handles the second part of your question.

Mr Morris: Commonwealth health programs do not extend to Norfolk Island under current arrangements, because Norfolk Island's health arrangements are the subject of Norfolk Island's own administration.

Senator ADAMS: I know that. This is almost a hypothetical question. With the funding, once they come under Medicare and the Australian tax system, would there be any provision that they would be able to become part of this rollout or serviced in some way, as with Christmas Island and Cocos Island?

Senator McLucas: The witnesses cannot answer that question.

Senator ADAMS: Can you take on notice as to how far the digital mammography has been rolled out?

Mr Thomann: It is a mixed picture. There are nine projects funded in round 1. While we have the detail here, to be absolutely precise, we would be better off taking it on notice unless my colleague Ms Campion is able to elucidate a few of them. But I would be more comfortable, given there are nine projects, taking that on notice.

Senator ADAMS: How are the 21 regional cancer centre projects progressing and how many are up and operating?

Mr Thomann: Of the 21 projects in round 2 which were funded for a total of \$540 million thus far, 16 are under contract and negotiations are progressing on the remaining five.

Senator ADAMS: Can you give me a list of those on notice, as to where they are sitting at the moment?

Mr Thomann: Where they are at in the process of contract negotiations?

Senator ADAMS: Yes.

Mr Thomann: Absolutely.

Senator ADAMS: That is just to save time.

CHAIR: Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS: I would like to ask about the Royal Hobart. With respect to the \$100 million provided to the Royal Hobart Hospital, separate to the \$240 million HHF allocation, what independent assessment was made on the merits of the expenditure?

Mr Thomann: Is that the merits of the proposal from the Tasmanian government?

Senator FIERRAVANTI-WELLS: As I understood it, \$340 million was pledged for the Royal Hobart Hospital as part of the government's election negotiations with Mr Wilkie. The government contributed \$100 million separately to the \$240 million allocated to the Health and Hospital Fund. The Portfolio Budget Statement at page 305 states that '... all health infrastructure spending proposals need to be assessed by an independent expert advisory body board appointed by the Minister for Health and Ageing'. With respect to the \$100 million provided to the Royal Hobart Hospital, separate from the \$240 million allocation, what independent assessment was made on the merits of the expenditure?

Ms Halton: The distinction here is that one is a reference to the HHF and the other is a decision of the government. That particular text you read is referenced to the HHF processes.

Senator FIERRAVANTI-WELLS: It is referenced to the HHF processes only?

Ms Halton: Correct.

Senator FIERRAVANTI-WELLS: In other words, the \$100 million did not receive any independent assessment on the merits of the expenditure; it was a decision of government purely to give out \$100 million?

Ms Halton: It is a decision of government.

Senator FIERRAVANTI-WELLS: All applications were supposed to be assessed independently by HHF. Can you explain the justification for providing only \$57 million for all of Western Australia in a regional infrastructure round while Hobart gets \$240 million, noting that Western Australia—and I am sure that Senator Adams will concur—has some of the most remote health infrastructure in the world?

Ms Halton: The way the HHF works is that projects that are put forward by protagonists are individually assessed by the board as to whether they meet the criteria. It is yes or no. In respect of the allocation from within those eligible projects the government decides how much money is available and, therefore, in that context, which projects will be funded. The truth is there was an application from Tasmania for the amount of money that you have nominated for a project that the board assessed as eligible. In terms of the projects from Western Australia, there were a number of projects but not a significant number of projects that were assessed as eligible.

Senator FIERRAVANTI-WELLS: So, you are saying there was no directive given by the department or the minister to the HHF?

Ms Halton: In terms of what was to be classified as eligible and ineligible, only the guidelines which were publicly released prior to the process, which then the HHF board—and I am a member of that board—used to assess those projects. There was absolutely no direction given.

Senator FIERRAVANTI-WELLS: And nothing explicit about giving a priority?

Ms Halton: There was nothing explicit, nothing implicit and nothing signalled—nothing at all.

Senator FIERRAVANTI-WELLS: In relation to the \$475 million to be invested in another regional round commencing before the end of this year, will there be a separate call for submissions or will a decision be made on the applications that were received in the previous regional round?

Mr Thomann: There will be the opening of a fourth round. Those applications that were found to be eligible by the board will be able to be considered again. We will be contacting them at the time of opening the next round and seeking their advice as to whether they wish simply to roll over their current applications, provide supplementary advice or withdraw from that process.

Senator FIERRAVANTI-WELLS: In relation to those HHF applications, of which Royal Hobart Hospital was one, have you written to the unsuccessful applicants?

Mr Thomann: I believe the applicants who were found not to meet the eligibility criteria by the expert advisory board were contacted on 6 April, and those applicants that were found to be eligible but were not funded in the 2011-12 budget process were contacted on 16 May and offered feedback.

Senator FIERRAVANTI-WELLS: We have gone through this in the past. Do you publish the results of that round or is that information available as to who applied and why they were successful or unsuccessful?

Mr Thomann: No. The 63 funded projects have been published in the budget process.

Senator FIERRAVANTI-WELLS: How many applications were there?

Mr Thomann: There were 239 applications; 237 were found to be compliant with the process and of those 114 were found to fully meet the criteria.

Senator FIERRAVANTI-WELLS: You are not able to give me a list of the 239?

Mr Thomann: No.

Senator FIERRAVANTI-WELLS: The government originally committed to provide \$10 billion for the HHF to be funded out of budget surpluses. Given that a budget surplus has not been delivered and this figure has been reduced to \$5 billion, how much of the 2012-13 surplus will be allocated to the health and hospital funds, if any?

Ms Halton: I do not think that is a question for us.

Senator FIERRAVANTI-WELLS: Treasury? I have got further questions in relation to that. I will put those on notice. My next question is in relation to the Royal North Shore Hospital. Are you aware of the issues that have arisen at Royal North Shore surrounding the redevelopment at that hospital?

Ms Halton: In what context?

Senator FIERRAVANTI-WELLS: We know Royal North Shore. We know it is a major hospital in Sydney. It services approximately 1.2 million people in New South Wales, about one in 17 of the Australian population. There is a redevelopment happening there which has caused some controversy and has been the subject of protests and all sorts of things in relation to it. My question is, first of all, are you aware that this is happening? Is this an issue on your radar? Even though it is not directly a responsibility of the federal government, Royal North Shore Sydney does provide a lot of services which I assume you fund in part directly and indirectly.

Ms Halton: I think it would be a fair observation to say anecdotally anybody who lives in this part of the world would have failed to have recognised that there are some issues about North Shore.

Senator FIERRAVANTI-WELLS: In terms of moneys that go to Royal North Shore are you able to provide for me information as to how much federal money goes to Royal North Shore under various programs?

Ms Halton: Not under this particular program, no. We do not—

Senator FIERRAVANTI-WELLS: We talked about health infrastructure, so I just assumed that I could ask questions in relation to it here.

Ms Halton: To be quite honest with you, we may have dribs and drabs of money but we do not give a lot of money directly to individual hospitals. It does not tend to be the way our moneys flow—even for example with the ACAT, the money would go to the state and then be passed through—so I am not aware. There might be a small grant somewhere but not that I am aware of.

Senator FIERRAVANTI-WELLS: In relation to this redevelopment was any application made by Royal North Shore or the New South Wales government in relation to funding for Royal North Shore Hospital at some stage? Please take it on notice if you—

Ms Halton: Yes, if that is all right, because I am not actually sure whether I am able to answer—

Senator FIERRAVANTI-WELLS: I would appreciate it if somebody could take on notice there is a major issue in relation to Royal North Shore Hospital in Sydney and for those of us who live in that area, and given that one in 17 Australians is a sizable proportion, there is also an issue about the mental health unit that was supposed to be relocated as part of the new development. That is not now happening because the hospital that is now going to be built is not going to be the same size. I have material which I am happy to provide to you. My concern is, particularly in the light of the discussion that we had earlier in relation to mental health and some services that may now fall to the state to have to provide, when you have a major hospital like that and a major mental health unit like that being non-operational or having difficulties, is that something that is on the Commonwealth radar—of your Department of Health and Ageing radar—when there are major issues about such a large institution? It is a broad question.

Ms Halton: The short answer is, yes, it is on our radar. We know it is going on. The issue in respect of whether they have applied for capital is an issue we will see whether or not we can give you an answer on. In terms of how that plays out, I would refer back to the earlier conversation we were having about things like performance authorities and all the rest of it. That is relevant in that context. But as the system currently operates it is of interest to us, and if particular issues bubble into our day-to-day work, yes, but as a general issue, no, we do not have any particular lever on that issue.

Senator FIERRAVANTI-WELLS: My concern from a patient perspective, given the state-wide services that they provide, and you are fully familiar with all of those right across the spectrum—

Ms Halton: Yes.

Senator FIERRAVANTI-WELLS: If the hospital is unable to accept patients from not just metropolitan Sydney but regional and rural areas, of course that will have ramifications across the health system. It is also a teaching hospital. At what point does it have to get so bad that there is some form of involvement by the Commonwealth? I am asking—

Ms Halton: But it does not. I mean, constitutionally, we go back to constitutional powers. We do not get involved.

Senator FIERRAVANTI-WELLS: So the point is that, if it does not matter that the services get so bad and there are major problems, the Commonwealth will just sit by. Will it raise issues? Will you raise it with the state government if you think that services are being affected across the state?

Ms Halton: As I say, certainly in the new world, and this is the thing we discussed this morning about the performance framework and other things, that is exactly what is—I think we said we had gotten straight to the point of where some of the discussion is currently going to about who notifies who and when and all the rest of it. But in the current framework—and

recognise that we have not finished that framework—no. It is a matter for ministers whether they ever raise an issue with one of their colleagues.

Senator FIERRAVANTI-WELLS: Can I just use this then as a practical example. Under the new framework, whenever it comes into operation, this is just the sort of issue that will come within the parameters of the performance authority's purview, because obviously, because of their redevelopment problems and because of whatever mistakes or otherwise have been made, they are not going to be able to perform and therefore it is going to affect their funding and other issues. It is as basic as that.

Ms Halton: Certainly in the new world, putting aside the contentious matters, I believe it is unequivocally accepted that particularly with the pricing work and with the work on reporting and transparency not only in respect of volume but also in terms of quality people will be able to have a view about what is going on where and at what quality and what the issues are.

Senator FIERRAVANTI-WELLS: In relation, say, to the decision we were talking about, the 1,300 or so beds that were part of the program, if there are redevelopment issues, that puts at risk potentially those beds going in and becoming operational in the system from the state's perspective. Obviously from the federal perspective you are limited in what you can do, but from the state perspective it might put at risk those beds as well?

Ms Halton: I would not want to get into a hypothetical. I just think we are getting into a dangerous area. However, the simple point is that the new world will be more transparent, and I would argue more accountable, as against the current world where, yes, we do know some of what is going on but—

Senator FIERRAVANTI-WELLS: Perhaps I could ask you to take on notice the issues that I have raised. There have been letters that they have sent out and published, and you are probably aware there will be a major rally on Tuesday at Royal North Shore about it.

CHAIR: I am going to have to pull you up because of time. But there will be a series of questions on notice on that issue.

Senator ADAMS: I would just like to ask about the regional priority round. I am just looking at the list on page 344 of the yellow book. I note there it is talking about 'Hospital beds, operating theatres', and then it says, 'A further five projects will support patients who need to travel to access treatment.' What are those projects? Is it part of PATS or what would that be?

Mr Thomann: Those are patient accommodation projects. There are five projects totalling \$19.95 million. Would you like me to itemise them?

Senator ADAMS: I just did not quite understand—

Mr Thomann: They are basically patient accommodation projects.

Senator ADAMS: So for anyone who has to travel to the city, for example in my state, PATS pays X amount for accommodation—not much. Is that—

Mr Thomann: It is to basically provide accommodation for patients and carers in various locations.

Senator ADAMS: Infrastructure?

Mr Thomann: Yes, for patients who are receiving treatment and who have come in from regional areas who need to be accommodated.

Ms Halton: We received a number of these sorts of proposals basically to provide reasonable quality accommodation for people, some of whom may have to be there for some time if they are accompanying a relative who has to have a lengthy stay.

Senator ADAMS: I thought it was actual funding for, as I said, perhaps PATS. Coming back to Norfolk Island, because I am on another committee that deals with this I just want to get some idea about funding for regional communities. If later they were to come in under our Medicare and tax system, would they be eligible for capital funding under the regional priority round?

Mr Thomann: It sounds like a hypothetical.

Senator ADAMS: I know, but it is just—

CHAIR: It does. I think the ‘if’ gave it away. You just cannot ask that question.

Mr Thomann: I am just informed that they did actually apply under the—

Senator ADAMS: I know they did and they were rejected because of their situation, but that may change.

Ms Halton: Yes. But there is another question, which is: are they regional? I think by definition they are not metropolitan.

CHAIR: No.

Senator BOYCE: I am not sure whom to direct this to.

Ms Halton: Palliative care proper, not HHF palliative or anything else, so will we just get the palliative people?

CHAIR: We will wait and see.

Ms Halton: Okay. Stay alert and alarmed!

Senator BOYCE: No, outcome 13. I am looking at a response to outcome 13, so I certainly will not ask that question here, but I will go back to an answer to a question on notice at last estimates in which you said that 75 per cent of palliative care services are now reporting to your data collection. Has that figure changed at all?

Ms C Smith: No, it is still the same number as when we reported in answer to that question.

Senator BOYCE: There was an announcement of \$8.6 million for palliative care support and services, and most of that, as I understand it, is to go to fund equipment loan schemes. Could you give me a state-by-state breakdown of those schemes?

Ms C Smith: I think you are talking about the announcement that was made in connection with Palliative Care Week—

Senator BOYCE: Yes, 26 May.

Ms C Smith: I think \$3 million was for the equipment loan scheme and the other part of the money was for the local community grants. We would need to take the state breakdown on notice.

Senator BOYCE: I would particularly like to know how much of that money went to each state because there is a strong concern within the palliative care community that, given that Queensland has now apparently stopped funding equipment loans in that state, the federal money may be used to top up what should be being provided by the states.

Ms C Smith: We will follow that up for you and give you a state breakdown.

Senator BOYCE: Is this money done in conjunction with the states?

Ms C Smith: Is your question in relation to the equipment?

Senator BOYCE: The equipment loan schemes.

Ms C Smith: That was actually money that went to Palliative Care Australia.

Senator BOYCE: Will they decide where exactly to send it?

Ms C Smith: They distribute it in accordance with the priorities they identify. We will get you some additional information on that.

Senator BOYCE: Certainly I would like that because it would be very concerning if all that is happening is that the Commonwealth government is replacing money that the Queensland government was putting into this area and is no longer doing.

Ms C Smith: I understand the concern you are raising. We will follow up with some additional information for you.

Senator BOYCE: Thank you. Those are my questions, Chair.

CHAIR: No further questions in Palliative Care? You have a question?

Senator FIERRAVANTI-WELLS: Just one question. The program that they are running about the balloons, 'Let's chat about dying', is just confined to palliative care, is it not? 'Let's chat about dying' and those balloons are not being used in suicide prevention or anything like that, are they?

Ms C Smith: Not that I know.

Senator FIERRAVANTI-WELLS: No, I am just asking. It had been suggested to me that they had been used in some suicide setting, if I can put it that way, and I found it quite distressing that balloons saying, 'Let's chat about dying' could be used in such a context. I appreciate the context in palliative care, but not in suicide prevention.

Ms C Smith: I can understand you would be concerned if that were the case, but I think you were at the event last week.

Senator FIERRAVANTI-WELLS: I was.

Ms C Smith: It was a very moving event in encouraging us to think ahead about the challenges involved.

Senator FIERRAVANTI-WELLS: And I do not have an issue with that. I was just concerned to hear that they could be used in a suicide setting, and that is what troubles me.

Ms C Smith: That has not been raised with us at all.

CHAIR: Thank you. Those are the final questions in that part of outcome 10, so thank you to the officers.

[18:19]

**Cancer Australia
National Breast and Ovarian Cancer Centre**

CHAIR: We have the two agencies separately listed but I know it is just one major organisation now. Could all the officers who could be questioned come forward, because I would imagine that questions could flow across the two areas.

Senator ADAMS: Last estimates, Dr Zorbas, I asked you about the transformation of your organisation, the National Breast and Ovarian Cancer Centre, into Cancer Australia. Would you like to just update me on how that transition is going, please?

Dr Zorbas: Yes, of course. Thank you. I think it is fair to say it has been a very busy year since the minister announced the proposed amalgamation of NBOCC and Cancer Australia, and everything is on track for that amalgamation to be effective from July 2011. The amalgamation has been overseen by a transition working group and that has had considerable consumer representation as well as representation from both Cancer Australia and NBOCC, and it is chaired by the Chief Medical Officer. A consultant has provided really helpful advice around the business and financial aspects of the organisations and bringing those together, so that advice is being used to develop the organisational and financial structures for the new agency.

I have been undertaking a strategic planning process since January of this year and I think that has been extremely successful in garnering the expertise of our stakeholders to help define the direction of Cancer Australia going forward, and it has also been very rewarding to experience the great and widespread level of support that we have for the agency going forward and its leadership role.

I think the other things are really internal in terms of developing an organisational plan and a structure, which I have done, which brings together the key components of the functions of the agencies into logical groupings and provides a plan for every staff member within that organisation going forward. The minister has also made a decision about the location of the agency, with the head office to be in Sydney and a smaller office in Canberra and other staff to be located at sites where they may reside, where their particular expertise is valuable to the organisation going forward. So, we are in the process of implementing the minister's decision around that location.

Senator ADAMS: How many extra staff will this involve?

Dr Zorbas: The current staffing level is about 56 staff across both organisations. Looking forward, we have had the opportunity in the budget to have some money transferred from administered funds into departmental funds, which will allow Cancer Australia, going forward, to build in-house expertise and capacity, and that will potentially give us the opportunity to grow that staffing level up to 84 staff.

Senator ADAMS: In the Canberra office, how many staff would you think you would have there?

Dr Zorbas: The relocation will be up to 18 months in taking effect, so there is a staged process. The first tranche of relocation will occur by end of January 2012 and the second by September 2012. We will ultimately have probably around six staff in the Canberra office.

Senator ADAMS: There has been a little concern from a number of consumers just with the merger and as to some of the programs, gynaecological cancer and breast cancer. So I note that the new Cancer Australia will have the three programs: Supporting Women in Rural Areas Diagnosed with Breast Cancer, the Breast Cancer Network Australia My Journey Kit and the funding for Hope & Hurdles. Could you just give me a brief description as to how that will work?

Dr Zorbas: Yes. Those three programs are programs that have been administered by the department and they are being transferred to Cancer Australia to administer. They are activities that are very important for breast cancer consumers and provide important resources—the Hope & Hurdles Kit and the My Journey Kit—to consumers. We will look to working with BCNA to ensure that funding is provided to continue those publications. In addition to that the Supporting Women in Rural Areas Diagnosed with Breast Cancer Project is being transferred to Cancer Australia, with both Cancer Australia and BCNA working to take those funds forward to support women and their health professionals, and particularly Indigenous women also, in rural and remote regions of Australia.

But the broader question of breast cancer work is very clearly being taken onboard in the new Cancer Australia. The funding that was appropriated to NBOCC has been transferred to Cancer Australia, and there is quite a detailed work plan that has already been developed to support the ongoing focus in breast cancer going forward. The budget announcement also gave welcome news of continued funding for the work in gynaecological cancers, and the work of NBOCC in ovarian cancer will be incorporated into that wider gynaecological cancer work within Cancer Australia.

Senator ADAMS: I think the problem was that people from both areas' support groups were very worried about their research dollars actually going to the right place rather than it going into Cancer Australia and being swallowed up by all the different cancers. From the gynaecological cancer side, could you just give me an idea about what funding is being allocated to research into, education about and awareness of gynaecological cancers and, in particular, ovarian cancer?

Dr Zorbas: In the budget that was just announced, approximately \$6 million has been allocated to support women with gynaecological cancers over the next four years, and this is particularly money for providing information and support to women and educational materials to health professionals working in the gynaecological cancer space. The work of Cancer Australia in research is within a different area of the organisation, if you like, and particular moneys may be used from the NCGC to support particular priority driven research in gynaecological cancers. I cannot give you an exact dollar amount that would go to that going forward.

Senator ADAMS: And the Jeannie Ferris award; that is still funded?

Dr Zorbas: The award, as you know, last year was provided to Merran Williams, who has only just returned from her trip to the United States where she investigated supportive care and survivorship centres, and we are looking forward to receiving her report about her experience about what she could bring back to us. The award for the scholarship this year unfortunately has not been made. There were not any applicants to apply for that award and we are looking to investigate how we might support applicants to apply for it within the next year.

Senator ADAMS: How was it advertised? Was it advertised on the website or just—

Dr Zorbas: Sorry, I cannot give you the details, but certainly it was broadly advertised within the Cancer Australia website and the newsletters that we promote, but the Churchill Fellowship themselves do advertise these quite widely. I know that all our consumer groups and individuals who work with us were made aware of the fellowship being available and it was discussed at some advisory meetings as well. It is a small group of people who would be, I guess, eligible to go forward for this and I presume that is why we were not able to—and disappointingly not able to—have anybody who applied.

Senator ADAMS: It is, especially for this committee.

CHAIR: In terms of the award, can we look at a way that, when someone has gone away on a trip and come back, we can arrange a function here in Parliament House—a briefing—and have them present the work that they have done? I think that would be a nice rounding aspect to the fact that it is a Jeannie Ferris award. If we can put that into your consideration, I think that it would just be useful, and for Merran as well, for her to be able to come and talk with people who want to listen to what she did. I think we could work on that and raise awareness about the whole issue, so we would be happy to help on that, would we not?

Dr Zorbas: With pleasure.

Senator ADAMS: Are there any specific programs or projects dealing with ovarian cancer this year that you are looking at, especially because this disease is very difficult to diagnose? Is there any awareness campaign or anything with GPs?

Dr Zorbas: In the years going forward, do you mean—in 2011-12? The work plan in ovarian cancer is actually quite formed, and we had some good discussion with our advisers around this work in particular. If I may go through just a couple of the areas that we are looking to work on, one is to develop more material on sexuality for women with both breast and gynaecological cancers, as this has been raised with us as an important issue for women. We are looking at also promoting important messages around Ovarian Cancer Awareness Month and probably around risk factors, which will be the culmination of work we are doing currently in developing a report around risk factors for ovarian cancer. We are looking at revising the guideline recommendations about the use of chemotherapy for women with ovarian cancer. This is important as it flows on from evidence that we have from work with the Queensland Institute for Medical Research which indicated variations in practice in the uptake of chemotherapy for women with ovarian cancer, so we are really looking to home in on those recommendations and then to implement those.

Generically, across all cancers, we are going to update the clinical practice guidelines for the psychosocial care of adults with cancer. We are also looking to develop health service strategies to support the delivery of best practice patient management for women with ovarian cancer, so having clinical pathways developed which are driven by evidence. They are probably the key areas that we will be working in in ovarian cancer going forward that have been identified. This program of work in ovarian cancer will be presented to the National Centre for Gynaecological Cancers working group, who are meeting in June, and will be considered as part of the whole work program within the gynaecological cancer area.

Senator ADAMS: Thank you very much.

Senator FIERRAVANTI-WELLS: Dr Zorbas, obviously there are breast cancer and prostate cancer, but what about other sorts of cancers—for example, oral or mouth cancer? Obviously I have a particular interest in this area, and I just want to see how they are going up in the pecking order in terms of not just research and the work that you are doing but awareness in the general community in relation to that.

Dr Zorbas: We have an interest in all cancers because that is, of course, our remit, and our work across all cancers is primarily in the research and clinical trials area. We work very closely with the collaborative clinical trials groups to ensure that we have covered the spectrum of cancers in the research and clinical trials area. The information about specific cancers we will draw on with AIHW, on incidents, mortality, survival data and so on, but we do not have the remit to specifically drill down areas of work other than in breast, gynaecological and lung cancers at this time.

Senator FIERRAVANTI-WELLS: There were some issues raised in relation to the use of alcohol based mouthwash in terms of incidences and increased incidences of mouth and throat cancer. Is that something that you are aware of, is that something in your remit, or where is the appropriate area of Health that worries about that sort of thing?

Dr Zorbas: I think with particular cancers what we aim to do is provide clear advice where there is strong evidence around reducing risk, and that is something we will be doing going forward, particularly where there are opportunities for lifestyle changes that can impact on the incidence of cancer across the board. That is part of the work of Cancer Australia and we will be looking to do that more so, going forward. The question is where there is strong evidence and where we can impact; we certainly will be doing that. Where the evidence is not so clear and not so strong then obviously that is an area for ongoing research.

Senator FIERRAVANTI-WELLS: I will not go into brand names, but it has been raised. I think there is evidence out there both ways, that they do affect and they do not affect, but I think, given the growing instances, perhaps at some stage we may see some further work on that. Thank you.

CHAIR: As there are no other questions in this outcome, thank you very much, Dr Zorbas. Thank you, Ms Halton. That brings to an end that section. When we come back we will go to the National Health and Medical Research Council.

Proceedings suspended from 18:35 to 19:49

CHAIR: We will reconvene with officers from the National Health and Medical Research Council. Welcome.

Senator ADAMS: I would just like to talk about the health impacts from wind turbines. I am going to be very careful not to go into the committee's report, because we are still doing that. I note, Professor, that you did say that you were going to have a planning workshop in June to discuss the latest health impacts in relation to wind turbines. Would you be able to tell me when it is going to be held and who the invited attendees are, please?

Prof. Anderson: Thank you for your question. The workshop is very soon, and perhaps Professor McCallum can help me with some details here. It is on 7 June, so it is coming right up. We will have an open session which we hope to webcast, with two overseas experts, Professor Leventhal and Professor Alves-Pereira who have different views on this and they will describe for the audience, including the web audience, what the issues are.

Senator ADAMS: Where are they? It would probably be better if, as you mention people, you could give us some detail so that we can find out whether they are involved with wind developers or are individuals. Where do they sit?

Prof. Anderson: They are both academics. Professor Leventhal is an expert in acoustic—

Prof. McCallum: Professor Geoffrey Leventhal is probably the leading acoustician who deals with health-related matters. He recently chaired a major conference on wind farms and health in Rome. Mariana Alves-Pereira is a younger researcher who has an alternative view to Professor Leventhal. She does work, again, on acoustics and health, but in a slightly different vein. She is Portuguese.

Senator ADAMS: Where is the other professor from?

Prof. McCallum: He is from the UK, from London.

Prof. Anderson: Then we have some Australian epidemiologists coming so people can study the incidence of ill health in society. We have got some people concerned about wind farms—community groups—coming. We will hear presentations in the morning and then have a workshop format in the afternoon when we can hear all views.

Senator ADAMS: And you have consumers who actually have or are suffering the ill-health effects from wind turbines?

Prof. Anderson: We have their representatives invited, yes.

Senator ADAMS: Could you tell me which groups and who these people are? I think that it is very important that this is on the record.

Prof. Anderson: We are certainly very keen to hear from such people.

Prof. McCallum: We have people representing the Waubra group from Victoria. We have some from South Australia and we have some from New South Wales, not far from here actually. They are people who have reported effects from wind farms, and then we will have the representatives and others in the audience as well. There is a panel session with people reporting, if you like, and grounding the session and giving their views on the effects of wind farms.

Senator ADAMS: Whereabouts is it to be held?

Prof. Anderson: In our building in Canberra.

Senator ADAMS: Is it open to the public?

Prof. Anderson: This one will be an invitation only meeting but, as I said, the first part of the meeting we will broadcast through the web to anybody who wants to hear. We want to get the views of these people to try to inform ourselves of whether we need to update that public statement that you are aware of and to get their views from all sides. Given that research is now beginning to be published in this area, I think that it is quite likely that we will need to do so, in which case we would of course, in the usual NHMRC way, consult with the community through open consultation processes.

Senator ADAMS: And as a result of your forum, would NHMRC consider doing research of their own into this problem?

Prof. Anderson: Let us see what happens. We fund research. We do the research in terms of looking at what is published—

Senator ADAMS: I realise that; we have seen the evidence of that.

Prof. Anderson: We fund research. At this stage we are not aware of anybody ever having applied to us for research funding into the potential health effects of wind farms, but if something emerges from our consultation, including an international perspective, and there is a need to do something specifically, we would certainly consider it.

Senator ADAMS: So this was by private invitation only, and then it is going to be available on the web so that we can watch it on the web?

Prof. Anderson: Yes, and if the committee wanted a report on the main outcomes of the workshop, I am sure we would be very happy to provide you with a briefing. I should not, perhaps, characterise it this way, but it is a way that we at the office of NHMRC are hoping we can get further feedback from the community and from experts two years on from the previous literature review of where the field has moved on to.

Senator ADAMS: I think that probably the advertising of NHMRC has gone worldwide and that statement, unfortunately, is being used by every wind farm developer and it is rather concerning that they are not prepared and they just say no. They just say that they are not prepared to look at any health effects associated with wind farms because they do not believe there are any. So I am very pleased that you have taken the opportunity to invite people from all aspects of the health effects. It has certainly been a worry, and as wind turbines are being set up in plague proportions—and in just listening to the number of new wind farms that will be going up in Australia—I think that if there is a problem we should try to fix it now.

Prof. Anderson: I am sure that you would also understand this, as elected representatives, that anything you say can be used by people who want to use it in a particular way. I think that a reasonable reading of that document does point out that we do acknowledge there are concerns, that there have been reports that people should see their doctor, that the evidence is at this stage quite thin, and so therefore—and we said this—a precautionary approach should be used at this stage. Some of our staff have been cleared to make that point to those who have been using the Blann, the short-stay map, in the way that you suggest and I do not want the committee or anybody else to misunderstand. We think that this is an important issue and we will continue to work on it. We are a scientific body and so we will be looking at the peer review evidence as the way to guide us. But in saying that, I am not dismissing for a moment that members of the community have concerns that are being brought up and they are important concerns that often—and this is a point that we made—do act as an early indicator of public health matters. So we are not dismissing those reports in any way.

Senator FIERRAVANTI-WELLS: In budget paper No. 2, under the National Mental Health Reform research funding, it says that the government will provide \$26.2 million over five years including \$5.4 million through the NHMRC for mental health research priorities. It will be conducted by the NHMRC which will meet the costs from within its existing resource. Can you explain how that will work? You get \$5.4 million to do mental health research and you do the research through your own—

Prof. Anderson: Yes. There are two aspects of it, as you point out. The first is some programs that will be transferred to the NHMRC from the department. These are: the Australian Venom Research Unit; three centres in dementia care, Centres of Research Excellence; and the Cochran Centre, also in Melbourne. These five—as there are three

dementia centres—are very much in the research and the research translation areas so they are good matches for NHMRC. So that is that lot. The \$26.2 million of funding will come from the Medical Research Endowment Account, our fund to support health and medical research.

Senator FIERRAVANTI-WELLS: The cookie jar.

Ms Halton: Oh, no, that is a worse description! Finance will hear you. Stop it!

Senator FIERRAVANTI-WELLS: Ms Halton, I know you have got a cookie jar.

Prof. Anderson: It is the absolute opposite of a cookie jar! It is a rigorous, highly competitive funding scheme—

Ms Halton: Composting heap, Senator—recycling.

Prof. Anderson: I am not going to confirm or deny the secretary's comments. That lines up with our strategic plan where we see that mental health was one of the major issues we were going to address this triennium, and the Research Committee has been helping us develop our ideas there. We have had two workshops with the mental health research community, one to set the scene and the second one to identify—

Senator FIERRAVANTI-WELLS: Was that one of 13 April?

Prof. Anderson: Correct. You are answering my questions—that is good.

Senator FIERRAVANTI-WELLS: It was attended by Professor McGorry and Professor Hickie, of course.

Prof. Anderson: And a bunch of really great researchers including those that we fund.

Senator FIERRAVANTI-WELLS: The same day they met the Prime Minister, but nobody seems to be able to recall that meeting, Professor. But you can vouch for the fact that they were in Canberra, thank you, Professor.

Prof. Anderson: They were at my lecture.

Senator FIERRAVANTI-WELLS: They certainly were.

Prof. Anderson: That was the second workshop we had. The first one was the previous year. The two things identified out of that were the need to build capacity in this research area. There is a big need but somehow the development of a new generation of researchers has not really come forward. We have been discussing that at great length with our Research Committee and they have got some very good ideas about how to do that. We already have a program of Centres of Clinical Research Excellence and Public Health Research Excellence and Health Services Research Excellence and we think that is a good way of building capacity. We have some translating research into practice fellowships and we think that is a good way of doing it. We have practitioner fellowships for people who do research but work in the health system providing health care to patients. We think that is a good way of doing it. These have all been discussed by Research Committee and have been developed as an idea.

The second part that came out of the workshop was about targeting research to areas of highest priority needs. The workshop has provided about seven or eight really good ideas out of that, which have gone to our Research Committee and they are thinking about the best ways of doing that. So the workshop was extremely useful and through Research Committee looking at that, we will focus what we will spend the \$26.2 million.

Senator FIERRAVANTI-WELLS: Going on figures from a couple of years ago, your spend on mental health research was about eight per cent or thereabouts.

Prof. Anderson: I think that it is more than that now. It is only just more than that.

Senator FIERRAVANTI-WELLS: Yes, I thought that it was only just.

Prof. Anderson: This year we have got 353 mental health grants totalling \$63.7 million, which is about nine per cent of the annual budget. There is a pretty tight definition of mental health. Other people think that autism is in mental health; I think the mental health people really do not. So there are always some definitional issues around that.

Senator FIERRAVANTI-WELLS: Ms Halton, this might be taken on notice. I notice from the budget statements that there is a transfer of dementia research funding. Last year's budget statements had a program on dementia, 4.6, which had some money in there—and I cannot off the top of my head remember how much it was. Does that mean that that has now gone over? Is that part of the moneys that have gone over? I notice that that program is no longer there, so effectively that research money that was previously in your department has gone over to—

Ms Halton: That is right, Senator. The essential point here is that all we are trying to do is align the administration of the portfolio in the best and most sensible way. If it is research where the expertise in managing that is with the NHMRC, it does not mean that we cannot have an influence particularly where they have been policy relevant, but what we are doing is moving to align where these particular things are administered to get the best value.

Senator FIERRAVANTI-WELLS: So 4.6 last year at \$34 million—

Prof. Anderson: Yes, those grants were on an MOU we had with the department on that around some specific areas. In the grants announced by Minister Butler from last year, there was \$4.9 million in dementia.

Senator FIERRAVANTI-WELLS: So in effect it is just a swap, money that was previously in the Department of Health and Ageing that has gone over to research. It is not new, as such; it is just existing money—

Ms Halton: Where it is administered.

Senator FIERRAVANTI-WELLS: Correct. I did not quite understand the mathematical calculation there. I think that is all I have a mental health research.

CHAIR: Thank you very much, Professor and officers. That does complete outcome 10. Now we will move to outcome 3, which is access to medical services. We will begin with outcome 3.1, Medicare.

[20:07]

Senator FIERRAVANTI-WELLS: In the past you have cut item numbers as a budget measure, such as cataract surgery—and I will not take you back to that. The portfolio budget statement states:

In 2011-12, the department will review existing MBS items for evidence of their quality and safety, to ensure that items listed on the MBS remain clinically relevant and consistent with best practice. The department will also review MBS fees to ensure they accurately reflect the costs involved in providing the services.

How will this review be conducted?

Mr Bartlett: There was a process two budgets back, the quality framework, which set these in train. As part of that, there are four pilot reviews underway at the moment: one on ophthalmology, one on obesity surgery, one on colonoscopy and one on pulmonary artery catheterisation. We have put together clinical working groups that have experts in various areas who conduct these procedures. They work with consultants that we use to assess what is being done, safety and quality, and whether what is being done reflects current clinical practice. They put together a report. That report then goes to MSAC. MSAC will look at it and make recommendations to the minister about what can or cannot be done through that review process. At the same time, one thing we have done in terms of fees is had some preliminary consultations with a range of people in the sector about looking at input based fee setting. A lot of the fee arrangements that are made at the moment are done on the basis of comparison. The difficulty with comparison is that it is very difficult to go back and work out whether what you have compared to remains valid. If, for example, you are doing an evaluation to try to work out whether an item is delivering an outcome, a comparative fee makes that very difficult to achieve. So we are trying to get to something that is much more predictable. MSAC has made a few comments along the way that, when it is trying to assess the cost effectiveness of an item, it is rather difficult to do that effectively when there is some uncertainty about the fee that will apply to the item when it is finally listed. Again, it is about giving more certainty to applicants and to assessors so that we come up with something that is more rigorous in terms of outcome.

Senator FIERRAVANTI-WELLS: I am conscious of time, so can you take on notice the evidence that will be considered in relation to each of those four projects? Will the outcomes be implemented as budget measures or will proposals be open for consideration by stakeholders and published publicly prior to decisions on implementation, contrasting that with what happened with cataract surgery?

Mr Bartlett: The process that we are going through is a consultative one. Stakeholders are offered a number of opportunities to comment on the way through, and they will be offered those opportunities to comment on the way through. As to final outcomes, government makes decisions about what the outcomes will be.

Senator FIERRAVANTI-WELLS: Are health consumers, as part of the stakeholder group, able to make submissions?

Mr Bartlett: Everyone can make submissions. I think the Consumers Health Forum have made submissions on a couple of the projects. They also have a consumer representative on MSAC. There are a number of ways in which consumers can provide input through this process and we are exploring ways to expand that.

Senator FIERRAVANTI-WELLS: Will you be recommending increasing rebates where the cost of inputs can be demonstrated to be greater than the scheduled fee? Can we record a smile?

Mr Bartlett: I can work through a long process about what a rebate does and does not represent.

Senator FIERRAVANTI-WELLS: That is not my question and the smile says it all.

Mr Bartlett: I know it is not your question, but the issue is that the rebate represents what is paid at the moment for the fee. When we look at it we will look at it in the context of

current relativities. It is not a matter of saying, 'Can we now therefore find an extra—it's only \$16 billion for the MBS at the moment—\$1 or \$2 billion to put in?' because by using some notional measure there may be an appropriate different fee to move to. That is a fairly subjective assessment at the best of times, given that most of what we are funding through the MBS are professional services.

Senator FIERRAVANTI-WELLS: The gist of my question, comparing it to cataract surgery, was particularly the involvement of consumers. That was the point that I was driving at. In relation to access to dental services, please give me an update on the number of dental services accessed under the Medicare scheme in 2009 and so far in 2010-11.

Mr Thomann: I presume you are referring to the chronic disease dental scheme?

Senator FIERRAVANTI-WELLS: Yes, I am.

Mr Thomann: In relation to the dental scheme we had 11,805,625 services, from 1 November 2007 to 30 April 2011, in respect of 684,840 patients.

Senator SIEWERT: How many was that again?

Mr Thomann: It was 684,840 different patients.

Senator FIERRAVANTI-WELLS: What has been the average growth rate in the number of services accessed per year?

Mr Thomann: I do not seem to have that information with me.

Senator FIERRAVANTI-WELLS: Do you want to take that on notice?

Mr Thomann: Do you want the figure for year to year?

Senator FIERRAVANTI-WELLS: Yes, please. Can you tell me what compliance measures are in place to ensure services accessed under the scheme meet the intent of the program and eligibility requirements?

Mr Bartlett: Compliance questions about this and other programs have to be directed to Medicare Australia. It is their responsibility.

Senator FIERRAVANTI-WELLS: Right. Would the services in your proposed dental health program be performed by public dentists employed by state and territory governments?

Mr Thomann: I presume you are talking about the CDHP?

Senator FIERRAVANTI-WELLS: Yes.

Mr Thomann: The answer to that question is yes.

Senator FIERRAVANTI-WELLS: How many are currently employed in the public system?

Mr Thomann: I will have to take that on notice, Senator.

Senator FIERRAVANTI-WELLS: You have obviously done a costing of the program with your proposal. You have the figure—but you do not have it with you?

Mr Thomann: I do not have the figure with me. We will have to take it on notice.

Senator FIERRAVANTI-WELLS: What would be the eligibility requirements for patients for the CDHP?

Mr Thomann: It would be for concession card holders and pensioners.

Senator FIERRAVANTI-WELLS: You said that Minister Roxon said, back in 2008, in her press release that you would give priority to patients with chronic health needs. How is that going to be achieved? How are you going to ensure that that happens?

Mr Thomann: That would need to be negotiated with the states and territories because it would be administered through the public dental scheme—as to how that policy intent would be achieved in each jurisdiction.

Senator FIERRAVANTI-WELLS: That means that you have done a costing, so you must have done an assumption. How many people do you think you are going to treat?

Mr Thomann: It is almost a million—990,000—services over three years.

Senator FIERRAVANTI-WELLS: Presumably, your costings have been based on not only the number of people you are going to treat but also the dentists employed to do that?

Mr Thomann: The commitment was an expenditure of \$290 million over three years.

Senator FIERRAVANTI-WELLS: Do you think you have enough dentists in the public system to deal with it?

Mr Thomann: We have not done an analysis. We can take it on notice.

Senator FIERRAVANTI-WELLS: You know how many people you are going to treat, you know who you are going to treat, you do not know how it is going to be achieved, you know how much it is going to cost but you do not know whether you have enough dentists to meet what you are going to do. That seems a bit strange to me. I would have thought you would know whether you have enough dentists in the public system to be able to achieve this. You have told me you would have enough dentists in the public system to be able to achieve what you want to achieve.

Mr Thomann: The point of the initiative is to create enough capacity in the system to deliver that service.

Senator FIERRAVANTI-WELLS: If you do not have the dentists how can you create the capacity? Surely your starting point must have been how many dentists there were in the public health system and whether you had enough dentists in the public health system to be able to do what you have estimated you are going to do. I just do not understand how you create a dental scheme like this and not know how many dentists you are starting with to be able to provide the service that you are assessing you will do. Somebody must know.

Ms Hancock: Commonwealth Dental Health Program was a 2007 election commitment for \$290 million over three years to provide up to one million additional dental visits. The core of the program was as a waiting list reduction. In that sense it was not hinged on the number of dentists at that time providing services in the public sector. The point was to provide additional resources to state and territory dental services to address their waiting lists.

Senator FIERRAVANTI-WELLS: And you are satisfied that there are enough dentists in the public health system to do what you want to do?

Ms Hancock: The states and territories certainly indicated that, with the additional funding provided to them by the Commonwealth, they would be able to provide those additional services.

Senator FIERRAVANTI-WELLS: Do we actually have a figure of the number of dentists in the public system?

Ms Hancock: I do not have that figure with me. The negotiations at the time, back in late 2007 and early 2008, were about the additional resourcing to be provided to each dental service.

Senator FIERRAVANTI-WELLS: Perhaps you could take on notice to provide that information to me.

Ms Hancock: Do you want the figure as of 2007—

Senator FIERRAVANTI-WELLS: Yes because—

Ms Hancock: or the current figure?

Senator FIERRAVANTI-WELLS: your assessments at 2007 were for \$290 million and for \$290 million today your assessment would be different, I would assume; you would probably be dealing with a lesser number. Do you need to revise your 990,000 or do you need extra funding to treat 999,000?

Ms Hancock: The government's commitment remains to invest \$290 million over three years.

Senator FIERRAVANTI-WELLS: So that likely means your 'almost one million' will be reduced. Do you know by how much?

Ms Hancock: No, we do not have that number.

Mr Thomann: We have not revised that estimate.

Senator FIERRAVANTI-WELLS: I would have thought that, particularly as you are still pushing this, you would do that revision. It is a bit unfair to start talking about almost a million based on assessments that are four years old.

Ms Hancock: I would not describe the department as pushing it, Senator.

Mr Thomann: If the government asks us to revise the estimate we will do so.

Senator FIERRAVANTI-WELLS: I appreciate that, but you are working off 2007 estimates. Anyway, take the questions I have asked on notice.

Senator SIEWERT: You gave us a figure of 684,840 for the number of patients treated under the chronic illness program. Can you give us a breakdown of which states those patients are in?

Mr Thomann: We can give it by services.

Ms Hancock: We do not have patients by state.

Senator SIEWERT: I was then going to ask what services were provided, so if the best I can get is a breakdown of services per state I can live with that.

Ms Hancock: Services by state I can give you now; the number of patients by state I would need to take on notice.

Senator SIEWERT: That would be great, thanks.

Ms Hancock: Services by state are: ACT, 51,377; Northern Territory, 7,070; Tasmania, 55,353; Western Australia, 91,829; South Australia, 864,995; Queensland, 1,255,235; Victoria, 2,743,806; and New South Wales, 6,735,960.

Senator SIEWERT: That is the number of services, not the number of patients?

Ms Hancock: That is the number of services provided. The number of patients will obviously be fewer.

Senator SIEWERT: What types of services were provided?

Ms Hancock: I would need to take that on notice. We can do a rough breakdown for you. There are hundreds of items, so we might group them, if that suits you.

Senator SIEWERT: If you could. Obviously I do not need to know every single one. I am trying to get an idea of the types of services delivered and how many people have used the full extent of the cap.

Ms Hancock: The extent to which patients spend the full cap of \$4,200?

Senator SIEWERT: Yes. I am looking for the bulk of the services used and whether they used the full cap. That would be appreciated. Thank you.

Senator ADAMS: Are you able to provide on notice details of how many of these services were provided to rural and remote areas?

Ms Hancock: I am not sure. We can certainly do it by state. We should be able to do a breakdown.

Ms Halton: We will have a look at it.

Senator FIERRAVANTI-WELLS: I would like to know the level of nurse practitioner referrals compared to general practitioners. From 1 November, nurse practitioners and midwives have been able to access the Medicare rebates, prescribe on PBS and refer to specialist medical practitioners. At the time when this was going through, there was an argument that nurse practitioners might refer to specialists more than GPs, leading to a higher burden on Medicare. Do you have information about how many nurse practitioners and how many midwives have Medicare provider numbers?

Mr Porter: Between 1 November 2010 and April 2011, 49 nurse practitioners have provided services and 21 midwives have provided services under collaborative arrangements.

Senator BOYCE: Are you able to tell us how many services?

Mr Porter: Yes. Nurse practitioners have provided 10,275 services and midwives have provided 1,210 services.

Senator FIERRAVANTI-WELLS: Would you provide me on notice the amount paid under those benefits in each of those categories.

Mr Porter: I can tell you that now: \$250,477 has been paid to nurse practitioners and \$84,272 has been paid to midwives in benefits.

Senator FIERRAVANTI-WELLS: What about the total value of benefits provided by specialist medical practitioners from referrals by nurse practitioners? You might have to take that one on notice.

Mr Porter: I would have to take that on notice.

Senator FIERRAVANTI-WELLS: Thank you. That is all I have on 3.1.

Senator ADAMS: I have a question on specialist services with telehealth.

Mr Bartlett: We can deal with that.

Senator ADAMS: Regarding the monitoring of the MBS item number for telehealth, I would like to know whether it is helping fill the gaps in access to specialist care for people outside major cities.

Mr Bartlett: The telehealth items will become available from 1 July, so in that sense it is obviously a little too early to say.

Senator ADAMS: Thank you.

Senator BOYCE: I have some questions which I imagine will be under the Department of Human Services around the melding of Centrelink and Medicare services. I have learnt the hard way and ask when it may not be obvious. What involvement has the department had in ensuring that Medicare clients will continue to receive the same service that they have?

Ms Halton: This is a question technically under a different program, but I can probably answer the question.

Senator BOYCE: Which program should it be under, then?

Ms Halton: It is probably too late in the evening to tell you the answer to that question. I think it is whole of portfolio. I do not know the exact one. It is either that or 'System Capability'. We have been in what feels like a constant dialogue—that may be a slight dose of hyperbole—with Human Services about these arrangements.

Senator BOYCE: For how long?

Ms Halton: As long as it has been discussed, basically. I have had discussions with the two secretaries, because, as you would appreciate, there has been a change in the position of secretary, and the head of Medicare Australia about this, particularly as they have taken the initiatives in relation to some combined offices—having the Medicare function in a Centrelink office et cetera. They have been quite careful to make sure that they are talking to us about what they deliver and how they are going to deliver it to ensure that the service offering, if I can use what seems to be the relevant jargon, is appropriate for Medicare customers. Our concern has been to make sure that people find the service available, accessible, timely, of a high quality et cetera. They have gone out of their way to assure us of that. We continue to have arrangements with Medicare in relation to the contracts we sign for them to run certain administrative parts of some of our programs. Unless there is a particular thing you need to focus on—

Senator BOYCE: No. The next question was going to be: how are you measuring it?

Ms Halton: We have a number of points of accountability with Medicare Australia, particularly in terms of particular things—if I use the term 'contract' you would know what I mean in this context—which go to how they administer particular programs et cetera. Obviously we are monitoring the informal feedback we get as well.

Senator BOYCE: Who will be reporting on that feedback, formal or informal?

Ms Halton: In terms of the public accountability about this, it is theirs. They are accountable to their minister and to the parliament as a department of state. They are not actually accountable to us in the way that they were, although the legislative arrangements are quite complex. As you would appreciate, a number of the powers in legislation remain with me, but in some cases I delegate them to the head of Medicare Australia. This is a quite

complex relationship. As to the service delivery, the customer focused facing side of their delivery, they are accountable to their minister and to the parliament directly.

Senator BOYCE: So there are no other bodies monitoring, unless perhaps we were to call in the Auditor-General to have a look. There would be no other way of assessing?

Ms Halton: No.

Senator BOYCE: If you were not happy with their performance, what would happen?

Ms Halton: I would probably jump up and down.

Senator BOYCE: How would anyone else know that this had happened?

Senator McLucas: You have not seen the secretary jump up and down!

Senator BOYCE: I am asking about formal accountability here, Ms Halton.

Ms Halton: Essentially, that is an issue of informal accountability between us as colleagues, and of course the minister has a direct relationship with the relevant minister. I would hope, in fact I would be confident, that it would not get to that point.

Senator BOYCE: Thank you.

CHAIR: We now move to output 3.2, 'Alternative funding to health service provision'.

Senator FIERRAVANTI-WELLS: In the portfolio budget statement, at page 147, under 'Targeted assistance', midway down the page it says:

In 2011-12, the department will fund organisations through health program grants to effectively overcome barriers to accessing services such as: primary health care; intervention counselling relating to addiction, lifestyle, social problems and mental health pathology ...

That is, for those who have difficulty accessing services through mainstream mechanisms. It also follows on to say that the organisations that are funded will have to report quarterly about the type and number of services they have provided so that you can assess whether the needs of the target audience are being met through the program. Can you tell me how many grants will be available?

Mr Bartlett: I think we will have to take that question on notice to give you a response. Some of these are quite long-standing grants so we will have to go and have a look.

Senator FIERRAVANTI-WELLS: Would you also take on notice to provide how much funding will be available per grant, what the selection criteria will be and, most importantly, how you will verify or audit information provided to you about the number and types of services provided, and where you will publish information on recipient organisations and funding provided. Is this part of what we were talking about this morning, Ms Halton.

Ms Halton: Yes it is, but let us be clear: to the extent that these are existing organisations in some cases, and we can give you the catalogue of who is in there at the moment, but as to criteria for the future that becomes a bit more difficult. But we can certainly tell you who is in here at the moment.

Senator FIERRAVANTI-WELLS: It says that you will do it in 2011-12.

Ms Halton: Yes, 'will fund', as in continue the flow of funding to organisations that already have a funding agreement with us. It is not a new category.

Senator FIERRAVANTI-WELLS: Okay, but there may be others that are coming online to which different selection criteria apply?

Ms Halton: I think that is improbable, but we will take that on notice.

Senator FIERRAVANTI-WELLS: If there is, could you let me know?

Ms Halton: We are happy to do that.

[20:36]

CHAIR: We will now move on to 3.3, Diagnostic Imaging Services.

Senator FURNER: The federal government relied upon licences for more than 60 existing MRI machines. How many more MRI licences will be made available in Queensland, firstly?

Mr Bartlett: As part of the outcome of the diagnostic imaging review and budget announcement, two categories of licence change were announced. Existing MRI machines in regional areas will get full licences from 2012 and existing MRI machines in metropolitan areas will get partial licences from 2012. In terms of regional areas in Queensland, we can confirm that it was announced as part of the budget that there will be three in regional Queensland.

Senator FURNER: And what are those locations?

Mr Bartlett: They are in Townsville, Mackay and Toowoomba. In addition, there are 13 in metropolitan Queensland that will get partial eligibility from next year.

Senator BOYCE: For next year, not this year?

Mr Bartlett: No, they are all from 1 November next year.

Senator FURNER: Where are those 13 located?

Mr Bartlett: Maroochydore, Ipswich, Noosaville, Southport, Maroochydore, Robina, Southport, Toowong, Annerley, Coorparoo, Southport, Herston and Chermside.

Senator BOYCE: And they will all be provided between November 2012 and November 2013?

Mr Bartlett: From 1 November 2012 they will have MBS eligibility for the provision of diagnostic imaging requests made by GPs for children under 16 for a range of indications and for a variety of cancer screenings. Those in regional areas will have full eligibility.

Senator FURNER: Are any more licences available in South Australia and Western Australia, or other states?

Mr Bartlett: In South Australia there are none in regional areas at this stage—although I should say that with this we are still clarifying a number of machines. We have based the lists we have on the information Medicare has, but as these machines did not have MBS eligibility there was no obligation for the providers to have let Medicare know about them. We are still in the process of clarifying that. So what I am giving you is the status at the moment. We are still working with people to clarify whether there are more. In terms of metropolitan South Australian, there are six—two in North Adelaide, one in Adelaide, one in Bedford Park, one in South Adelaide and one in Kurralta Park.

Senator FURNER: And in Western Australia?

Mr Bartlett: In Western Australia at this stage there are none in regional areas and four in metropolitan areas—two in Midland, one in Subiaco, one in Myaree.

Senator FURNER: And they are all earmarked for that period, 2012?

Mr Barlett: That is right. I should add one other thing. As part of the budget announcement, 12 further full licences will be allocated to areas of need in the period between 2012 and 2015. They are over and above the existing machines that are out there.

Senator FIERRAVANTI-WELLS: Is that areas of need? Was that the criterion?

Mr Barlett: That is the description.

Senator FIERRAVANTI-WELLS: Is there a defined criterion?

Mr Barlett: Not as yet.

Senator FIERRAVANTI-WELLS: Do we know when we are going to get the criteria?

Mr Barlett: That will be worked through in the next 12 months.

Senator FIERRAVANTI-WELLS: It is a bit like the GP superclinics: we got the criteria after they had decided where they were going to put them. Conveniently, that covers the period over the next federal election. Somebody must have given some thought to that. Have you got some idea as to where they are going to be or have you done some work—

CHAIR: Senator, you know that the officer cannot give an opinion.

Senator FIERRAVANTI-WELLS: I withdraw that. Has any work been done in relation to location of those licences?

Mr Barlett: No, Senator.

Senator FIERRAVANTI-WELLS: Not yet.

Mr Barlett: No.

Senator FIERRAVANTI-WELLS: I will ask a question in relation to the diagnostic imaging services. This is on page 151 of the portfolio budget statement. It is \$75.5 million over two years to allow GPs to refer patients for some MRI services, and initially the GPs will only be able to refer patients under 16 years of age. Can you give me a breakdown of the costing of the \$75 million allocated for the referrals? For example, is there expected to be a higher radiology service utilisation?

Mr Barlett: The expectation is that as a result of this measure there will be a number of MRIs done which are not being done at the moment.

Senator FIERRAVANTI-WELLS: How many?

Mr Barlett: I would have to take that on notice in terms of the exact number.

Senator FIERRAVANTI-WELLS: It is \$75 million, so you cannot tell in terms of the quantity deliverables. Can you tell me what the clinical evidence was that was relied upon to initially restrict referrals to people aged 16 years and younger?

Mr Barlett: The process leading up to the extinction of MRI requesting to GPs for adults in 2013 includes working with the sector, the colleges of GPs and radiologists, to develop guidelines which will be embedded in decision support as part of GPs being able to request MRIs for adults. It was felt, based on the information that was provided during the DI review, that there was a clear case that there was benefit in giving children under 16 earlier access to MRIs in this way. Long-term exposure to radiation is obviously problematic, so the younger you are when you start being exposed to radiation, the greater the potential long-term

problems. That was the logic for bringing that one in before the other prerequisites, which are there for the broader access to MRI requesting for GPs.

Senator FIERRAVANTI-WELLS: I understand that previously you had advised that the outcome of the diagnostic imaging review would be reflected in this year's budget. That was not the case?

Mr Bartlett: That was the case, Senator.

Senator FIERRAVANTI-WELLS: So the extent of the implementation of that review is in the budget.

Mr Bartlett: The budget reflects the areas where additional expenditure is being put in, and that is focused on MRI. There are a range of other things that are to be done over the next five years with the sector to look to addressing a number of the other issues that came up as part of the review. I have just mentioned development of guidelines for decision support. There is a need to have a look at a range of issues that came up in terms of roles of radiologists, professional supervision and accreditation of practices, all of which are intended to respond to issues that were raised during the DI review and ensure that we get better practice.

Senator FIERRAVANTI-WELLS: So there are a range of measures in that review where you are having consultation with the sector on the specifics of any MBS changes?

Mr Bartlett: Further consultation with the sectors, yes.

Senator FIERRAVANTI-WELLS: So we could see more budget announcements where there has not been consultation—do you see what I am getting at? Would you be discussing any changes to the MBS with the sector? Is it likely that we could see some budget announcements in future?

Mr Bartlett: We have come out of a two-year review process. As part of that review process, there was extensive consultation with the sector. It went through a budget process and the outcome was announced. The response from the sector has been positive. We continue to consult with the sector and we will consult with them as things go along. There may well be further things that go into budgets but, again, the track record in terms of interaction with the sector has been a very positive one.

Senator FIERRAVANTI-WELLS: Picking up on your previous point about exposure to radiation, it has been put to me that often there are circumstances where a patient is referred for a series of CT scans and then ultimately has to have an MRI anyway. Do you monitor or have statistics on that? I am not sure whether I have asked this before. I looked for an answer to a question on notice. If you have provided it to me in the past, can you say so. I want to see if, when you do a comparison, you can tell if Mr Bloggs has had X number of CT scans before he goes on to having an MRI, and that he has been exposed to radiation as a consequence of the CT scan. Wouldn't it more be cost-effective for him to have an MRI first—go straight to an MRI? Is that the sort of statistic you can look at in terms of usage?

Mr Bartlett: You did ask that question last time.

Senator FIERRAVANTI-WELLS: I was looking for the answer just before. I went through the list thinking, 'Where was it; what number was it?'

Mr Bartlett: The difficulty we have got is, yes, we can look at what is there. We can see whether somebody has had one or more CTs before they have an MRI. What we cannot see is whether or not that progress was appropriate. It may well be that they are going through a process of diagnosis with some not particularly clear symptoms and that they move from an ultrasound through a CT to an MRI, and that is entirely appropriate. Medicare statistics will never tell you that. They do not have the clinical data to enable that assessment and for an appropriate list to be made.

Senator FIERRAVANTI-WELLS: No; it had been put to me. Thank you. I will go back and look again. I do not have any other questions in this section.

CHAIR: Pathology services, 3.4—there are no questions? Right. Output 3.5, chronic disease, radiation oncology? There are no questions. Output 3.6, targeted assistance, medical? There are no questions there. Okay. On that basis we have gone through what is there so we may take an early break.

Proceedings suspended from 20:50 to 21:04

Professional Services Review

CHAIR: We are now talking with officers from Professional Services Review.

Senator BACK: I understand from the various media reports and other comments that the Professional Services Review process has had a few issues in recent times. I understand that the department is working with the PSR, of which you are the director—

Dr Webber: Yes.

Senator BACK: and the AMA to review practices and increase transparency. Could you tell the committee just what is being undertaken and what the background to that is.

Dr Webber: The background is that in the review of PSR in 2007, one of the recommendations was to set up a professional services review advisory committee consisting of PSR, the department and the AMA, with Medicare as an observer. Through that mechanism the committee has met on several occasions recently looking at PSR's processes because there has been some concern expressed by the profession of alleged lack of transparency and so forth. That is what we are seeking to address through that process.

Senator BACK: Were there a series of recommendations as part of the 2007 review and are you now at the stage of a new review or has there been some recent activity that has caused the accelerated concern and therefore the process being undertaken at this time?

Dr Webber: There were not any specific recommendations in the 2007 review apart from setting up the advisory committee, but there has been quite a lot of comment and concern by some in the profession about PSR's activities and hence the appropriate medium to explore that was the advisory committee.

Senator BACK: Is it the department's experience that many general practitioners are practising with, if you like, an overall fear that the PSR could come 'knocking' at any time? That term has been put to me and no doubt others—perhaps to you also. Can you comment on that?

Dr Webber: Most certainly I can. PSR only ever sees less than 0.1 per cent of all practitioners. In fact, Medicare Australia do the initial review of practitioners and they would review approximately 400 to 600 practitioners per year in the normal course of their audit

activities. Medicare can resolve 90 per cent of those people they see and we only see about 10 per cent of the people Medicare review.

Senator BACK: About 10 per cent of the 400 to 600.

Dr Webber: That is right, on average. The chances of somebody coming to PSR are extraordinarily slim.

Senator BACK: You feel that that fear is an unwarranted concern that members, particularly general practitioners, have?

Dr Webber: I think it is unwarranted, yes.

Senator BACK: General practitioners having the concern that this might be hanging over their heads is certainly not conducive to good clinical care of patients, is it?

Dr Webber: It should not ever be a concern of good clinical care; it should be independent.

Senator BACK: That is exactly right. A concern put to me, and I put it to you, is that particularly in country areas, as well as more widely, there are GPs who are refusing to accept what they predict will be difficult cases to deal with because of their concern that they will not be able to fit them into a six-minute consultation. Is that a correct term? Are these doctors turning patients away for fear that they will not be able to fit them into the scheduled time period for which they would be able to make a Medicare claim? Is that an experience you have had?

Dr Webber: It is not. The standard consultation in the Medicare schedule is up to 20 minutes. A six-minute consultation would be described as a brief consultation. Most general practitioner consultations would be done under item 23, which is a consultation of up to 20 minutes.

Senator BACK: At the end of a 20-minute period—I have no doubt a lot of psychological or psychiatric type consultations would take longer than that 20-minute period—what happens in the event that a doctor finds they are moving to or will exceed that period? How can they act?

Dr Webber: There is no problem with that. If a consultation lasts longer than 20 minutes it is usually by nature a fairly complex interaction; it is not a simple sore throat. If the consultation goes over that time the doctor is entitled to claim a level C consultation or a long consultation.

Senator BACK: Subsequently, in the event that they were the subject of some audit process by Medicare, how would a doctor defend or justify, how would they, in a sense, cover themselves against any possible allegation that they may be rorting, that they did not conduct a consultation longer than that 20-minute period for which they then are claiming a longer period?

Dr Webber: Medicare has no power to look at medical records in that sort of instance, but if that particular case came to PSO and that person was subsequently referred to a committee of their peers, the committee has to take into account the medical record and the oral evidence of the doctor to make a judgment as to what happens in a particular consultation. To be clear, a consultation or any service is appropriate if two fundamental criteria are met: one is that the service met the item descriptor of the NBS or the PBS guidelines and, secondly, that it would

be seen as clinically appropriate by that doctor's peers and met the standard of the general body.

Senator BACK: So those are the two criteria. Is it the case then that Medicare, in determining whether that 400 to 600 that you mentioned per annum should be the subject of some further scrutiny, uses statistical triggers to determine that—some sort of normal curve, and someone falls outside the normal curve?

Dr Webber: I cannot speak entirely for Medicare, but my understanding is that it is mostly through fairly sophisticated computer algorithms that people are initially reviewed. Also it can be from tip-offs from patients or staff, but it is mainly through computer data.

Senator BACK: I will come to the Medicare process in a moment, but what role, if any, could the Minister for Health have in determining the number of reviews that Medicare would undertake in a year? Is there a role? I ask the question because I did see reported:

The PSR is under extra pressure after Health Minister Nicola Roxon increased the number of reviews undertaken by the agency in a bid to save the government extra money.

Is there a capacity for the minister herself to demand or require or be involved in the process of determining the number of reviews that are conducted?

Dr Webber: No.

Senator BACK: There is no role at all?

Dr Webber: No.

Senator BACK: Thank you. Coming to your own assessments as the director, my understanding—and you might correct me or confirm—is that in the event that you are requested to undertake such an investigation, about 15 per cent of those that you assess initially are dismissed without any penalty. Is that a reasonably accurate figure?

Dr Webber: That is a rough average for the last five years.

Senator BACK: Would you regard that as being unduly high—one in seven?

Dr Webber: No. I would have to say that of all the people I have referred to me by Medicare—and these are people who Medicare initially discovered by statistical mining, people whose behaviour has not changed after Medicare has given them an opportunity to do so—all of the statistical data that I receive from Medicare is fairly abnormal when I see it. However when I dig deeper and look at their medical records and talk to the doctors, they are actually providing a good service and are abiding by the schedule and there is no reason to take the matter any further.

Senator BACK: So no further action is taken with that 15 per cent. I then understand that about 50 per cent of those cases referred to you have what I will call a 'negotiated settlement', that is, as a result of the process—and perhaps you can describe it to us—you as director participate in some process with the doctor or the other health professional, the practitioner if it is not a medical practitioner, concerned and they will acknowledge their mistake and there may be a penalty imposed, which I know has got to go on to another determining authority. The term I have heard used by doctors who have approached me is 'go away money' so that the disruption and the cost of challenging it is behind them, it is not worth it and they get on with it. Is that an accurate—

Dr Webber: No, that is an incorrect categorisation.

Senator BACK: Perhaps you could then give us an accurate one.

Dr Webber: Of all the people that I see, as you say, 15 per cent are dismissed. The 50 per cent with whom I can negotiate an agreement are those practitioners who, firstly, while their behaviour is inappropriate, and that might be because of non-adherence to the schedule or for inappropriate behaviour clinically, if that behaviour is in the mild category and the practitioner has insight into that behaviour and demonstrates behaviour change and it is overall in the milder category of inappropriate practice, then it is appropriate to negotiate an agreement. These agreements can be for quite a small amount of repayment because the repayments are not a fine. They are repayments of benefits paid, so there is no extra fine in that.

Senator BACK: No penalty on top of that?

Dr Webber: No.

Senator BACK: Of those who then go on to this committee, which we will come to, my understanding is that in the past three years there has been a 100 per cent success rate—I guess that term depends on whose eyes you look at it with. Is it the case that with all of those cases in the last three years that have gone on to be referred to the committee in accordance with the act the parties have been found guilty, for want of a better term?

Dr Webber: Guilty is not the right term. They have been found to have practiced inappropriately. That is true.

Senator BACK: So it is 100 per cent. If they were invited to deal back in the negotiated settlement, the odds are pretty well stacked in favour of them being willing to actually try to reach that negotiated settlement with you. Would that be a fair summary?

Dr Webber: It is a negotiated agreement, but it is my call whether I offer that. As I said to you, I would not be inclined to negotiate an agreement where there is gross inappropriate practice or other practices—

Senator BACK: Or where you believe there is a case for gross—

Dr Webber: Or a very significant case to answer, yes.

Senator BACK: I do not want to go line and verse through the act, but the Medicare CEO, as I understand it, requests the director in writing to review the provision of services by a person over a specific period of time. That is the catalyst that kicks it off.

Dr Webber: Yes.

Senator BACK: In so doing, in that correspondence, the CEO of Medicare must include to you the reasons for that request.

Dr Webber: Yes.

Senator BACK: Then the Medicare CEO must also give the person written notice of the fact that they are to be under review.

Dr Webber: That is true.

Senator BACK: Does the letter which goes to the person who is now the subject of this notice include notification of the reasons, the ones that are presented to you? Do they get a copy of that at that time?

Dr Webber: Yes. They get exactly the same copy of the request to review as I do.

Senator BACK: In that particular case, under the act, if you decide to undertake a review then you must also give the person notice of your intention.

Dr Webber: That is correct.

Senator BACK: So by this time the person to be the subject of review has got full information about all aspects associated with the review that the CEO of Medicare has requested and that you are intending to proceed with?

Dr Webber: That is true.

Senator BACK: At that point we then move to the question of the committee. There have been some difficulties under the act. Is that correct? Under the act there are certain actions that have got to be taken, particularly involving the AMA approving members of the committee and also the panel and that has not been happening. Is that correct, as I understand it to be?

Dr Webber: That is currently subject to a Federal Court action, so I cannot comment specifically on—

Senator BACK: But that is what the Federal Court action is considering?

Dr Webber: Indeed.

Senator BACK: The person who is under review—and I understand that it is all written out in the act that once the committee is appointed to undertake the investigation of this person—

Dr Webber: There is big jump between the referral and the committee. There is a lot of process to get to the committee process.

Senator BACK: To get to that. For the sake of time, and unless there is anything that you wish to alert me to, it is my understanding that in the event a certain person is to be the subject of a review a committee is formed – or a committee is delegated to undertake the review.

Dr Webber: Just so you are clear, the committee is only formed following my review. It is not formed to undertake a review.

Senator BACK: What is the committee formed to do, then?

Dr Webber: The committee is formed to form a committee of inquiry after I have made an initial assessment and review of that person. So it is some months down the track.

Senator BACK: In your process then, would you meet with the person who is the subject of review?

Dr Webber: Absolutely.

Senator BACK: At that point in time would they be able, for example, to present to you evidence? Would they be able to bring along a fellow clinician or a person of their profession? Do they go through the process at that point with you?

Dr Webber: They certainly do.

Senator BACK: Then, presumably, you would have the option, having heard that evidence, to make a determination that there is no case to answer, let us say.

Dr Webber: Indeed, that has happened.

Senator BACK: How often?

Dr Webber: In 15 per cent of cases. As I said to you, the Medicare statistics that come to me all look very abnormal and very different from somebody's peers. I have a process that I take whereby I will request medical records from that person covering Medicare's concerns and a range of issues across the person's practice. I will meet with the doctor, discuss the concerns that I have found in their records and hear any evidence that they might wish to bring, or listen to a colleague or an expert if they wish to bring one along to bolster their case. Only after that process do I make a decision.

Senator BACK: We will then move from the 15 per cent that you have exonerated to the second group that by negotiation you have been able to work out. We now move to the third group. Incidentally, would you ever be in a position to refuse if a practitioner or clinician wished to, in their review process with you, bring along a specialist or whoever? Are you in a position to decline or refuse that capacity?

Dr Webber: I have never done so.

Senator BACK: Under the act, could you? Obviously, I know transparency and natural justice is supposed to be at the fore. What would be the circumstances under which you could refuse Professor Twyford from representing or being there with me in that review process? I just elevated you Mr Twyford.

Dr Webber: There is nothing in the act that says I have to meet with that person. I could do it all on the papers. The act is silent about that meeting. But I find that the meeting facilitates my decision making.

Senator BACK: If you did in fact refuse that could it possibly trigger an opportunity for a person afterwards to appeal on abuse of process or something?

Dr Webber: Yes, certainly.

Senator BACK: Okay. So we are now at that stage where the first have been dealt with and the determination has been made that they are to be, if you like, the subject of a more formal review by committee. Could you just explain to me the structure of the committee.

Dr Webber: There is a chair. If we are talking about doctors it is a medical practitioner. It does not have to be of the same specialty or group as the person under review, they just act as a chair. There are at least two other members of the committee who have to come from the same group, be it a surgeon or a physician or a general practitioner, as the person under review. A committee can have more than two other members, or it can bring in expertise. We have had several committees reviewing people who practice in a particular niche area and the committee has elected to bring in somebody who has particular expertise to give them advice.

Senator BACK: Would it ever be the case, for example, that some part-time practitioners or some retired GPs may be called upon to form a committee?

Dr Webber: No. All our committee members are charged from people who are still in active practice.

Senator BACK: Would it be your practice to have somebody on a committee with some degree of legal training who could then assist other members of the committee in terms of due process?

Dr Webber: No. In a committee hearing we always have a lawyer present to advise the committee on due process and legal niceties of the act. The person under review has the option to have a legal representative as well.

Senator BACK: That is in that process. Yes, I have read that and understand that. When this review process is underway, the concern that has been expressed to me by several people is a breakdown in what they refer to as their capacity to be able to have the medical merit of their action taken reviewed in a way which they regard as fair from the committee. You have told me that part-time practitioners and retired GPs do not form membership of the committee. You have also told me that you would tend to select committee members who have some degree of either special interest or specialty in the area—in other words, genuinely peers of the person under review.

Dr Webber: As much as possible. We have copped some criticism in that area, but sometimes it is not possible to find someone who is following a particular practitioner's very narrow niche.

Senator BACK: Do you believe that practitioners, clinicians, members of whichever profession, genuinely have the opportunity to present before the committee the medical merit of the action they have taken and that that medical merit is able to be properly assessed by their peers in coming to a determination?

Dr Webber: I would have to say that I have been satisfied that that is the case. The practitioner being reviewed has the opportunity to bring along an expert witness, to produce any document or journal article to support their case, and the committee is bound to take that into account in its reasoning. The committee issues a draft report at the end of the hearing process and the doctor has an opportunity to comment on that draft report if there has been an error of fact or a misunderstanding.

Senator BACK: Can they bring a patient along?

Dr Webber: No.

Senator BACK: Could the committee, if it was minded, accept a written submission from a patient?

Dr Webber: Yes, they could do that.

Senator BACK: They are not bound to; they could?

Dr Webber: They are bound to examine any written submission.

Senator BACK: So, as you quite rightly say, the committee, particularly if its intention is to find inappropriate practice, produces a draft report. It sends it to the practitioner or clinician, who then has an opportunity to comment.

Dr Webber: Yes.

Senator BACK: In the event that they feel they have not been properly serviced or heard by the committee, do they have an opportunity to request that that be reopened so that, for example, more specialist evidence could be presented to the committee?

Dr Webber: No. In their response to the draft report they can adduce any other evidence from a specialist that has not appeared before the committee. They can certainly produce that sort of material, and they have a month to do that, but they do not have an opportunity to reopen the hearing, no.

Senator BACK: The view has been put to me that the charges only come at the end of the process, at which time the clinician has no further opportunity to argue the medical merit of their action. Would you believe that is a valid criticism of the system or would you believe that it is an unfair criticism of the system?

Dr Webber: It is the way the system has been set up, because only a PSR committee can determine if there is inappropriate practice or not. I cannot, under the act, say, 'This is inappropriate practice.' All I can say is that there 'may be inappropriate practice' and refer that case to a committee.

Senator BACK: No, I am at the stage now of the committee having gone through its processes. They prepare a draft report and it goes on to the person under review. Really in a sense that it is probably the time at which the person under review would have clarified for them beyond doubt, if you like, what it is claimed that they have done that has been inappropriate. My question to you is, do they still have an opportunity in terms of their own satisfaction of medical merit to put before the committee a view which is at variance with that of the draft report?

Dr Webber: Yes, they do.

Senator BACK: They cannot call more evidence?

Dr Webber: They can produce more evidence in a written form, yes.

Senator BACK: Okay. I understand there is an appeal process to the Federal Court and that is after the determining authority has made its final determination. Is that appeal to the Federal Court only on the basis of due process and procedure or can it also include an appeal based on, once again, the doctor's perception that medical merit had not been adequately addressed?

Dr Webber: No, the appeal can be on the basis of an error of the administrative law or procedural fairness natural justice issues, but not on the basis of the merit of a committee's decision.

Senator BACK: Sure. Can I ask you to comment on this particular instance which I understand happened. You may or may not be aware of it. A doctor performed a consultation with a patient on a matter that was not physical, I understand, psychiatric or psychological or whatever. Prior to concluding the consultation, the doctor was sufficiently concerned about the person's stress levels to suggest that the doctor undertake an ECG under a stress test. The person said yes, that is a good idea. The doctor did not do a resting ECG on this occasion; they simply went straight to the stress test. They performed the ECG. The ECG showed evidence of an abnormality. The doctor immediately referred the person to a cardiologist and within 48 or 72 hours the person had a quadruple bypass.

The doctor was subsequently cited for their failure to undertake a resting ECG. They brought before the committee the evidence of an associate professor of medicine, a cardiologist who, amongst other things, in a written report said, 'It was very reasonable not to do a resting ECG. You are to be congratulated for ordering a prognostic test. You probably saved a man's life.' Another consultant cardiologist from one of the universities said, 'I believe your assessment and management of this patient was exemplary.' My understanding in that case was that the doctor was actually cited for their failure to undertake a resting ECG, and

those of us who have some knowledge of this process would know that an ECG done under stress would obviously be of far more clinical value. I ask you to comment—

CHAIR: I do not want to intrude, because I know you are on a flow, but we seem to be getting into a specific case.

Senator BACK: I am, that is correct.

CHAIR: I did not want to jump too quickly but I am wondering about the appropriateness in this forum to be talking about a particular case. There are other ways you could get this information.

Senator BACK: Thank you for your guidance. The question I would ask is, would the process undertaken by the committee not surely take into account the evidence of those two specialists in affirming the behaviour of the doctor on an occasion like that?

Dr Webber: The committee would always take into account any evidence that is produced. I cannot speak on that particular instance because I am not familiar with it. I cannot help you with that one, I am sorry.

CHAIR: Senator Back, you are trying to establish standard practice, aren't you.

Senator BACK: I am, chair.

CHAIR: Without going into the details of a particular case, which does worry me, in terms of the general process of the review it is the weighting of evidence from particular professionals.

Senator BACK: That is it, and it is also seeking from Dr Webber the assurance that the committee is so structured that members of the committee would (a) have the competence themselves to be able to assess the action taken by the doctor, and (b) the willingness to accept the evidence of properly skilled and, if you like, trained people to be able to help them in that decision. That is the process that I am trying to explore.

Dr Webber: That is true although, just to reassure you, remember that there are two aspects to a committee's decision making. One is adherence to the schedule and the other is the clinical appropriateness, or the acceptability, of what was done clinically by the general body of that person's peers. In a particular instance it is hard to know which of those two arms was inappropriate.

Senator BACK: So your suggestion in a case like that would be, perhaps, that in the event that peers, as mentioned, indicated the correctness of the eventual decision, the appropriateness of the action does not appear to be under question. So you are suggesting that it is the second of those two you told me earlier—that it may or may not have met the item descriptor under the PBS guidelines. Is that right?

Dr Webber: That is true. We have had many examples where somebody has done a perfectly adequate consultation and written everything beautifully but it is judged to be inappropriate clinically, and vice versa.

Senator BACK: The last question I have is related: in my state of Western Australia we have a medical practitioner who is using treatments associated with people recovering from heroin addiction. I understand that the length of the consultations is very often inordinately long, and I do not think this doctor is the only one who suffers this circumstance. Can you explain to me in the terms that you have responded with that in the event that, for example, a

consultation went for an hour—which is three times the 20-minute limit you indicated to me—how that person would justify or defend to you, or subsequently to a committee if you were not satisfied, that the actions they had taken were, in fact, good clinical practice and in accordance with the best interests of the patient?

Dr Webber: Very easily, with their medical record.

Senator BACK: And whose judgement would it be that the medical record was not adequate?

Dr Webber: It would be the committee's.

Senator BACK: Or yours?

Dr Webber: In addition—

Senator BACK: Would that be the length of their written records?

Dr Webber: No.

Senator BACK: The quality of their written records?

Dr Webber: The content and the quality.

Senator BACK: So with the person in the consulting room who has just suffered a severe circumstance of any type and who really just needs that clinical support of the doctor, the doctor, in fact, may not be establishing new medicine, diagnosis, clinical signs or whatever but just simply exercising good medicine in the time they spend with the patient. How would they convey the quality of their record-keeping to you, or to a committee, in that circumstance? You could just as simply say, 'Listen Blue, you've swung the lead. I reckon you only had a 15-minute consultation and you have just said, "Oh, the patient is very distressed. They've even got more distressed"'. How would they actually be able to convince you, because they would fall well outside Medicare's normal curve?

Dr Webber: Firstly, I think that most committee members—and, certainly, I would—would see the type of patient and the type of presentation as a complicated and difficult presentation which, if done properly, would need that sort of time. It has been a requirement since 1999 that if one claims Medicare benefits one has to have adequate and contemporaneous records. The contemporaneous is straightforward, but adequate records in the PSR context mean firstly that there is enough in the record to justify the item claimed and, secondly, that the record is legible and that it would enable another doctor to carry on the care of that patient and understand what happened in that particular consultation.

Medical records in any investigative process, whether it be the PSR process or any other legal process are really what can make or break a practitioner.

Senator BACK: As part of this review that you are undertaking, is it the hope or expectation that the specialties or the actions of those under review will be reviewed by people more closely aligned to the area of medicine or the other aligned practice that they are undertaking? Is that the nub of what your current review is leading towards?

Dr Webber: Yes, that is certainly part of it. The other part is full disclosure on our website of all our documentation and so forth so that there will be no surprises as to what people are going to receive. It is difficult to get a committee in very small niche areas. To give you an example—and we have not had one of these instances—if one had a facio-maxillary

surgeon to review, there are probably only about 50 in Australia and they all know each other by first name. It would be very difficult to get a committee to review one of their own.

Senator BACK: Though better one of them, surely, than somebody totally unskilled in that specialty.

Dr Webber: Certainly, but it illustrates the problem with very small specialties and people who have niche practices. Yes, they do feel sometimes aggrieved that we have not been able to provide a person who does exactly the same work as they do, but we do our best.

Senator BACK: It is a good thing Christiaan Barnard is not around; you would have had great difficulty in having him assessed. Thank you.

Dr Webber: Thank you very much.

CHAIR: We will move on to outcome 12, Health workforce capacity.

Ms Halton: While my colleagues are coming to the table, I wonder if I might inform the committee of something. GPET is an organisation that appears regularly before this committee. Over the weekend one of our colleagues at GPET, Rodger Coote, died quite suddenly. He was not a very old man and he had three small children. While our thoughts are obviously with his family and friends, the department wanted to take the opportunity to acknowledge the work that he has undertaken and the contribution that he has made to general practice. He was a senior manager with GPET since the company began 10 years ago. As the chief operating officer he led many of the key projects, national selection processes and work on data and information. He worked very closely with us in the department and provided a significant service to government, regional training providers and those on the training program.

I think it is important that we acknowledge his significant and positive contribution to the delivery of high-quality general practice education and training. Given it was such an untimely death, we wanted to inform the committee but also to place on record our thanks to him and our acknowledgement of his wife and family. His children are too young to understand what these things mean, but I think in time it will be an important thing for them to know that people acknowledge his contribution.

CHAIR: Thank you. On behalf of the committee, it is important to acknowledge Mr Coote and the times that we have met with him and his generosity in sharing his skills and knowledge with committee members over many years. I think that should be acknowledged, so we are pleased to do that.

Senator McLucas: Chair, I join with the secretary and the committee in acknowledging Mr Coote. It seems that his passing is very untimely. Our thoughts are with his family at this sad time.

CHAIR: Thank you, Secretary, for advising the committee and for giving us the chance to make that acknowledgement on the record.

[21:44]

CHAIR: We are going to go to 12.1. Is there anything on rural health force?

Senator ADAMS: Following review of the administrative arrangements in the Health and Ageing portfolio, the 2011-12 federal budget includes the establishment of the Health Workforce Fund. The fund brings together a number of programs that support the delivery of

a high-quality, well-distributed future health workforce. How will the fund be administered to ensure that targeted schemes to encourage GPs, nurses and allied health professionals to work in rural and remote areas are not prejudiced?

Ms Jolly: The Health Workforce Fund was established in the current budget. The programs that you have mentioned all have key targets that have been announced and they will still continue to be monitored and delivered. Many of those are rural in nature, so it will be part of the normal performance arrangements of the fund to continue to report on both programs and those measures.

Senator ADAMS: So they will not all be mixed up and lost? That is the worry.

Ms Jolly: At the moment the fund, and the budget documents themselves of course, comment that current programs and contracts continue. Many of those programs that you mentioned are under contract for several years to come and, as I said, are also subject to some fairly public announcements around things like the number of GP training places to be delivered. Those will continue.

Senator ADAMS: At the National Rural Health Alliance conference in Perth they had a workshop the day before for all the health service managers. One of their worries was that everyone else seems to have programs funded for their particular area of expertise. With the Medicare Locals coming on board, and the local network boards, the health service managers were quite concerned about whether there would be any support provided for managers as part of the arrangements for Medicare Locals.

Ms Jolly: I might ask my Medicare colleagues to come to the table.

Senator ADAMS: I know I keep coming back to it, but this is quite an important one. In a nutshell, really, the current health service managers are wondering if there is any type of funding program where they can actually go and have training as managers and get involved with the Medicare Locals.

Ms Morris: The answer to that at present is no, Senator. There would be no specific program funded for that. Medicare Locals will be funded for two things. One will be an amount of core funding to open their doors, do business and achieve, in a broad sense, the objectives in the Medicare Locals guidelines, and the other will be specific program funding. I think I can safely say that there is no program funding, but they may well choose to spend money on the sort of training you are envisaging, if there is a demonstrated need in an area for it. I could not rule out that they would do it, but they will not be mandated to do it through a specific program requirement.

Senator ADAMS: I think there is a group of people who feel that they are out in limbo. They are really not quite sure where and what and how their positions—

Ms Morris: Thank you for raising it. We will take it on board. We will talk to Medicare Locals, as we fund them, about this and see what they consider the need to be and what they might be able to do.

Senator ADAMS: Thank you. That should make them happy. At last estimates I asked questions about problems associated with staffing the cancer centres and a number of the radiation oncology positions. I see in the budget that places have been funded, but how much interest has there been in people taking up these areas of expertise? Is this the wrong program?

Ms Halton: It is not this program.

Senator ADAMS: So where do I go with that one?

Ms Jolly: Medicare outcome.

Senator ADAMS: It is a workforce one.

Ms Halton: No. I think it is in 3, isn't it?

Ms Flanagan: If it is an outcome that we have already done we might, if possible, take it on notice, if that is all right.

Senator ADAMS: I asked it in the workforce area last time because there was a shortage of those people. I thought I had read 'funding' in this particular outcome—but maybe I did not.

Ms Halton: Are you talking about the regional cancer centres, Senator?

Senator ADAMS: Radiation oncologists and technicians. I want to know whether there has been any—

Ms Halton: Yes, 3.5 is radiation oncology, so that is access to medical services.

Ms Jolly: Senator, it has been moved into the Health Workforce Fund in the arrangement, but we were informed that you wanted to discuss items by the old programs. So that would still be under 3.5. So, my apologies.

Ms Halton: That is exactly why we brought both documents. We had a very clear piece of instruction that you were going to ask the questions under the old program structure.

Senator ADAMS: Okay. I have just jumped the gun and gone to the new one simply because it was about issues that I had raised last time.

Senator FIERRAVANTI-WELLS: Ms Halton, can I just comment on this. Given the changes that have happened, it really would be helpful if, for the next estimates or before that, you produced for us a document which consolidated a listing of all your programs and where they are going to be, but getting down to a bit more direct detail.

Ms Halton: It is in the back of the PBS, Senator.

Senator FIERRAVANTI-WELLS: Is that it?

Ms Halton: It is in the back. It is basically maps of where they were and where they have gone to.

Senator FIERRAVANTI-WELLS: And that is it; that is all of them?

Ms Halton: Yes.

Senator BOYCE: I thought we were asking under the old system.

Senator ADAMS: No, it is under the new one. But I did not because I was following up on what I had asked last time.

Ms Halton: That is exactly why I have got a large stack of documents here. We brought last years as well as this years because of the advice we had that you wanted to use the old structure.

Senator ADAMS: Can anyone answer the question, or would you like to take it on notice?

Ms Jolly: I think I would have to take that on notice to get you the detail of that.

Senator ADAMS: Thank you. Right, we will see how we go with this one. This is for Health Workforce Australia.

CHAIR: They are here.

Senator ADAMS: I know they are here. I can see them. But rather than have everyone leap up from the table, perhaps I will keep that question for later.

CHAIR: Senator, can I clarify that that is the end of questions on rural workforce.

Senator FIERRAVANTI-WELLS: No, I have got questions on rural workforce.

CHAIR: The agency is really 12.2. That is where I would see it, and we were going to move onto that area. So if we could complete the rural workforce questions first and then come back and give everybody a go with 12.2. Senator McEwen's questions are in 12.2. Senator Adams, do you have anything else under Rural Health.

Senator ADAMS: No.

CHAIR: Senator Siewert's questions are in 12.2. Senator, if you would go into your rural workforce questions under 12.1.

Senator FIERRAVANTI-WELLS: Can I first ask what the timing is. When are we starting? I do not want to be caught afterwards.

CHAIR: You will be the last questioner on rural workforce, and I would think anything up to a quarter past would be easily met with rural and then we will go onto the general questions.

Senator FIERRAVANTI-WELLS: I will try and hurry it up. In terms of rural workforce, in budget paper 2009-10, \$64.3 million over four years was budgeted to assist in recruiting and retaining general practitioners. Rural doctors report significant concern among doctors in parts of rural and remote Australia as anomalies have arisen which may impact on the operational viability of some rural practices and the sustainability of their workforce. What evaluation has been done on the General Practice Rural Incentives Program which was based on the Australian Standard Geographical Classification-Remoteness Areas system? What were the main findings? Can anybody help me on that one?

Mr Andreatta: You are referring to the General Practice Rural Incentives Program, which we refer to as GPRIP. That program commenced in July last year. I did not catch everything you read out about a review.

Senator FIERRAVANTI-WELLS: What were the main findings? Have you done an evaluation of that program based on the Australian Standard Geographic Classification - Remoteness Area classification system?

Mr Andreatta: No. The program commenced in July, so we are not even a year into that program. We have adopted the new RA classification for that program, and payments had been made to eligible providers under that program from the first quarter following 1 July last year.

Senator FIERRAVANTI-WELLS: I will put some more questions on notice about that. They are some questions referred to me to ask. In Budget Paper No. 2, at page 241, the 2010 budget had an announcement, as part of the National Health and Hospitals Network, to deliver better health and hospitals for rural Australians and their families. It referred to GP training

places. Can you confirm that the 450 GP training places provided this year were exclusively for rural areas?

Ms Jolly: Sorry; could you just repeat the page number and the year?

Senator FIERRAVANTI-WELLS: It is Budget Paper No. 2, 2010-11, at page 241.

Ms Halton: We do not have Budget Paper No. 2 for 2010-11.

Ms Jolly: Senator, what I can tell you is that the GP training program is fully subscribed, so all the training places have been offered. Fifty per cent of training places on that program are for rural pathway registrants. I cannot comment on the exact paper that you have in front of you, but I can tell you that that program is fully subscribed.

Senator FIERRAVANTI-WELLS: The number of GPs will grow from 900 in 2001. So 450 were for rural areas?

Ms Jolly: I will take that particular number on notice—

Senator FIERRAVANTI-WELLS: If not, how many were provided?

Ms Jolly: I can tell you that 50 per cent of the training program is rural places. I will ask Mr Hallinan to give the exact figure for this year.

Mr Hallinan: That is correct. There are 900 new entrants to the General Practice Training Program this year. Applying the 50 per cent rule, 50 per cent of that cohort will be training in rural Australia—ASGC-RA categories 2 through 5.

Senator FIERRAVANTI-WELLS: I will put some questions in relation to that. Because they refer to the budget paper and you do not have that in front of you, it is probably best if I just put those on notice. There is another question relating to training specialist doctor initiatives, under the 2010-11 budget, which I will ask on notice. It is in relation to whether that has been delivered.

Ms Jolly: That program is also well on track and in fact delivering more training places this year than was estimated in those documents.

Senator FIERRAVANTI-WELLS: Last year's budget also contained a provision, as part of the hospitals network workforce, for more places in GP training and more nurses and allied professionals. You were to conduct a review to assess the appropriateness, effectiveness and efficiency of locum activities.

Ms Jolly: There was an announcement of a locum scheme for nursing and allied, which has commenced this calendar year. I am not familiar with a specific review.

Senator FIERRAVANTI-WELLS: I think it might be under rural locum support. On page 326 of the portfolio budget statement it says:

In 2010-11, the department conducted a review to assess the appropriateness, effectiveness, and efficiency of these activities.

Ms Jolly: I was commenting on the wrong locum scheme. My apologies.

Senator FIERRAVANTI-WELLS: That is okay.

Mr Andreatta: Senator, you are referring to the National Rural Locum Program. We have undertaken a review of that program. The program consists of three different locum schemes: the Specialist Obstetrician Locum Scheme, the General Practitioner Anaesthetist Locum

Scheme, and the Rural General Practitioner Locum Program. That review has just been completed. We are currently looking at the findings and recommendations.

Senator FIERRAVANTI-WELLS: Did you have engagement with stakeholders in relation to that review?

Mr Andreatta: Yes. I will check on the organisation we had to undertake the review. There were stakeholders engaged in that review. I cannot give you the details.

Senator FIERRAVANTI-WELLS: Just take that on notice, thank you. When will the recommendation be forwarded to government?

Mr Andreatta: The review will feed into the work around the establishment of the new funds. These programs are in the workforce fund and, as part of the development of new guidelines for that fund, the review findings will be taken into consideration.

Senator FIERRAVANTI-WELLS: I want to ask some questions on the rural locum scheme for nurses. Again, this was part of the 2010-11 budget. Would you prefer me to put that on notice?

Ms Jolly: We are happy to have those on notice.

Senator FIERRAVANTI-WELLS: Indeed, there is also the rural locum scheme for allied health professionals. There is no point in me referring you to a budget paper.

Ms Jolly: Those schemes are under contract. We are happy to take those questions on notice.

Senator FIERRAVANTI-WELLS: That completes my questions on the rural workforce.

Senator SIEWERT: I am not sure whether this question applies here or under general questions. I am not sure where you are targeting these programs. It is about the Aged Care Workforce Fund. Can ask that now?

Ms Jolly: That is under aged care.

Senator SIEWERT: I should have asked under aged care. Because it was about the workforce, I thought I should ask now.

Senator FIERRAVANTI-WELLS: Regarding the document that is at the back, is that available in Word format? Ms Halton, it would be useful to have it in an A4 folder that we could keep here and flip through.

Ms Halton: We will endeavour to provide it.

Senator FIERRAVANTI-WELLS: That would be very helpful. It would save a lot of time. A practical suggestion at this hour of the night, Senator Moore.

CHAIR: Health and Ageing have often given us really good diagrams to help us. It is just one of those things. We keep asking these questions and the officers are very cooperative. We have finished outcome 12.1, so now we will move on to outcome 12.2.

Senator McEWEN: I would like to follow up on questions about the GP training program. The number of places under that have gone from 600 to 900 in 2011 and will go to 1,200 by 2014—is that right?

Mr Hallinan: That is correct.

Senator McEWEN: Can somebody tell me how many of those training places will be in South Australia?

Mr Hallinan: We do not have estimates of where they will be in the next few years. That is a level of detail that we would usually refer to GPET.

Senator McEWEN: Was it the intention to distribute them based on population through the states?

Mr Hallinan: Yes, the allocations tend to follow population distribution quite closely.

Senator McEWEN: So who do I find out that information from—how many are in South Australia?

Mr Hallinan: We can take that on notice and provide it to you.

Senator McEWEN: That would be good. You have already stated that 50 per cent of the places in the training program overall will go to regional areas—is that right?

Mr Hallinan: That is correct.

Senator McEWEN: So I can assume that 50 per cent of whatever South Australia's allocations are will go to regional and rural?

Mr Hallinan: It is a national target, so I am not sure I can provide that assurance for you.

Senator McEWEN: All right; that is all I had on that. The other thing I wanted to ask about was the dental clinic at the Adelaide Dental Hospital that is being funded as part of this budget.

Senator McLucas: While you are digging around for South Australia, I wonder if you could dig around for Queensland as well.

Senator McEWEN: Certainly. Perhaps you could also take on notice the number of GP training places in Queensland. That would be good.

Ms Jolly: We will be able to provide that for this year, as Mr Hallinan says, but we cannot project that forward. We can certainly give you where places are allocated this year.

Senator McEWEN: Okay; thank you for that. The dental clinic at Adelaide Dental Hospital also comes under this area, I believe.

Ms Jolly: I am not sure.

Mr Hallinan: It could.

Ms Halton: Give us more hints.

Senator McEWEN: There was an announcement made: 'dental workforce'. Here it is: department outcomes, 12. Nobody knows anything about that one?

Ms Flanagan: Can you give us a page reference. Are we in the 2011-12 budget statements?

Senator McEWEN: Yes, we are. 'Dental workforce' is mentioned on page 329. It does not specifically mention the Adelaide Dental Hospital.

Ms Jolly: There is the announcement of a dental intern training program, which is why you see a reference in outcome 12 to dental workforce. That is certainly a program we will be managing. There is not necessarily through that program any model that would link it to the

clinic that you refer to. That program is under development and discussion with states and territories and others at this stage. So I would need a little bit more information.

Mr Hallinan: We have co-funded a dental clinic in an Adelaide hospital that was recently opened.

Senator McEWEN: Yes, that one.

Mr Hallinan: It was part funding through a program.

Senator McEWEN: This is the one I am talking about. The question I am interested in is: given that the federal government has co-funded that new teaching dental clinic, how many additional dental training hours will that provide? Are you able to answer that question?

Mr Hallinan: I do not have that level of detail with me.

Senator McEWEN: All right. Then you would not be able to tell me what kind of dental services will be provided to the people of Adelaide either.

Mr Hallinan: No.

Senator McEWEN: So my foray into questions did not get me very far.

CHAIR: Fifty-fifty!

Senator McEWEN: Thanks anyway.

Senator SIEWERT: With the dental health internships, we have 50 places?

Ms Jolly: Yes, 50 annual places from 2013.

Senator SIEWERT: They are for public dental facilities, aren't they?

Ms Jolly: Predominantly, yes.

Senator SIEWERT: Can you then go into the 'predominantly'.

Ms Jolly: Certainly. The dental intern program, as I indicated, has 50 places starting from 2013. There will be a development phase over the next 12 months which will be in consultation with the Dental Council, with dental deans and with states and territories to work out what is the best way of locating dental trainees—or not dental trainees; they are dental graduates. So the model is based predominantly in a public dental service, but you might find that there are rotations out of a public service into other locations. But that design is still under development. So certainly that thinking is still being discussed.

Senator SIEWERT: Presumably who is going to which state or territory is part of that consultation process.

Ms Jolly: Yes.

Senator SIEWERT: I always like to ask about evaluation at the beginning of programs. What is the evaluation process to be, or have you not thought about that?

Ms Jolly: That would be part of the consultations as well. We have not actually got to that.

Senator SIEWERT: You are including that in the consultation process?

Ms Jolly: Yes.

Senator FIERRAVANTI-WELLS: I have found the Mental Health Nurse Incentive Program on page 336 of the portfolio budget statement. It was part of one of the initiatives under the 2006 package. Initially there was \$191.6 million over five years. Without traversing

the history, I understand that in the first Rudd budget this program was taken down to just under \$50 million. Can you give me a history of this program? The original statement in relation to it says that by 2010 it was estimated that more than 36,000 patients with severe mental illness would be receiving specialist mental health nurse support each year. The figures on page 336 are not the same. Please take me through what the program has achieved during that time. Over the life of the program did you spend all of the \$191.6 million?

Ms Jolly: When the Mental Health Nurse Incentive Program was first introduced it had a forward growth that was a fairly steep curve. That forward growth was never recognised, so the program estimates were reduced. Money was never taken out of the program, but the estimates were adjusted to meet the demand that was coming through the program.

Senator FIERRAVANTI-WELLS: Was the money rolled over?

Ms Jolly: No, it is an allocation based program. If an agency or an organisation is eligible it applies and it gets access to the program. The funding for that program becomes an estimates process and we look at what we think the program is going to cost or to spend in a certain year. In the first instance, the estimates thought the program was going to grow faster than it did. The program has steadily grown throughout and was in the budget, not the recent one but the previous budget, with a further increase to the program put into the model. Ms Walker will talk through the details of the funding. The program continues to grow to those numbers. It has had a steady and forward growth.

Senator FIERRAVANTI-WELLS: It says that by 2010-11 it was supposed to have helped more than 36,000 patients.

Ms Jolly: I do not have a cumulative figure, so can we take that question on notice? We certainly have figures.

Senator FIERRAVANTI-WELLS: I am trying to compare the original announcement of 2006 with the information on page 336.

Ms Jolly: We do not have the full program, but we are happy to take that on notice.

Senator FIERRAVANTI-WELLS: On notice, can you take me through the funding over the period?

Ms Jolly: Yes.

Senator SIEWERT: Has the evaluation program for the mental health nurses commenced?

Ms Walker: We are just undertaking the evaluation of the tenders for that evaluation at the moment, and we expect to have chosen the successful tenderer by the end of June.

Senator SIEWERT: I presume that means you called for tenders and went through that process?

Ms Walker: Yes indeed.

Senator SIEWERT: Are there terms of reference for the evaluation? If they are on a website, just tell me, but I have not been able to find them, in a loose sort of way.

Ms Walker: No, not the terms of reference; basically we have gone to market and advertised the criteria that we would like potential tenderers to address, and they have submitted their tenders for that. So it is not a matter of terms of reference at this stage.

Senator SIEWERT: So you just say, 'We want to evaluate this program; these are the sorts of things we want to know'?

Ms Walker: Indeed.

Senator SIEWERT: And then organisations who are tenderers put in a bid to say, 'This is how we would do it'?

Ms Walker: That is correct—including methodology and so forth on how they are going to approach it.

Senator SIEWERT: Is the criteria for what you want it to cover available somewhere publicly?

Ms Walker: Not at this stage, no.

Senator SIEWERT: Are you able to provide that to the committee for the tender documents?

Ms Jolly: Certainly, but we can take that on notice. The criteria for the evaluation matched the program design. That will be fine. We will be happy to provide that detail.

Senator SIEWERT: Perhaps the tender documents—would that be appropriate?

Ms Jolly: Let me take that on notice—

Senator SIEWERT: Okay. But, if not, the criteria.

Ms Jolly: but certainly we can provide you with the elements of what we are evaluating under that program.

Senator SIEWERT: Okay. In the criteria, you would have articulated that you needed consultation as part of this process?

Ms Jolly: Yes.

Senator SIEWERT: And do you then suggest who will be consulted, or is that up to the consultant or the tenderer to work out?

Ms Jolly: The evaluation has an advisory panel—

Ms Walker: A reference group.

Ms Jolly: A reference group, sorry; I should use the correct term. So we will take advice on the consultation strategy that sits as part of the evaluation for that program. That is done in consultation with the sector in terms of making sure that it matches exactly what we are evaluating.

Senator SIEWERT: Okay.

Ms Walker: You can expect patient outcomes, program take-up, demand profile, cost-benefits and program structure and compliance all to be addressed as part of the evaluation. Those are just the broad categories.

Senator SIEWERT: Thank you. I will ask the inevitable: who is on the advisory panel?

Ms Jolly: And we will take that on notice.

Senator SIEWERT: Thank you. When do you expect the review to be finished?

Ms Jolly: We are expecting it to be finished in the second half of this year, possibly towards the latter half of the second half of this year.

Senator SIEWERT: I sort of figured that, given the fact that you are not appointing anyone until June. But is it the idea that it will be done before Christmas?

Ms Jolly: Yes. I mean, I think that is certainly the intention.

Ms Walker: Can I just correct that? We will certainly be commencing it before Christmas but, because of the length of the evaluation, it will be the middle of next year that it will be completed.

Senator SIEWERT: And presumably—and I will ask this because I have to—it will be given to the minister and the minister will decide then when it is to be released publicly?

Ms Jolly: That is correct.

Senator SIEWERT: Thank you.

CHAIR: Right. On to the agency?

Ms Halton: Chair, just before we go to Senator Fierravanti-Wells, I have an answer for Senator McEwen. Because Senator McEwen sat here so patiently, I have found some of the details of that Adelaide clinic—it is amazing what you can find: 52,500 hours of clinical training over the next five years. It is a 10-chair facility. I think we all know how important undergraduate training for dental and oral health students is. So the advice I have is: 52,500 hours for that five-year period. And, Senator McEwen, you asked the question about, I think, what we contributed, or maybe you knew that that was \$2.1 million. It will certainly assist. Again, we are quite conscious of the need to increase the number of dentists. I think when David Kalisch was here earlier he talked about the Dental Statistics and Research Unit that is located at the University of Adelaide, so they do have a tradition. But they have increased their number of dental students, I understand, by 60 per cent. I hope that at least gives you one answer to a question, so that your whole day has been worth while!

Senator McEWEN: That is very good. Thank you very much, Ms Halton.

Ms Halton: My pleasure. My apologies, Senator Fierravanti-Wells.

Senator FIERRAVANTI-WELLS: Ms Halton, I feel bad today—I have shared my germs. I would like to ask questions about dental plans with Health Workforce Australia. Those yellow books are very effective, Ms Halton.

Ms Halton: Yes, I know—and I am anticipating for Hansard.

Senator FIERRAVANTI-WELLS: Mr Cormack, did Health Workforce Australia have any involvement or provide advice regarding the proposal for a dental intern year and the establishment of a National Advisory Council on Dental Health?

Mr Cormack: No, we did not.

Senator FIERRAVANTI-WELLS: When did you first learn that the government was going to propose a dental intern year and a national advisory council?

Mr Cormack: I learned that on budget night.

Senator FIERRAVANTI-WELLS: If you look at the Health Workforce Australia Act, it talks about developing and evaluating strategies for the development of the health workforce. It seems unusual that, for a measure like this, which falls squarely within your parameters, your advice was not sought. Is there a reason why that did not happen?

Mr Cormack: It is probably not a question you should put to me.

Senator FIERRAVANTI-WELLS: It is not a matter for you; it should be put to the department. Ms Flanagan, you look happy to answer that one.

Ms Flanagan: Do I?

Senator FIERRAVANTI-WELLS: Yes, you do, at 10.20 this evening.

Ms Flanagan: Health Workforce Australia has been set up as an authority under Commonwealth legislation. Its board is set up and drawn from jurisdictions. There are going to be particular new policy proposals that the Commonwealth government develops. This particular one was one of those. We felt we had enough information within the department to be able to provide appropriate advice to government. That is how this new policy proposal came to fruition.

Senator FIERRAVANTI-WELLS: So you basically will determine—or the government will determine—if you want them to evaluate? Their function is to develop and evaluate strategies for the development of the health workforce. Is there any reason why this strategy to develop health workforce was not deemed appropriate for them to have a look at?

Ms Flanagan: I just explained that the role of Health Workforce Australia—and Mr Cormack might also—

Senator FIERRAVANTI-WELLS: Is to take work that is given to them.

Ms Flanagan: It certainly has a range of functions that have been given to it, but there are going to be times when the Commonwealth wants to take particular decisions around workforce. We might draw on research, for example, that is prepared by Health Workforce Australia to do that. They certainly have work commissioned of them, but there are also very clear functions that they have been asked to undertake.

Senator FIERRAVANTI-WELLS: In relation to the advice that the National Advisory Council on Dental Health will provide, how will that differ from advice that Health Workforce Australia could provide?

Ms Flanagan: The intention is that the new dental council be drawn from the sector, so we are looking from a wide range of representatives from the dental sector. It could be people that teach dentistry—that run dental schools, for example; those that are employed in the profession et cetera. So the make-up of the council is being looked at the moment.

Senator FIERRAVANTI-WELLS: Mr McCormack, have you made any recommendations in respect of dental workforce strategies?

Mr Cormack: We have a referral to look at a particular aspect of dental practice, which is the scope of practice by dental therapists, hygienists and oral therapists. That is a piece of work that we are currently undertaking and we will be providing that advice back through to ministers towards the end of this year.

Senator FIERRAVANTI-WELLS: I do not know if you were present when I asked those questions in relation to dentists working in public hospitals. Are you able to assist us on how many public dentists are currently employed in Australia?

Mr Cormack: The advice I have is that there are 10,404 registered dental practitioners across Australia and, as of 2006, 1,647 are employed in the public sector.

Senator FIERRAVANTI-WELLS: In relation to issues about spare capacity in terms of the public dental workforce in jurisdictions around Australia, is that information within your purview?

Mr Cormack: It is not a matter that we have turned our minds to at the present time.

Senator FIERRAVANTI-WELLS: In relation to the government's plan for the chronic disease dental scheme, have you done any work in relation to assessment or estimates of shortage or potential shortage of dentists working in the public system across Australia?

Mr Cormack: Not yet.

Senator FIERRAVANTI-WELLS: Do you envisage that you might?

Mr Cormack: That may be a matter that we would turn our minds to, but at this point in time we have not done that.

Senator FIERRAVANTI-WELLS: Earlier we heard evidence that, back in 2007-08, when the scheme was announced, it was a program for \$290 million over three years. Given the statistics that you have given to us, one could assume that the statistics available to the government at that time would have been the 2006 statistics that you have just given me.

Mr Cormack: I would not necessarily assume that, but I was not involved at that point in time. The agency was not in existence at that point in time. I think that is probably a matter best asked of others.

Senator FIERRAVANTI-WELLS: So where have you drawn that 2006 figure from? Could you give me a reference as to where that is?

Mr Cormack: Yes. It is in the AIHW dental services research unit's dental labour force survey of 2006. I cannot tell you when it was published. I would have to take that on notice.

Senator FIERRAVANTI-WELLS: All right, if you do not mind. So at this point in time the only figures we have are as at 2006 and we do not have any later information in relation to dentists working in the public systems around Australia? This is just to get that correct.

Mr Cormack: We do not have any published information on that available at the present time.

Senator FIERRAVANTI-WELLS: Do you have any statistics in relation to the number of people commencing dental school? How many commencing dental school places have there been each year from 2008 until this year? Is that the sort of information you would have?

Mr Cormack: I do not have the specific number of commencing dental students. I do have graduates for each year from 2009, working backwards from another report. I am happy to share those with you.

Senator FIERRAVANTI-WELLS: Perhaps if you could do that on notice. As you can see, I am very interested in dental statistics so, yes, if you could provide to me what information and what statistics you do have. If there are in links would you provide those to me and I will happily go and have a look at those.

Mr Cormack: Yes.

Senator FIERRAVANTI-WELLS: Thank you, and I will turn to another area.

Senator FIERRAVANTI-WELLS: I want to ask about clinical training and simulated training but before I do I will ask this question. You would be aware, Mr Cormack of the issues and the problems that APRA have had in relation to the registration and implementation of the national registration for health professionals. What is your perspective? What role have you had? Has it just been in monitoring or have you had more direct involvement than simply being aware and viewing from the sidelines?

Mr Cormack: I am certainly aware of the public reportage of those issues and the Senate inquiry. Our interest in relation to APRA is in relation to the workforce data, which we will begin to have access to. We are certainly looking forward to being able to use that data to better plan our health workforce for Australia and to quantify many questions about the workforce.

Senator FIERRAVANTI-WELLS: Is there be any impact on clinical training as a result of those problems? Are you aware of any?

Mr Cormack: I have not been made aware of any.

Senator FIERRAVANTI-WELLS: I will just go back to clinical training. How much funding is provided for clinical training per medical student per annum in Australia at present? Is that the sort of information that you would have available?

Mr Cormack: I do not have that information available. I am able to advise, in some detail, about the programs we are responsible for administering in relation to medical student training but I do not have an answer for that specific question.

Senator FIERRAVANTI-WELLS: I will put some questions on notice in relation to that. Are you aware of the proportion of clinical training that currently occurs outside the tertiary public hospital system?

Mr Cormack: We do not have precise figures on that. The best available information that we have is based on a 2009 survey, which indicates somewhere in the order of 65 to 70 per cent of clinical training activity takes place in the public sector. That is the best available information that we have.

Senator FIERRAVANTI-WELLS: Are you aware of any medical graduates—Commonwealth supported international full-fee paying students—who have been unable to secure internships? Is that the sort of statistic that you have?

Mr Cormack: We have an interest in that matter and I am advised that for the current year, 2011, there have been no incidents of international full-fee payment medical students being unable to secure an internship in 2011.

Senator FIERRAVANTI-WELLS: To what extent are private hospitals being used and being considered for medical internships?

Mr Cormack: There are some limited examples of internships in the private sector. That is an area we would be interested to look at but it is a pretty minor contribution to the overall number of internships required.

Senator FIERRAVANTI-WELLS: Is there any funding mechanism in relation to that through the private hospital systems? Are you aware of that?

Mr Cormack: I am not aware of any specific funding to support internships in the private hospital system.

Senator FIERRAVANTI-WELLS: What health professions are currently using simulated learning in clinical training?

Mr Cormack: We are aware of at least 22 professions. They are the ones that we have had dealings with in the development of this program.

Senator FIERRAVANTI-WELLS: In relation to that, are you seeing any reduction in the average time that students spend with real patients in real clinical settings, given the expansion of simulated learning?

Mr Cormack: No, we are not—not at this point.

Mr Cormack: We are not aware of any reductions.

Senator FIERRAVANTI-WELLS: How does the cost of providing simulated learning compare to actual clinical experience? There are obviously costs both ways, but is one more cost effective?

Mr Cormack: It can be more cost-effective for different types of training. There can be relatively low cost simulation training through the use of actors, simulated patients, and very basic simulated learning experiences. They, as I am aware, are relatively inexpensive. Then, of course, there are others that use more sophisticated hardware and software where the costs would be significantly higher. But I am not aware of any specific information to be able to say definitively which costs more.

Senator FIERRAVANTI-WELLS: There has been no evaluation, that you are aware of, of the value of simulated learning as opposed to the clinical experience?

Mr Cormack: I am aware that there has been some research undertaken. However, I do not have those findings available. I am happy to take that on notice.

Senator FIERRAVANTI-WELLS: If you could point me to that research that would be good. Could you take on notice to provide me with a breakdown of the mental health workforce in Australia? Do you have any statistics in relation to that?

Mr Cormack: We have some information which may be able to assist.

Senator FIERRAVANTI-WELLS: I would be grateful if you could provide me with that on notice. Thank you.

Senator ADAMS: I have a question on the involvement of Health Workforce Australia with the education sectors. Do you have any involvement with planning issues like curriculum development between education and health?

Mr Cormack: We do have some involvement. In a formal sense, we have a standing advisory committee of our board that is comprised of the higher education and training sector. They provide advice to us and we provide advice to them on a range of matters in common. Secondly, in relation to our Simulated Learning Environments program, we have worked closely with 18 professional groups to identify those aspects of the professional entry curriculum which might be suitable to be undertaken at least in part in a simulated learning environment. We have had a number of formal activities and exercises involving those professional groups.

Senator ADAMS: The National Training Plan: would you like to give us a brief description of that and how it is going.

Mr Cormack: The National Training Plan is a project that was approved for us to undertake by the Australian Health Ministers Conference in November last year. The National Training Plan will provide estimates of the numbers of doctors, nurses and midwives that will be required to make Australia more self-sufficient in these professions by 2025. The National Training Plan involves quantifying the current stock or availability of the health workforce, projecting it out to 2025 and coming up with a number of different scenarios, such as the status quo, which is simply the current level of balance between supply and demand projected out to 2025, in different scenarios whereby there might be an improvement in that supply and demand imbalance. Then we work backwards from 2025 and develop a number of annual training plans.

Those annual training plans provide guidance to the universities in terms of the numbers of professional entry students they may wish to undertake, and to the training sector—that is, the public and private hospitals—in terms of the numbers of new graduate places and internships that might be required. They will also provide advice to assist in the determination of the numbers of specialist training places that might be required across all the different medical specialties in particular. That piece of work is well advanced and we will be providing an interim report to health ministers in August and a final report by December this year.

Senator ADAMS: Are you looking at rural placements in that as well?

Mr Cormack: Yes. We will be looking at a national level, a jurisdictional level and a regional level. In particular, we will be looking at distributional aspects of the supply and demand situation for doctors, nurses and midwives, and rural areas are very much in scope.

Senator ADAMS: At the present time, how closely are you working with the states on the issue of workforce shortages?

Mr Cormack: We certainly work very closely with them. A jurisdictional policy group, a committee, has been set up. It comprises the nine jurisdictional directors-general, secretaries and chief executives. We meet with them on a quarterly basis. We have active involvement with the states and territories in all of our projects. They are typically members of the advisory groups and committees that oversee those projects. I am a regular attendee at the AHMAC health workforce principal committee, which is comprised of senior jurisdictional health workforce officials. We work very closely to complement their workforce activities and also to align their efforts with our own.

Senator ADAMS: Can you tell me what you are doing on Aboriginal health workers?

Mr Cormack: We commenced the Aboriginal and Torres Strait Islander Health Work Force Project last year. It has three or four specific aims. The first is to identify the range of activities, the scope of practice undertaken and the necessary supports and training requirements that are in place for Aboriginal and Torres Strait Islander health workers. The second component is to provide some specific advice to assist with the pending registration of Aboriginal and Torres Strait Islander health practitioners, and they are due to come into the national scheme in July 2012. The third element is a workforce plan, and the fourth element is a targeted development program to boost the training, skills and capacity of Aboriginal and Torres Strait Islander health workers.

Committee adjourned at 22:43