COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

STANDING COMMITTEE ON COMMUNITY AFFAIRS

ESTIMATES

(Budget Estimates)

WEDNESDAY, 30 MAY 2007

CANBERRA

BY AUTHORITY OF THE SENATE

INTERNET

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **http://www.aph.gov.au/hansard**

To search the parliamentary database, go to:
http://parlinfoweb.aph.gov.au

SENATE STANDING COMMITTEE ON

COMMUNITY AFFAIRS

Wednesday, 30 May 2007

Members: Senator Humphries *(Chair)*, Senator Moore *(Deputy Chair)*, Senators Adams, Allison, Boyce, Carol Brown, Patterson and Polley

Participating members: Senators Barnett, Bartlett, Bernardi, Mark Bishop, Boswell, Bob Brown, George Campbell, Carr, Chapman, Crossin, Eggleston, Chris Evans, Faulkner, Ferguson, Fielding, Forshaw, Heffernan, Hogg, Hurley, Hutchins, Joyce, Kemp, Kirk, Lightfoot, Ludwig, Lundy, Marshall, McEwen, McGauran, McLucas, Milne, Nash, Nettle, O'Brien, Parry, Payne, Robert Ray, Siewert, Stephens, Stott Despoja, Watson, Webber, Wong and Wortley

Senators in attendance: Senators Adams, Allison, Barnett, Boyce, Carol Brown, George Campbell, Eggleston, Humphries, Joyce, Lundy, McLucas, Moore, Nettle, Parry, Patterson, Polley, Stephens, Stott Despoja and Webber

Committee met at 9 am

HEALTH AND AGEING PORTFOLIO

In Attendance

Senator Mason, Parliamentary Secretary to the Minister for Health and Ageing

Department of Health and Ageing
Whole of portfolio
Executive

Ms Jane Halton, Secretary
Mr Philip Davies, Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Professor John Horvath, Chief Medical Officer
Ms Wynne Hannon, General Counsel, Legal Services Branch
Mr David Kalisch, Deputy Secretary
Mr David Learmonth, Deputy Secretary

Business Group

Ms Margaret Lyons, First Assistant Secretary
Ms Georgie Harman, Assistant Secretary, People Branch
Mr Stephen Sheehan, Chief Financial Officer, Finance Branch
Mr John Trabinger, Assistant Secretary, IT Strategy and Service Delivery Branch
Ms Laurie Van Veen, Assistant Secretary, Communications Branch
Ms Tatiana Utkin, Assistant Secretary, Strategic Management Branch
Mr David Watts, Assistant Secretary, Legal Services
Mr Dean Herpen, Assistant Secretary, Corporate Support Branch
Ms Ida Thurbon, Assistant Secretary, IT Solutions Development

Portfolio Strategies Division
Mr Jamie Clout, First Assistant Secretary
Ms Shirley Browne, Assistant Secretary, Parliamentary and Portfolio Agencies Branch
Mr Damian Coburn, Assistant Secretary, Policy Strategies Branch
Ms Jacqueline Ball, Acting Assistant Secretary, Economic and Statistical Analysis Branch
Ms Mary McDonald, Assistant Secretary, Budget Branch
Ms Linda Powell, Assistant Secretary, APEC Taskforce

Audit and Fraud Control
Mr Tony Kingdon, Assistant Secretary, Audit and Fraud Control Branch

Outcome 1: Population health

Population Health Division
Ms Jennifer Bryant, First Assistant Secretary
Ms Joy McLaughlin, Assistant Secretary, Chronic Disease and National Health Priorities Branch
Ms Jennifer McDonald, Assistant Secretary, Food and Healthy Living Branch
Ms Jenny Bourne, Assistant Secretary, PHD Divisional Pool
Ms Virginia Hart, Departmental Officer, Drug Strategy Branch
Mr Peter Morris, Assistant Secretary, Strategic Planning Branch
Ms Andriana Koukari, Assistant Secretary, Targeted Prevention Branch

Therapeutic Goods Administration
Dr David Graham, National Manager
Dr Rohan Hammett, Principal Medical Officer
Dr Leonie Hunt, Assistant Secretary, Drug Safety and Evaluation Branch
Dr Sue Meek, Gene Technology Regulator
Dr Roshini Jayewardene, Team Leader, National Industrial Chemicals Notification and Assessment Scheme
Dr Margaret Hartley, Director, Office of Chemical Safety
Ms Rita Machalan**,** Assistant Secretary, Office of Devices, Blood and Tissues
Dr Marion Healey, Director, National Industrial Chemicals Notification and Assessment Scheme

Australian Institute of Health and Welfare
Dr Penny Allbon, Director
Ms Julie Roediger, Deputy Director
Dr Andrew Kettle, Head Business Group
Ms Susan Killion, Head, Health and Functioning Group

Outcome 2: Access to pharmaceutical services

Pharmaceutical Benefits Division
Ms Rosemary Huxtable, First Assistant Secretary
Ms Sarah Major, Assistant Secretary, Community Pharmacy Branch
Dr John Primrose, Medical Adviser, Pharmaceutical Benefits Branch
Mr Stephen Dellar, Assistant Secretary, Pharmaceutical Evaluation Branch
Mr Declan O'Connor-Cox, Assistant Secretary, Access and Systems Branch
Ms Sue Campion, Assistant Secretary, Policy and Analysis Branch

Outcome 3: Access to medical services
Medical Benefits Division
Ms Megan Morris, First Assistant Secretary
Ms Joy Savage, Assistant Secretary (General Manager), Office of Hearing Services
Mr Peter Woodley, Assistant Secretary, Diagnostics and Technology Branch
Ms Samantha Robertson, Assistant Secretary, MBS Policy Implementation Branch
Ms Catherine Farell, Acting Assistant Secretary (General Manager), MBS Policy Development Branch

Outcome 4: Aged care and population ageing
Ageing and Aged Care Division
Mr Andrew Stuart, First Assistant Secretary
Ms Carolyn Smith, First Assistant Secretary, Office of Aged Care Quality and Compliance
Ms Carolyn Scheetz, Assistant Secretary, Compliance Branch
Ms Alison Killen, Assistant Secretary, Community Care Branch
Mr Peter Broadhead, Assistant Secretary, Policy and Evaluation Branch
Mr Iain Scott, Assistant Secretary, Prudential Regulation Branch
Ms Fiona Nicholls, Assistant Secretary Quality, Policy and Programs Branch
Ms Melinda Bromley, Assistant Secretary, Office for an Ageing Australia
Ms Allison Rosevear, Assistant Secretary, Residential Program Management Branch
Aged Care Standards and Accreditation Agency
Mr Chris Falvey, Corporate Affairs
Mr Ross Bushrod, General Manager
Mr Mark Brandon, Chief Executive Officer

Outcome 5: Primary care
Primary and Ambulatory Care Division
Mr Richard Eccles, First Assistant Secretary
Mr Leo Kennedy, Assistant Secretary, Service Access Branch
Ms Judy Daniel, Assistant Secretary, Primary Care Chronic Disease Branch
Ms Lisa McGlynn, Assistant Secretary, eHealth Branch
Ms Jennie Roe, Assistant Secretary, GP Divisions and Information Branch
Ms Sharon Appleyard, Assistant Secretary, Rural Health Branch
Ms Sallyann Ducker, Acting Assistant Secretary, Primary Care Policy and Analysis Branch
Mr Lou Andreatta, Assistant Secretary, Primary Care Financing Branch

Outcome 6: Rural health
Primary and Ambulatory Care Division
Mr Richard Eccles, First Assistant Secretary
Mr Leo Kennedy, Assistant Secretary, Service Access Branch
Ms Judy Daniel, Assistant Secretary, Primary Care Chronic Disease Branch
Ms Lisa McGlynn, Assistant Secretary, eHealth Branch
Ms Jennie Roe, Assistant Secretary, GP Divisions and Information Branch
Ms Sharon Appleyard, Assistant Secretary, Rural Health Branch
Ms Sallyann Ducker, Acting Assistant Secretary, Primary Care Policy and Analysis Branch
Mr Lou Andreatta, Assistant Secretary, Primary Care Financing Branch

Outcome 7: Hearing services
Medical Benefits Division
Ms Megan Morris, First Assistant Secretary
Ms Joy Savage, Assistant Secretary (General Manager), Office of Hearing Services
Mr Peter Woodley, Assistant Secretary, Diagnostics and Technology Branch
Ms Samantha Robertson, Assistant Secretary, MBS Policy Implementation Branch
Ms Catherine Farell, Acting Assistant Secretary (General Manager), MBS Policy Development Branch
Outcome 8: Indigenous health
Office of Aboriginal and Torres Strait Islander Health
Ms Lesley Podesta, First Assistant Secretary
Mr Mark Thomann, Assistant Secretary, Program Planning and Development Branch
Mr David de Carvalho, Assistant Secretary, Policy and Analysis Branch
Ms Rachel Balmanno, Assistant Secretary, Health Strategies Branch
Ms Haylene Grogan, Assistant Secretary, Services of Concern Taskforce
Dr Tim Williams, Senior Medical Advisor
Outcome 9: Private health
Acute Care Division
Ms Kerry Flanagan, First Assistant Secretary
Ms Bernie Towler, Medical Officer
Mr Charles Maskell-Knight, Principal Adviser, Medical Indemnity Branch
Ms Gail Yapp, Assistant Secretary, Acute Care Strategies Branch
Ms Yael Cass, Assistant Secretary, Acute Care Strategies Branch
Ms Penny Shakespeare, Assistant Secretary, Private Health Insurance Branch
Mr Brendan Gibson, Assistant Secretary, Healthcare Services and Financing Branch
Outcome 10: Health system capacity and quality
Primary and Ambulatory Care Division
Mr Richard Eccles, First Assistant Secretary
Mr Leo Kennedy, Assistant Secretary, Service Access Branch
Ms Judy Daniel, Assistant Secretary, Primary Care Chronic Disease Branch
Ms Lisa McGlynn, Assistant Secretary, eHealth Branch
Ms Jennie Roe, Assistant Secretary, GP Divisions and Information Branch
Ms Sharon Appleyard, Assistant Secretary, Rural Health Branch
Ms Sallyann Ducker, Acting Assistant Secretary, Primary Care Policy and Analysis Branch
Mr Lou Andreatta, Assistant Secretary, Primary Care Financing Branch
Regulatory Policy and Governance Division
Ms Linda Addison, First Assistant Secretary
Ms Teressa Ward, Assistant Secretary, Governance and Agency Relationships
Ms Jenny Hefford, Assistant Secretary, Regulatory Policy Branch
Ms Kylie Jonasson, Assistant Secretary, Research Policy and Biotechnology Branch
Cancer Australia
Professor David Currow, Chief Executive Officer

National Health and Medical Research Council

Professor Warwick Anderson, Chief Executive Officer

Dr Clive Morris, Acting Chief Operating Officer

Outcome 11: Mental health

Mental Health and Workforce Division

Professor Rosemary Calder, First Assistant Secretary

Mr David Dennis, Assistant Secretary, Workforce Distribution Branch

Mr Allan Groth, Assistant Secretary, Workforce Infrastructure Branch

Ms Maria Jolly, Acting Assistant Secretary, Workforce Education and Training Branch

Mr Nathan Smyth, Assistant Secretary, Mental Health Reform Branch

Mr Greg Poyser, Assistant Secretary, Mental Health and Suicide Prevention Branch

Professor Rick Mclean, Principal Medical Adviser, Medical Education, Training and Workforce, Mental Health and Workforce Division

Professor Harvey Whiteford, Principal Medical Adviser, Mental Health and Workforce Division

Outcome 12: Health workforce capacity

Mental Health and Workforce Division

Professor Rosemary Calder, First Assistant Secretary

Mr David Dennis, Assistant Secretary, Workforce Distribution Branch

Mr Allan Groth, Assistant Secretary, Workforce Infrastructure Branch

Ms Maria Jolly, Acting Assistant Secretary, Workforce Education and Training Branch

Mr Nathan Smyth, Assistant Secretary, Mental Health Reform Branch

Mr Greg Poyser, Assistant Secretary, Mental Health and Suicide Prevention Branch

Professor Rick Mclean, Principal Medical Adviser, Medical Education, Training and Workforce, Mental Health and Workforce Division

Professor Harvey Whiteford, Principal Medical Adviser, Mental Health and Workforce Division

Outcome 13: Acute care

Acute Care Division

Ms Kerry Flanagan, First Assistant Secretary

Ms Bernie Towler, Medical Officer

Mr Charles Maskell-Knight, Principal Adviser, Medical Indemnity Branch

Ms Gail Yapp, Assistant Secretary, Acute Care Strategies Branch

Ms Yael Cass, Assistant Secretary, Acute Care Strategies Branch

Ms Penny Shakespeare, Assistant Secretary, Private Health Insurance Branch

Mr Brendan Gibson, Assistant Secretary, Healthcare Services and Financing Branch

Outcome 14: Biosecurity and emergency response

Office of Health Protection

Ms Cath Halbert, First Assistant Secretary

Ms Raelene Thompson, Assistant Secretary, Surveillance Branch

Mr Simon Cotterell, Assistant Secretary, Health Protection and Policy Branch

Mr Rob Cameron, Acting Assistant Secretary, Health Emergency Management and Biosecurity Branch

Dr Julie Hall, Principal Medical Officer, Office of Health Protection

CHAIR (Senator Humphries)—Good morning. I declare open this meeting of the Senate Standing Committee on Community Affairs which is meeting as the estimates committee for the Health and Ageing portfolio today. We will begin with an examination of that portfolio's budget estimates. I propose to call on the supplementary and budget estimates in the order of the circulated program. Under standing order 26, the committee must take all evidence in public session. This includes answers to questions on notice. Officers and senators are well versed in the privilege, protections and immunities and the scope of questioning for estimates. If you need reminding, the secretariat has a copy of the usual rules applicable to estimates hearings. We will try to keep to the time frames allocated. I welcome Senator Brett Mason, Parliamentary Secretary to the Minister for Health and Ageing, to his inaugural estimates on that side of the table. I welcome Ms Jane Halton, who is a veteran, and officers of the Department of Health and Ageing. Minister, do you wish to make an opening statement?

Senator Mason—No, Mr Chairman.

CHAIR—The first item on the agenda is, as usual, whole of portfolio corporate matters. We will have questions.

Ms Halton—Chair, before we have those, can I start by saying that, because last time the *Canberra Times* found so amusing our conversation about the safety net and the bills that were apparently cascading from under my fridge magnet, Medicare Australia has helpfully provided for senators' benefit a magnet—and, given this is National Reconciliation Week, it is an Aboriginal and Torres Strait Islander magnet—so you can also put your Medicare bills on your fridge. I will table that for senators' benefit.

CHAIR—I am not sure that you can table a magnet.

Senator WEBBER—We can do all sorts of extraordinary things.

Ms Halton—That is right. This is a flexible committee.

CHAIR—Thank you, and we will proceed to questions.

Senator McLUCAS—Firstly, can I start by thanking the departmental secretary for the fridge magnet. I will enjoy using that. Secondly, I thank the department for responding to our questions on notice. Most were in by the due date and a number came subsequently. I want to place on record our thanks for getting most of them in by the due date and certainly all by three weeks ago. That was useful. I have a few questions that I am not sure which outcomes they should be under. I refer to national health priority areas. Can you tell us which outcome they will appear under?

Ms Halton—Population health it should be.

Senator McLUCAS—Under outcome 1?

Ms Halton—Yes.

Senator McLUCAS—Broadband for health?

Ms Halton—That is under 10.

Senator McLUCAS—Radiography and the inquiry that was chaired by Professor Baume? Its report is *A vision for radiotherapy*.

Ms Halton—I think it would be under 3 but we will confirm that.

Senator McLUCAS—Thanks for that. First of all, I want to go to global health spending. There seems to be some difference of opinion about what the total health spend is. Can you provide us with a figure that is the total health spend for the Commonwealth?

Ms Halton—Yes. I will get my budget area people to come to the table. When you say there is 'confusion', can you tell me what the confusion is?

Senator McLUCAS—There is some suggestion that it is $52 billion and there is some suggestion that it is $42 billion.

Ms Halton—This we can explain.

Mr Clout—Senator, there are several figures that get used from time to time. There is the portfolio figure for Health and Ageing. There is total government spending on health and ageing. There is total government spending on health. The last two of those are broader than this portfolio, and they include spending on DVA and Health and Ageing. They also include the running costs for Medicare Australia on the programs that they run in relation to health. They also include some of the money that goes through the ATO for the private health insurance rebates that are claimed through the tax system rather than through health funds.

Senator McLUCAS—Could you go through each of those categories, please?

Mr Clout—The total spending on health for the whole of government? The total spending for health and ageing for the whole of the Commonwealth government is $51.8 billion.

Senator McLUCAS—And that is made up of what?

Mr Clout—The Health and Ageing portfolio. Do you want the actual figures for these?

Senator McLUCAS—Yes, please.

Mr Clout—I will have to get a calculator and come back to you. We could give you a table, if you like. I have not got one that has subtotals in it. I have six items here under the Health and Ageing portfolio and three items under DVA. I will need to get a calculator and add those up.

Senator McLUCAS—That is fine. So that whole of government total spend is through the Department of Health and Ageing and DVA, and you will give me the figures later.

Mr Clout—It is the Health and Ageing portfolio plus DVA components relating to health and ageing plus Medicare Australia components relating to Health and Ageing plus ATO PHI rebates and the ATO medical expense tax offset. That totals $51.8 billion.

Ms Halton—That is where the commonly used figure of $52 billion comes from.

Mr Clout—It is often referred to as the total government spending on health and aged care.

Senator McLUCAS—And the portfolio spend is $42 billion?

Mr Clout—The portfolio spend is $46 billion.

Ms Halton—It was $42 billion last year.

Mr Clout—The health function—which is broader than just this portfolio—is this portfolio less aged care plus the health components from DVA, Medicare Australia and the

ATO. That comes to $42.9 billion. You can source that from Budget Paper No. 1, table 8 in statement 6.

Senator McLUCAS—And that is the figure that we were going on, because that is what it says in the budget papers.

Mr Clout—It depends on whether you are talking about health, health and aged care or the Health and Ageing portfolio.

Senator McLUCAS—Hence the confusion. Do you have the figure as a percentage of total federal government spending with you?

Mr Clout—The proportion of government spending is around 22 per cent.

Senator McLUCAS—That is the whole cross-government spend?

Mr Clout—That is all of health and ageing spending across all government. It roughly remains that way through the forward estimates. Some observers have made their own calculations, but what they cannot see are the moneys that are in the contingency reserve for some of the major items.

Senator McLUCAS—Particularly, the private health insurance rebate.

Mr Clout—The private health insurance rebate and the ACCA both have components in the contingency reserve. When they are included, it remains above 22 per cent across the forward estimates.

Senator McLUCAS—Could we do a calculation and work out what is in those reserves?

Mr Clout—You could probably figure it out very broadly, but we are talking about one-decimal-place figures on very large sums, so it would be give or take hundreds of millions.

Senator McLUCAS—I will try.

Mr Clout—There are several items in the contingency reserve, not just one, so you would have to make some assumptions about the splits.

Ms Halton—It is not just the two; there are other things in the contingency reserve.

Senator McLUCAS—What percentage is the $42.9 billion of the total federal government spending?

Ms Halton—It is 18 per cent.

Mr Clout—It is 18.2 per cent in 2007-08.

Senator McLUCAS—This is all making sense now. I want to go to the ATO PHI rebates. How is the total spend on health calculated?

Mr Clout—The figure that they comprise?

Senator McLUCAS—Yes.

Mr Clout—For 2007-08, the ATO components are $178 million for the PHI rebates and $380 million for the medical expense tax offset.

Senator McLUCAS—I want to go to the question of health spending as a proportion of total budget projections. The projections in the budget show that health spending as a

proportion of total government spending is projected to fall from 18.24 per cent, which I think is in the 2007-08 budget—is that right?

Mr Clout—In the 2007-08 budget the figure for health spending is $42.9 billion. The functional statement figure for health, not including aged care, is 18.2 per cent. Again if you allow for elements in the contingency reserve, it remains at a level slightly above, across the forward estimates period. People making their own calculations based on the table on page 6.12 in Budget Paper No. 1 will not have those figures. So they may reach a difference figure. It is not a complete picture of the health spending.

Ms Halton—They are doing that on disclosed figures.

Senator McLUCAS—What is the purpose of printing that graph?

Mr Clout—The purpose of publishing at the functional level is so that government accounts can be broadly comparable over time and with other countries.

Senator McLUCAS—So that does show that between 2007-08 and 2010-11 health spending as a proportion of total government spending falls from 18.24 per cent to 17.65 per cent. Is that correct?

Mr Clout—I am not sure that we have done those calculations but we could verify the mathematics for you. The budget papers do say that the figures do not include total amounts. For instance, with the healthcare agreements it says that they include only the base funding plus the standard indexation parameter, which is not the full amount of the estimate. In Budget Paper No. 4, federal financial relations, there is a note to that table as well on the ACCAs that says there is an amount in the contingency reserve that is not published. So people looking at this table and reading the text that goes along with it should see that it is not the whole picture—there is disclosure but there are other amounts.

Ms Halton—And those people who try to retrofit a growth curve going back through previous budgets, which I know some people have tried to do, and then say, 'Aha, this is different,' are right. It is different, because basically the treatment of the ACCAs in particular in terms of the contingency has changed. So the ACCAs used not to be a forward projection in the contingency. That changed with the ACCAs.

Senator McLUCAS—So essentially the fall of health spending as a proportion of total government spending—

Ms Halton—Identified health spending.

Senator McLUCAS—does not include the contingency reserves?

Ms Halton—Yes, that is right.

Senator McLUCAS—But the 2007-08 figure does?

Ms Halton—Correct. Basically what you see in that table is attributed expenditure, and what happens with the contingency reserve is that the contingency reserve is not attributed to a function. As I said, I have seen several analyses that go back and say, 'Aha, this is different. Expenditure is dropping.' But the thing that is different is that we used not to have forward projections on the ACCAs actually in contingency. So they are right, but it is a treatment change rather than actually a real change.

Senator McLUCAS—So the actual ACCA would be in there not—

Ms Halton—The base ACCA is in there, but what we used to have in the forward estimates was base plus growth. So what happens now is that the growth has come out and gone into contingency.

Senator McLUCAS—Is that growth or indexation?

Ms Halton—That is growth.

Mr Clout—It is growth above a standard indexation amount.

Senator McLUCAS—Is there some way, without ascertaining what the PHI rebate is going to be in the future, that you could provide the committee with some understanding of the quantum of those figures that are not included in that graph?

Ms Halton—No, that is the whole point. The government has taken a decision that it will actually not release what it has got item by item in the contingency.

Senator McLUCAS—I am not suggesting that you release it item by item, but I suppose if we are going to compare apples with apples then I am concerned that this is not a particularly useful piece of information.

Ms Halton—That is a decision by government basically about the classification. We are not empowered to release those figures. That is the whole point about going in contingency: we do not control what can be released in relation to what is in the contingency reserve.

Senator McLUCAS—There is a contrast, then, with the *Intergenerational report*, which finds that health spending as a share of GDP should nearly double—by 2046-47, admittedly. How can you explain this slight dipping—without the contingency and other pieces of information—to a near-doubling?

Mr Clout—The *IGR* is about health spending as a proportion of GDP, but we are talking here about health spending as a proportion of total government spending. So there are a range of things moving, over that 40-year period, in the *IGR*.

Senator McLUCAS—You would imagine, though, that they are not that disparate.

Ms Halton—They could be.

Senator McLUCAS—This graph essentially shows a plateauing or a slight rise.

Mr Clout—I would be more comfortable if Treasury took any questions around the relationship, over 40 years, between government spending and GDP. That is something that we as a portfolio have not examined. I believe there is some commentary around that in the *IGR*, but it is certainly not something we could go into any detailed commentary on.

Senator McLUCAS—That is fair enough. Was DHA consulted in the development of the second *Intergenerational report*?

Ms Halton—At length.

Senator McLUCAS—How? What sort of inputs did you have into the development of that report?

Ms Halton—Multiple. Mr Clout can give you a bit of the flavour.

Mr Clout—It was an ongoing process from quite some time back. We had several meetings, quite regularly, with Treasury, as well as ongoing conversations between the Treasury officers responsible for preparing the IGR and officers in our statistics branch and throughout the divisions who are at responsible for Medicare, PBS and other items of spending. It was around data sources, methodologies and presentation, and we continued those discussions right up until around the end of last year.

Senator McLUCAS—I dare say that you had lots of conversations, meetings and whatever, but what were the data sources that Treasury was asking you to provide—population health? What sort of information was inputted to the *IGR* 2?

Mr Clout—There were mainly discussions around Treasury showing us the way they were proposing to go. They already had *IGR* 1 under their belt, so they were basically following that pattern. They talked to us about any particular modifications or changes in their methodology or the way they would weight various datasets. They opened up a discussion with us around how we would see that—whether it was a sensible thing to do, what sorts of figures that might give us as we get further out, how that looked against what happened in *IGR* 1 and those sorts of things.

Senator McLUCAS—What about the PBS? What sorts of information did they request of Health and Ageing in terms of the PBS?

Mr Clout—It was not so much a request for information from us. They already had a great deal of the information with them, and they fed that into their model. So it was not so much a request to provide a wheelbarrow full of data; it was more a case of telling us the approach they intended to take on PBS and asking us how that would work.

Ms Halton—With all due respect to the colleagues involved, I would characterise it more as being a sort of 'nerds' discussion of modelling approaches'.

Senator McLUCAS—I did not think we had any nerds!

Ms Halton—We do, and we are proud of them! We have some people who do some quite detailed statistical modelling. It is a very complicated science.

Senator McLUCAS—Being a nerd is hard, yes!

Senator Mason—It's not that hard!

Ms Halton—I think he is speaking as one who knows! Our modellers spent quite a lot of time talking to their modellers about the elements of the mathematical approach that they were proposing to take.

Senator McLUCAS—Yes, I understand that. Were the people involved looking at it purely from the point of view of cost input, or were they looking at it from the point of view of the epidemiology?

Ms Halton—Utilisation, yes—exactly. Our people feed in elements in relation to what they think is coming onto the market and what they think in terms of utilisation—all of those drivers. You will have seen that in this *IGR* there has been a change in what is seen as being the impact of the PBS on long-term growth and health expenditure and, therefore, on the

proportion of outlays. That is a direct result of some changes in assumptions that were made by the Treasury modellers based on the input of our modellers.

Senator McLUCAS—I remember when we had this discussion after *IGR* 1 that there was some question about what input the Department of Health and Ageing actually had into that process.

Ms Halton—That is right.

Senator McLUCAS—So you are confident that the information in *IGR* 2 is more accurate in terms of the PBS?

Ms Halton—Yes. We have had a much greater level of engagement. In fact, I have actively thanked Ken Henry for the engagement we have had this time. Last time we had engagement but it was not to the level of detail that enabled the estimates to be as informed as they could have been. This time it has. Sometimes their approach may be different from the one we might have taken, but they have a macro perspective that we do not necessarily have. But I do think there were much more detail and a better level of engagement this time.

Senator McLUCAS—Moving on to chronic illness, what sort of influence did DHA have in informing the *IGR* 2 on the potential impact of chronic illness in the compilation of the report?

Mr Clout—The *IGR* 2 projections do not attempt to take into account the changing burden of disease over the next 40 years.

Senator McLUCAS—They do not?

Mr Clout—No. It is too complex a process and it is beyond the purpose of the *IGR*, which is more or less to give a broad projection of what would happen without changes in policy settings, just given the ageing of the population, rather than the changing composition of the burden of disease within the population. That is a different purpose, and that is the sort of thing that the AIHW report on changing the burden of disease is about; it is more about informing government policy around that sort of issue. But the purpose of the *IGR* is to ask: 'Under current government policy settings, what is the impact of ageing, of the changing demographics?' It is just about the ageing component, rather than the changing burden of disease, that we might expect in any given age group over the next 40 years.

Senator McLUCAS—So there is no analysis of the impact of growing obesity on the economics of our nation?

Mr Clout—As people get older, their disease pattern changes and their requirements for certain medical services or drugs change. That is taken into account.

Senator McLUCAS—But that does not cover obesity, which is generally considered to be more of an issue for younger people, with potentially extraordinary impacts on our economy if it is not dealt with. That is not included?

Mr Clout—It is insofar as we are getting into areas where—

Ms Halton—The health impacts are, yes; but, in terms of any productivity impact, that is really a question you would have to ask Treasury. We factor in—in terms of expected utilisation for the MBS, PBS et cetera—growth in demand for what we fund for benefit. So

we are cognisant of changing patterns of disease, and our modelling attempts to bring those things in. But it is in relation to our programs. I suspect what you are going to are issues in relation to broader community productivity, labour market engagement et cetera, and those are questions we cannot answer.

Senator McLUCAS—No, but you have data that can input into coming to some conclusions about the impact of obesity—which I am just using as example, but I think it is a good one—on overall productivity. Was there consideration early in the piece about including a section on the impact of chronic and preventable disease in the *Intergenerational report*?

Mr Kalisch—The data that Treasury use for their modelling is largely drawn from the existing expenditure data, which reflects changing burdens of disease already. So, essentially, what the numbers reflect are already growing obesity, already growing changes in the burden of diseases.

Ms Halton—You double-count, effectively; so that factor is in there.

Mr Kalisch—So that is in there in the base information that they use to then draw their projections from.

Senator McLUCAS—But the level of obesity now is not what it is going to be in 10 years. We know that.

Mr Clout—But, to the extent that is growing, it will also be growing—

Ms Halton—In the PBS and in the MBS.

Mr Clout—at that rate, or an exponential rate.

Senator McLUCAS—In expenses but not in terms of productivity. So the question I am asking is: was there consideration early in the development of IGR to add in a section about the impact of chronic and preventable disease on, overall, the economics of the nation?

Mr Kalisch—I think you are looking at a level of sophistication that is far above what the modelling would take into account, but—

Senator McLUCAS—No. It is a process question. Was there discussion earlier in the piece to include the impact of preventable and chronic illness in the IGR?

Ms Halton—Let us see if we can come at this a different way. We have had a lot of conversations with the Treasury about the impact and the importance of this, and in fact they are very engaged on the issue in relation to the importance of health promotion and tackling these issues. But when it comes to modelling and the construction of the IGR in terms of those issues—other than the impacts on our portfolio—we cannot comment. What I can say is that we have had a lot of engagement with them on the importance of those issues. But as to the modelling side that is not related to us: we can tell you what is in ours, and to have factored in an extra factor for obesity, increasing burden of disease, et cetera, would be a double count for us, because we already have it in our modelling. It is already part of how we model growth.

Senator McLUCAS—In terms of expenses?

Ms Halton—That is right.

Senator McLUCAS—But not in terms of impact?

Mr Kalisch—It is really the expenses side that is being modelled here. And that is the driver—

Senator McLUCAS—But surely DOHA is the entity within our government that has the most information about the burden of disease and preventable disease?

Ms Halton—That is true.

Senator McLUCAS—I am asking a question about whether or not that was going to be part of the IGR 2, early on, and then a decision changed?

Ms Halton—Not that I am aware of.

Senator McLUCAS—Not that you are aware of? Okay. I will turn now to another issue. At last estimates, we asked a set of questions. We wanted a list of all lapsing programs, the year in which the programs were originally funded and, for each lapsing program, information on expenditure to date by financial year, or on any program expenditure which had been rephased or redirected. And, for the out years, we wanted to know for which programs expenditure had been published. Do you recall that question, Mr Clout?

Mr Clout—Yes.

Senator McLUCAS—The answer you gave us was that it was an issue of budget classification and, as such, could not be answered until after the 2007-08 budget. So can we have the answers now, given that we have had the 2007-08 budget?

Mr Clout—Yes. We have now prepared a draft response to that question, now that we know the outcome of the budget. Pending final clearance, could I table that later in the proceedings?

Senator McLUCAS—That would be lovely. Thank you very much. There are a series of initiatives that I will hand up where we are looking for the allocation and actual expenditure on a year-by-year basis. If I provide those to DOHA now, could you give those back to us during the next two days?

Ms Halton—Yes—well, subject to there being no problem with them, we are happy to do that.

Senator McLUCAS—Has Crosby Textor undertaken any services for DOHA, including market research, public opinion polling, strategic counsel, campaign and communication services or any other services?

Ms Halton—I am getting a 'no' from the back. I am not aware of one. No; not to our knowledge.

Senator McLUCAS—Could you confirm that? So, basically: any contract at all with Crosby Textor?

Ms Halton—We do not believe so, but we will confirm that.

Senator McLUCAS—Thank you. You would be aware that the House of Representatives Standing Committee on Health and Ageing's report entitled *The blame game*—the report on the inquiry into health funding—was tabled in 2006?

Ms Halton—Yes.

Senator McLUCAS—What progress has there been in responding to those recommendations?

Mr Clout—The department is finalising a draft response. It has involved consultation with several other agencies—the Department of the Prime Minister and Cabinet, the Department of Education, Science and Training, the Department of the Treasury and the Department of Veterans' Affairs—and I think we are getting fairly close to finalising it.

Senator McLUCAS—When do you expect the response to be tabled?

Mr Clout—That is very much a matter for the government, when they have been given a final response to consider.

Senator McLUCAS—Is the draft complete?

Mr Clout—It is not yet with the department's executive.

Ms Halton—I have not seen it yet, but I am tracking it.

Senator McLUCAS—What is the time frame to get it to the executive?

Ms Halton—Soon.

Senator McLUCAS—That is an oft-used word.

Ms Halton—It is on my resubmit list.

CHAIR—Are there any other questions on cross-portfolio issues?

Senator MOORE—I would like an update on staffing and property, but we can put that on notice. I would like to know, between annual reports, your current staffing level across the board, and I would like to get a snapshot of the department's property. Also, we would like to know about Indigenous employment in the department—a general question that we are asking of a lot of departments. Health and Ageing always has a higher level. I would also like to get some data on that and on whether your department has been part of the ongoing program that the government has just announced to enhance Indigenous employment in the public sector.

Ms Halton—Yes, it is. I launched our reconciliation action plan yesterday morning, and that has had wide engagement right across the department. I think I now have amongst the highest numbers of Indigenous SES staff in the service.

Senator MOORE—Have you spoken to Dr Harmer about this? There seems to be a bit of a competition going on.

Ms Halton—You know I am going to win!

Senator MOORE—Can we have a copy of that reconciliation plan?

Ms Halton—We have not had it beautifully published yet, but I am happy to get it for you.

[9.37 am]

CHAIR—We will now move to outcome 1, Population health.

Senator MOORE—I will lead off with questions about the Bowel Cancer Screening Program, which is one of my personal favourites. We have asked questions about that at each

estimates since that was introduced. Can we get an update on where that is at and also on how the funding is going? Specifically, I would like to know where the ongoing process of the rollout is up to.

Ms Bryant—The bowel screening program is now being implemented in all states and territories. It commenced in the Northern Territory in March and in Tasmania in April, so that is now—

Senator MOORE—So every state is now on line.

Ms Bryant—We now have every state on line. Across the board, we have now sent out close to 300,000 invitations, which covers about 30 per cent of the potential pool of invitees. We have had close to 90,000 participants, which gives us about a 30 per cent participation rate. We have had 5,124 participants with positive FOBT as at 30 April, which is a positivity rate of about 5.7 per cent. The early signs are that there are substantial benefits for those who have their disease caught earlier.

Senator MOORE—How do those figures compare with the expectations from the original program?

Ms Bryant—For this early stage of the program, and given the last start in some states and territories, we are about where we predicted the program to be. But it is not where we predict it will reach.

Senator MOORE—Do you have a plan? Do you have benchmarks for what you would like to achieve along the way? Do you measure how it is going against those benchmarks?

Ms Koukari—No, we have not set participation rates and we had no expectations about participation rates throughout the life of this phase of the program. However, what we had expected was that participation rates would increase as the program rolled out, and that has indeed occurred. That is a lot to do with the impetus the program creates.

Senator MOORE—There was a delayed start in some states. Why?

Ms Koukari—Some states required additional time to ensure that they had the capacity and infrastructure available to commence. They also wanted to decide whether to roll out in terms of geography or birth date.

Senator MOORE—And what have they chosen?

Ms Koukari—Queensland chose a geographic rollout, New South Wales chose a birth date rollout, the ACT chose a birth date rollout, South Australia chose a geographic rollout, Victoria chose a birth date rollout, Western Australia chose a geographic rollout, Northern Territory chose a geographic rollout and Tasmania chose a birth date rollout.

Senator MOORE—Is there going to be any evaluation on how they compare in terms of uptake? That is a threshold decision about how you are going to roll it out—whether by birth date or by geography—and there is quite a good spread. So, in terms of the evaluation of the strategy, is there going to be any comparison?

Ms Koukari—That is certainly one of the things that we will take into account when we do the evaluation.

Senator MOORE—How is the budget going? Do not say that it is going well. How is it going in terms of the expenditure expectation for these 12 months? How much of the budget has been spent?

Ms Bryant—If you are asking for 2006-07, we have not got the end of financial year—

Senator MOORE—How much has been spent to date?

Ms Koukari—Year to date, we have spent $10.4 million.

Senator MOORE—Out of?

Ms Koukari—Out of $43.4 million.

Senator MOORE—We have two months to go.

Ms Bryant—That is $43.4 million across four years.

Senator MOORE—We have two months to go in this one. What was the expected allocation for 2006-07?

Ms Koukari—Approximately $14 million.

Senator MOORE—So you expected to spend $14 million. Because it is $10.4 million—and I know we have two months to go—is it understood that it will just roll over?

Ms Koukari—Yes.

Senator MOORE—So there is no problem with that?

Ms Koukari—No. In fact, it has been rephased.

Senator MOORE—It has been rephased?

Ms Koukari—Yes. It is in the PBS as rephased money.

Senator MOORE—In terms of your assessment up to date, are there any other issues apart from the delayed rollout in some states that have appeared?

Ms Bryant—I do not think that any issues have appeared that have not been resolved.

Ms Koukari—No.

Senator MOORE—There is an advisory group. Are all states and territories meeting regularly?

Ms Koukari—There is a program advisory group. I chair that group. It met last week.

Senator MOORE—How often does it meet?

Ms Koukari—It meets three to four times a year.

Senator MOORE—And it looks at benchmarks and takes a snapshot of how it is proceeding?

Ms Koukari—Yes. We discuss participation rates at those meetings.

Senator MOORE—The last state came on a month and a half a go.

Ms Koukari—The beginning of April.

Senator MOORE—So when is the next quarter? If you met yesterday, you should be meeting again in three months time.

Ms Koukari—Yes. In fact, I think we have a date—mid-July.

Senator MOORE—By which date, for the first time in a meeting, you will have all states with some data to provide.

Ms Koukari—Indeed. In fact, we have that now.

Senator MOORE—Is that data public?

Ms Koukari—It is not published publicly, but we are making it available to stakeholders, and all states and territories have the data available to them.

Senator MOORE—Is it available to us? I know you have to take advice on that.

Ms Bryant—We certainly have a table of the data I was reading from, and we could table that for you now.

Senator MOORE—If we could get that, and then if there is any further information we will follow up on that. But what you are giving me is what you can give me now?

Ms Bryant—Yes.

Senator MOORE—Okay. Turning to follow-up services: we had a discussion about follow-up services when the program was first being discussed. Once someone has been assessed, how is the rollout of follow-up services? It is all very well to be screened, but we had some concerns in some states about how quickly people could access follow-up.

Ms Koukari—As far as we know or we have been advised, there do not appear to be any particular issues in providing follow-up colonoscopy services.

Senator MOORE—So those 5,134 who had some positive indication—they are all going through a follow-up process now?

Ms Koukari—They would be. It takes us a while to capture the data on those people, and until we have the data we do not know at exactly what point in time they had their colonoscopy services, but we certainly know from the pilot that they had services provided within quite a short period of time. I think most of them happened within a two-month period.

Senator MOORE—In terms of the financial process, there was a four- or five-year period for this. We are at the end of the first year. So of the $10.4 million—I am just double-checking the figures—anything that has not been spent will flow over; there is no loss of funding?

Ms Koukari—That is right.

Senator MOORE—I want to get these figures right in my own mind. About 30 per cent of the people who you were hoping to send out invitations to—I have difficulty accepting the term ‘invitation’ in this case—nonetheless, about 30 per cent of the people you wanted to have information sent to have got it now?

Ms Koukari—In terms of the rollout plans that we have with each state and territory, we have invited 298,000 people—almost 300,000—

Senator MOORE—About 300,000 people have received information about this process now.

Ms Koukari—That is right, and that is about 30 per cent.

Senator MOORE—Is that the full extent of the numbers you wanted? What was the expected number of people that would receive information about this program?

Ms Koukari—We would have hoped that, if we had had a rollout as of August last year from each state and territory, we would be halfway through the process.

Senator MOORE—Which would be how many?

Ms Koukari—It would be about 450,000.

Senator MOORE—That is what I am trying to get in my head. About 300,000 people have got information—

Ms Koukari—And invitations.

Senator MOORE—And invitations—and you would have hoped to have had about 450,000 at this stage.

Ms Koukari—Yes.

Senator MOORE—Ninety thousand, about 30 per cent of the people who have received information, have responded. Is that right?

Ms Koukari—That is right.

Senator MOORE—Did you have any figures on how many you wanted to have come back by now?

Ms Koukari—No. That is one of the pieces of information we need to get from this phase of the program as well.

Senator MOORE—Between now and July? In my own mind, phases are when you all get together and have a look at what is going on. Is that not the right way to look at it?

Ms Bryant—In terms of the overall final level of participation for a population-level screening program, we would view that as something that is being assessed over the life of the program, from 2006 to 2008, and it is an issue that will specifically be looked at in the evaluation of the overall program over that period.

Senator MOORE—I see that looking at the whole program, but I would have thought that there would have been benchmarks in your program plan for what you would have planned to have achieved along the way so it would not just be an evaluation at the end to look at how the whole thing went—that in the 2006-08 plan there would have been points along the way where you would have said, 'By this point in the program it is expected that 450,000 invitations will have gone out; on the basis of the program plan 200,000 people would have responded.' That is what I am trying to see: whether you have those benchmarks in place against which you are assessing how you are going.

Ms Koukari—What we have done is that we have adjusted. We know that by this stage we would normally have had 50 per cent of the invitations out. What we did was adjust our project plan to take into account the rollout dates of each of the different jurisdictions as

listed. We then went back and readjusted. So we are actually at the point we should be in terms of invitations, given the implementation dates in each of the states and territories.

Senator MOORE—That gives me more confidence that there was a plan.

Ms Koukari—Yes.

Senator MOORE—So you have actually adjusted things along the way.

Ms Koukari—We need to do that for the register or we would not be able to send out invitations.

Prof. Horvath—Looking at the positivity of 6.2 per cent, which is exactly in the range of what we predicted and what other studies have shown—

Senator MOORE—I am sorry, maybe I have written this down incorrectly, but I have 5.7 per cent written down. Do I have the wrong figure?

Prof. Horvath—Sorry, it is 5.7 per cent. That is in that range.

Senator MOORE—Sure, it is close. I just wanted to make sure that I had not got it wrong.

Prof. Horvath—Yes, I was looking at the wrong piece of paper. My apologies.

Senator MOORE—It happens.

Prof. Horvath—I have bits of paper coming at me from all directions correcting me now. What that shows, though, importantly, is that it is not a skewed population. One of the concerns always at the beginning of a study like this is that you suddenly have a skewed population. It is like blood pressure screening studies in shopping centres. They have an abnormally high positivity rate because people who know they have blood pressure problems go along and have it measured for the heck of it.

Senator MOORE—Okay, I understand that.

Prof. Horvath—So this is actually a very nice figure that suggests that the people who have responded are in fact an appropriate cross-section.

Senator MOORE—Was there any expectation at the beginning about what you hoped to find—'hoped' is the wrong word to use when we are looking at someone's illness, but was there any expectation that it would be around six per cent of the population?

Prof. Horvath—Yes, that was the sort of range—

Senator MOORE—So that was what you thought it was going to be?

Prof. Horvath—Yes.

Senator MOORE—And so far in the screening program that has been validated?

Prof. Horvath—Correct.

Ms Halton—Professor Horvath might want to reconsider his use of the words 'nice figure'. It was the figure that he was anticipating.

Prof. Horvath—It might be better to say 'appropriate figure'.

Senator MOORE—So, in terms of working towards the next round, after July there will be another evaluation when the meeting gets together and then we will go. Is there any way,

Ms Bryant or Ms Koukari, that we could get an update of how it is going along the way? We have a Senate estimates discussion of the process and there is in general information on your website, but are there updates about how it is going? The information on the website is talking about the overall program. It really does not say what is coming out.

Ms Halton—When we put in the inevitable answers to questions on notice we can give you an update on notice if you like, if that would be helpful.

Senator MOORE—That would be fine. It just would be useful to get a snapshot. If the department is taking a snapshot of how it is going, that would be useful.

Ms Halton—We will give you a snapshot of what it looks like in a couple of months time.

Senator MOORE—Thank you.

Senator CAROL BROWN—I have some questions about the participation rate. You averaged it out at 30 per cent. I noticed in the summary you sent around, with the three states that started in August-September last year, that Queensland is only 18.5 per cent. Are you looking at the reasons why that is so low compared to the average?

Ms Koukari—That is actually the proportion of the total number of invitations that have gone out. The participation rate is almost 30 per cent in Queensland.

Senator CAROL BROWN—Yes, sorry; I read the wrong figure.

Senator MOORE—On that same point, Queensland started earliest. It is noble to see, Senator Mason, that Queensland was the first one to start.

Senator Mason—Always ahead of the game.

Senator MOORE—We have only send out 18.5 per cent. Is that a question—as to why Queensland sent out 18.5 per cent?

Ms Koukari—That is based on the schedules that Queensland asked us to put in place in terms of their geographic roll-out so that they could ensure that there was sufficient colonoscopy capacity in that area to provide the follow-up services for the people with positive FOBTs.

Senator MOORE—So in the next round of discussion, would you be seeing whether Queensland has an effective plan? If they only wanted 18.5 per cent to start with, would you be expecting them to be at a higher percentage by the time you have your next snapshot?

Ms Koukari—Absolutely. And by the end of the screening period we would expect them to be at 100 per cent.

Senator MOORE—Thank you.

Senator McLUCAS—Can we go to the meningococcal C vaccination program? According to my notes, the total allocation is $298 million over four years beginning in January 2003. Can you give us the forward estimates from then over the four years for the program?

Ms Bryant—That figure is not something we have here with us. We can probably get it for you in the course of the day.

Senator McLUCAS—That would be great. It started in January 2003, so we are close to completion of that original program—is that right?

Ms Bryant—Yes. I think there is an ongoing program. There was the catch-up program, but I think there is a continuing program as well.

Senator McLUCAS—But I am just talking about that original four-year allocation of $298 million. Of that money, how much has been spent?

Ms Bryant—Again, that is a figure we will get for you.

Senator McLUCAS—Thank you. Could you provide the committee with information about the take-up rate?

Ms Bryant—Again, on separate take-up: I have the number of cases that have been reported in each year but I do not have the actual take-up and coverage. But, again, that is something we could pull out; let me confer with my colleagues. Senator, I am advised that the ongoing program of infant—12 month—injections will be captured in the Childhood Immunisation Register, and so we could probably give you a percentage take-up in that coverage in that group. But the catch-up program in school-aged children is not captured in the register. It is done through a school based program and, consequently, we do not have data about that take-up.

Senator McLUCAS—So it is being rolled out through the schools?

Ms Bryant—Yes, but it is not captured in the national register. There is not a register capturing meningococcal vaccinations in school-aged groups.

Senator McLUCAS—Are we funding the vaccinations?

Ms Bryant—We are funding the vaccine. So we could give you an estimate of the numbers of doses and so on. We could probably obtain that type of information for you. Yes, I am advised we can do that.

Senator McLUCAS—And out of that we could extrapolate what?

Ms Bryant—We could probably do some extrapolation but it would be that—an extrapolation.

Senator McLUCAS—Because we might be picking up people who were outside that one to 19 age group who have been vaccinated?

Ms Bryant—You could pick up a little bit of leakage, yes. But I would not anticipate it would be that high.

Senator McLUCAS—How much was spent on the awareness campaign?

Ms Halton—Sorry, Senator; there is something I need to check. I think one of the questions you just asked was in relation to the forward estimates for this program—was that right?

Senator McLUCAS—It started back in 2003, so I am trying to track back in terms of the spending over the previous years, but will it complete in this current financial year or next year?

Ms Halton—As you know, we can tell you what is available for this year, but we cannot go forward because of the standard approach to government reporting in relation to forward estimates.

Senator McLUCAS—I have been able to get some information in some programs in FaCSIA. We might come to that at a later point, but I think we can get some—

Ms Halton—We can go back.

Senator McLUCAS—You can go back and I think in some cases you can go forward, and that is what we will intend to do today. Ms Bryant, how much was spent on the awareness campaign?

Ms Bryant—For meningococcal C?

Ms Bourne—I have been advised that there was $7 million for that campaign. I believe that it was generally spent in 2003-04. There was advertising, printing and brochures.

Senator McLUCAS—Are there any plans to spend further money on awareness campaigns for meningococcal C?

Ms Bourne—Not that I am aware of.

Senator McLUCAS—Can we go to rotavirus now. The vaccine was added to the national immunisation program. When will the vaccination program begin?

Ms Bryant—New vaccines will be available on the program from 1 July 2007 for all babies born after 1 May 2007.

Senator McLUCAS—How is it administered? Is it part of their general vaccination program?

Ms Bryant—It is an oral vaccine and, depending on the brand, it is either two or three doses. For one brand it is given at two, four and six months of age—that is CSL's RotaTeq. For GlaxoSmithKline's Rotarix, it is a two-dose schedule, given at two and four months. It would be usually be an oral vaccine given at the same time as other infant vaccinations.

Senator McLUCAS—Will it be available free of charge?

Ms Bryant—The vaccine will be free of charge, depending where a person has the vaccine administered. If they are taking the baby to their GP there may be a consultation fee; if it is a baby immunisation clinic then there would not necessarily be a charge.

Senator McLUCAS—What is the total cost of the program?

Ms Bryant—The total cost of the program is $124.4 million over five years.

Senator McLUCAS—What is the 2007-08 component of that?

Ms Bryant—In 2007-08, for the vaccine itself, $22.3 million.

Senator McLUCAS—What are the other costs in 2007-08?

Ms Bryant—There is only a vaccine cost in 2007-08, of $22.3 million.

Senator McLUCAS—What are the costs in further out years?

Ms Bryant—In the out years, the figure goes up. What I can say to you, given the comments Ms Halton made a few minutes ago about the forward estimates, is it is a total of $124.4 million over five years.

Ms Halton—Yes, that is right, and that is vaccine costs.

Senator McLUCAS—What other components are there to that total $124.4 million?

Ms Halton—It is just vaccine.

Senator MOORE—Is there an awareness campaign or information campaign?

Ms Bryant—We do have a communication strategy for GPs and updating our publications and so on, but I believe we are covering those departmentally and they are not part of this vaccine figure.

Senator MOORE—It goes into already existing strategies, so there is no new funding?

Ms Bryant—Yes. It is updating of publications and so on and strategies of communication that we already have, so it is not a component of that $124.4 million.

Senator McLUCAS—So there is no TV or public campaign.

Ms Bryant—No. There is no TV or public campaign of that nature.

Senator CAROL BROWN—So the vaccination is just added to the list of the normal vaccinations you take in?

Ms Bryant—Yes.

Senator MOORE—We have got some questions about Gardasil.

Senator WEBBER—Before we go into the specifics of the program, given some of the events of the last week or so and some of the extraordinary media commentary, particularly in the *Age*, about the reactions of a group of young women to being vaccinated, Professor Horvath, could you give us your view of what I thought was a bit of mass hysteria and some inflammatory comment that went with vaccinating those young women?

Prof. Horvath—I think that with any vaccination campaign—and it is well documented in the literature—there are a whole lot of psychological issues around it. If you look at Army recruiting, for example, you would see films of Army recruits for national service and you would see fit young men like my colleague, Mr Learmonth, standing up there; and they would faint at the sight of the needle coming down the line. Healthy people do have all sorts of reactions to it. One of the things we have to be very aware of is that when you run a campaign for a group of fit young women there are going to be a whole lot of issues and myths around getting needles and vaccinations. At the same time, as with any new product, we need to keep a very close eye on all reactions to ensure that we are not missing something that is the beginning of a reaction that we were not aware of. So we are keeping a very close eye, and my colleague Dr Hammett, from the TGA, has kept a very close watch on all reports to ensure that there are not any reports of a similar nature coming from the large overseas vaccination programs. But part of the issue of the state programs is to reassure the population—and they do this very well—that the studies so far on Gardasil have indicated that it is effective and safe. Some of the things we have seen coming out of these reports are perhaps predictable, related to anxiety, but we are treating them with an appropriate degree of caution.

Senator STOTT DESPOJA—There was anxiety obviously relating to the health impacts; but, as you would have seen in my home state of South Australia, there was quite an alarmist headline, prompted by the fact that two private schools in Adelaide have decided not to offer the vaccine on the basis that it may lead to 'promiscuity'—their word, not mine. I am

wondering if that kind of media is addressed or whether or not, through either the Independent Schools Association or other bodies, there is some engagement by the health department or others to try to challenge some of these concerns.

Prof. Horvath—Certainly not from my part of the portfolio. I will ask Mr Learmonth to comment, but I do not believe that we have any plans to do that.

Mr Learmonth—I do not think we have any plans.

Ms Bryant—In the case of South Australia, the Independent Schools Association had been contacted by the South Australian authorities, and I am advised that they did encourage the two schools in question to, as a minimum, make the information product available for the girls to take home to their parents so that they could make an informed choice about it, if they were not going to allow the vaccine to be administered in the schools—

Senator STOTT DESPOJA—Are you aware of that because of the department's or the government's engagement with the Independent Schools Association? I want to make it very clear on the record that I do not want to cast aspersions on the association. It was their spokesperson who said that the two schools had made that decision and that it was not a decision of the Independent Schools Association.

Ms Bryant—It is our understanding that it was not their decision, and they did encourage that. Our advice comes via discussions with the immunisation coordinators in the states and territories.

Senator MOORE—I have some questions about the rollout and numbers. I will read them out and see what answers you can give me. We would like to see how it is going state by state, so we would like state-by-state figures where possible. My understanding is that with Gardasil, like with other immunisations, you have an immunisation coordinator in each state. Is it correct that they would be maintaining figures?

Ms Bryant—There is a state or territory government immunisation coordinator in each state and territory. We would have to take questions on notice to get information from them. Each state or territory commenced the immunisations on a slightly different date.

Senator MOORE—Naturally. We would expect that.

Ms Bryant—I think South Australia started in April. We will have to take your question on notice to obtain that information from them.

Senator MOORE—The information we would like is: the timing for vaccinations for women aged under 18; when the vaccination will be available for women aged 18 to 26; and when the vaccine's free availability will end for those two age brackets?

Ms Bryant—I can probably answer some of those now. For 18- to 26-year-olds, the vaccines will be available through community programs and particularly general practice in July—not 1 July, but in July. Again, the date will vary slightly across jurisdictions, depending on their local arrangements. For the catch-up groups, the vaccine is available for two years. So, for the 18- to 26-year-olds in the community-based program, it will be available until 30 June 2009.

Senator MOORE—So that is a standard. The Commonwealth document says that the vaccine will be free for women aged 18 to 26 from 1 July 2007 to 30 June 2009.

Ms Bryant—Yes; it is a two-year catch-up. For the school-age children—the under 18s—there will be an ongoing program. It will become part of the regular immunisation schedule for approximately year 7. Some jurisdictions are doing it in the final year of primary school and some of them are doing it in the first year of high school. It is around 12 or 13 years, depending which year they administer it in. That will be an ongoing program on the ongoing immunisation schedule. For the catch-up groups in the school-age cohort, it is available over a two-year period. Essentially, it will be administered in the school calendar years 2007 and 2008.

Senator MOORE—So that will be the 13- to 18-year-old catch-up group?

Ms Bryant—That is correct.

Senator MOORE—And that will still be done through the school program where available, will it?

Ms Bryant—There is a schedule we could get for you where it shows which years the states have advised us what they intend to do. So years 7, 10 and 11 this year and years 8, 9, and 10 the next year et cetera. We could get you that table.

Senator MOORE—Would that schedule spell out the arrangements between the Commonwealth and the state on this program? I want to know whether the states have to purchase a vaccine and apply to the Commonwealth for reimbursement? Is that how it works? How does it work exactly?

Ms Bryant—Yes. The states have their own procurement arrangements. We give them the funding and they purchase the vaccine.

Senator MOORE—You are going to give me the schedule about what they said they are going to do. Is there any rule or guideline that says they must do it within a certain time? The Commonwealth has announced that this is going to happen but it is going to be implemented by the states. If one state does not do it, is there an issue around that? Is there a piece of paper that you can give me that spells out that arrangement?

Ms Bryant—I think all jurisdictions have indicated that they are fully supportive of the program and they will ensure coverage of years 7-12 over the two-year period. The way they roll it out does vary from jurisdiction to jurisdiction. In some more non-metropolitan areas, states are seeking to do a whole school at once, so they are doing years 7-12 when they visit the school. In some of the metropolitan areas they might be doing year 7 because they will just do that as part of the ongoing program and they will do 10, 11 and 12 in one year and 8 and 9 in the next year. It does vary but that is how they are managing the program and I do not think that there is any issue that they will not roll it out to all eligible girls over the two-year period. On the information they have given us, they will do that.

Senator MOORE—Are there any delays that you have already seen?

Ms Bryant—No, we are not aware of any delays at this stage.

Senator MOORE—How will the vaccine be made available to GPs for the community based exercise?

Ms Bryant—I understand that we give the states the funding to purchase the vaccine, they purchase it from the supplier and they have distribution mechanisms to GP fridges. So they have a distribution network that gets it out there into fridges.

Senator MOORE—So the GPs relate to the states—the immunisation coordinators—for that process?

Ms Bryant—That is correct.

Ms Halton—That is an existing relationship because that is the mechanism for other vaccines.

Senator MOORE—Because it has had media coverage—the actual rollout has started, hasn't it?

Ms Bryant—Of Gardasil?

Senator MOORE—Yes.

Ms Bryant—Yes.

Senator MOORE—When will there be an evaluation process? Have you built in an evaluation process to see how it is going?

Ms Bryant—We have the ongoing mechanisms to monitor for any adverse events that Professor Horvath has spoken of and there is our ongoing program management of expenditure and so on with the states and territories, but an evaluation of the vaccine per se—no. Senator, I am advised a little differently if we can just—

Ms Bourne—I have been advised there is a formal evaluation set down for year 4 of 2009-10 for this vaccination.

Senator MOORE—That is for the process. I understand the issue around an adverse event, because that triggers a process. This is a new program and I am interested in how you evaluate the rollout process? We have had information that all the states are online. How do you find out that the rollout is proceeding as they have claimed it is? How do you monitor that the number of young women in each of those categories that you are going to give me has, in fact, had the option to have the vaccine? How do you find out where people have chosen not to? That is another issue about people who are vaccinated within the age groups. How do you know how many women of 13 going to school have refused to have the vaccination? That is the kind of data.

Ms Bryant—We are establishing a register for the HPV program. At the moment the states and territories are collecting data with the consent forms and so on that parents sign. They are holding that data at the moment. We will be building a register to capture data in a similar way to the childhood immunisation register, but it is subject to the passage of legislation.

Senator MOORE—To build the register?

Ms Bryant—Yes; to allow the states to transfer the necessary data to the Commonwealth.

Senator MOORE—Will that be state or federal legislation?

Ms Bryant—It will be federal legislation.

Senator MOORE—So is that happening?

Ms Bryant—It is in process at the moment. It is something that we would hope to see very shortly.

Senator MOORE—Minister, this may well be a question for you rather than for the department. With a program like this, where we knew it was happening and we knew we would have to collect data, I am interested that the register legislation was not in place at least at the same time as the rollout started. I want to find out whether it is common to have a lag like that. All immunisation is subject to public scrutiny because people have very strong views about it, as everybody here knows. But this one in particular has caused a degree of discussion leading up to the time of implementation. My expectation was that the processes around capturing the information and also ensuring that everybody knows what is going on would have been in place. The information Ms Bryant has just given—that the mechanical process for ensuring that the data collection is done has not gone through parliament yet—interests me. Is it common to have a delay in getting those kinds of mechanical processes in place? I am happy for the department to answer, but I am going to the government representative as well.

Senator Mason—Senator Moore, I do not know.

Senator MOORE—That is fine.

Senator Mason—I do not know what the process normally is. I know that there is an evaluation process which has been built in.

Ms Bryant—The lead time for implementation of this program was particularly short. Whilst we normally have a longer time to take account of the need for any of these processes, in this instance we did not have that lead time before implementation of the program. The legislation is being progressed. We expect it to be introduced in the winter sittings. In anticipation, we have conducted a procurement process, in consultation with other agencies as necessary, to engage someone to build the IT and the design of the register and so on. We have been consulting with the states and territories on the data items to be captured. We have arrangements in place with them because they can capture the data. They are capturing it and holding it but they cannot transfer it to us until the necessary framework is in place.

Ms Halton—Can I make a comment about this, because I was quite involved in this at the time. Essentially there was a decision here, when the company brought the product for consideration for funding. We have talked in this place at great length about the amount of time it takes for the PBAC to go through its processes. This product was considered in a very speedy fashion. Because this is a school based program, you have to make a decision very early about which school year you are going to roll it out in. The choice here was: do we roll this product out in this school year and still have some things mechanically to follow up on or do we wait until 2008 while the legislation et cetera catches up? The decision was that we should not deny these girls access to the product, so we rolled it out knowing full well that we would have to play a bit of catch-up on the legislation in relation to this matter. But, as Ms Bryant said, data is being captured; it is just not coming to us. So, essentially, yes, we have the legislation following along, but it was a conscious decision that we would not delay the

rollout as a consequence of the need for legislation on that particular matter. It was the prudent public health decision, in my judgement.

Senator MOORE—Are there any other administrative fix-ups that have to be finalised before the program is fully functional? Is that the only thing that is left to be concluded?

Ms Halton—That is right.

Ms Bryant—That is right.

Senator MOORE—The reason I ask is that there was a degree of interest in the parliament about this particular process and to the best of my knowledge this issue about needing to have follow-up legislation was not discussed—certainly not with the community affairs committee. As long as we are absolutely certain that the data is being collected and that there is going to be no possible slippage in that process, we will be happy. Do you have to have a new register for all the new vaccines that come on? Do the other ones that we have talked about need to be put onto a register or is it just this one?

Ms Bryant—The rotavirus vaccines, for example, can be captured in the existing childhood immunisation register.

Senator MOORE—So you did not need to do any IT amendments for that?

Ms Bryant—We did need to talk to Medicare Australia to get them to update their data fields and create provision for it, but it did not require complex IT development.

Senator MOORE—When the meningococcal vaccine came on, did there need to be a new program done for that one? You might want to take that on notice. I am interested because it is a particular discussion that we have not had before.

Ms Bryant—I am advised that the childhood injection for meningococcal is already in the childhood register.

Senator MOORE—I would hope so, because it has been around for a long time. My question is: when it came in, did you need to have similar legislation—an IT amendment?

Ms Bryant—No, because the childhood register has an existing framework.

Senator MOORE—I will not labour the point—it is just that my interest has been caught by this. But in terms of the process there are existing school based immunisation programs. I would imagine that data is being collected on those and passed on. I am interested as to why there needs to be specific legislation and the kind of register discussion that you have mentioned today to add Gardasil. You might want to take that on notice and give us a brief on how this works.

Ms Bryant—We can certainly take on notice to give you a brief.

Ms Halton—This issue here is data matching. This is a three-dose—

Senator MOORE—Absolutely.

Ms Halton—Essentially, it is about the follow-up issue: if you get someone who has one, what happens for the next couple? There is the IT issue, which is making sure that you have the tick in the box on the register if you have had it—

Senator MOORE—Or chosen not to.

Ms Halton—Or chosen not to; indeed. In this particular case, because it has a couple of points of intervention there is more complexity and the data-matching and follow-up issues are in a different league, if that makes sense.

Ms Bryant—The register will have capacity to, for example, issue reminder letters and so on to people.

Senator MOORE—I know that we are going to have a discussion in the parliament about passing the legislation, but if we could get some information from you about exactly what is going to be asked and what is involved in this register that would be very useful. Costings would be useful, also. You said that there is an IT amendment that has to go through, and every time we talk about IT we talk dollars. We did not even think about how much this particular element of the roll out is going to cost. There have been some discussions about vaccine shortages because of this coming in so quickly. Is there any discussion about availability and access to vaccine?

Ms Bryant—The states and territories indicated to us what cohorts of girls they would immunise in the particular years—whether is was year 7, year 10, year 11 or whatever. Obviously, we have the ABS data about—

Senator MOORE—How many there are.

Ms Bryant—Yes, how many girls there are in each year et cetera. We went to some pains to carefully map—with the state's proposed immunisation schedule and the population cohort—what requirements there would be. We have sat down with the CSL and ensured that we know when they will have particular dose numbers in the country and have matched them up with the requirements that the states and territories have given us. There is not a vaccine supply issue with Gardasil for the school-based program.

Senator MOORE—What about the 18- to 26-year-old women?

Ms Bryant—There is not a problem with the 18- to 26-year-old women for GPs, either. To an extent, there is a perception of an issue around the older women. That may be because, in some states and territories, it is not 1 July that they will have the doses in the GP fridges; it will be a date in July. There may be some misconception about it not being available from 1 July—but it being available on 10 or 15 July—but, from our point of view, there is no shortage or supply problem.

Ms Halton—There may be a slight misunderstanding here. We need to be very clear that the product is not indicated for a whole group of women who have had more than a certain amount of sexual activity—not to put too fine a point on it—and there may not always be complete understanding of that issue in the community. Obviously, the general practitioners are going to have to be quite careful in how they explain those issues to people.

Senator MOORE—And the media could be useful on that issue.

Ms Halton—The media would be exceptionally useful. I agree with that entirely. I suspect that some of the commentary one sees—and I have seen some of that commentary—may actually be, at least in part, driven by that lack of understanding, as much as a real practical issue around supply.

Senator MOORE—So, from the department's point of view, there has not been a vaccine shortage?

Ms Bryant—There is no vaccine shortage.

Senator MOORE—So no state has come to you and said that they are short or they need more?

Ms Bryant—No.

Senator MOORE—And they have all got the funding they requested?

Ms Bryant—They have all had the vaccine funding. You would be aware that the government announced a further $103 million. That funding was to support the states in the delivery. It was a generous level of funding to support them in the delivery of the program. Going back to your earlier question, that funding also included the developmental costs for the register.

Senator MOORE—Ms Bryant, I think the adjective 'generous' is often not used in the state-federal relationship. So there was funding allocated?

Ms Bryant—It was funding that met the states' request.

Ms Halton—Which means that it was generous.

Senator MOORE—You agreed to give us some information. Does the information you are going to give us indicate the mapping that you have done? Can we get that information?

Ms Bryant—The mapping against the years—

Senator MOORE—The mapping of the numbers and the need.

Ms Bryant—We can give the approximate number of doses that will be administered in 2007 and 2008.

Senator MOORE—You talked about the information exchange between the states and the Commonwealth about the number of women, the expected time and that kind of thing. Is that the kind of data that is going to be available in the brief that you give us?

Ms Bryant—I will have a look at what data we can give you. We can certainly give you the number of doses we expect to be administering in 2007 and 2008.

Senator MOORE—Will that be linked to the figures from the Australian Bureau of Statistics and so on?

Ms Bryant—Yes, we can do that.

Senator MOORE—If we can have that map it would be useful. There has been a fair bit of media commentary on the whole issue, but one thing that has come out is the access to men and boys. There has been a fair bit of publicity in Queensland about the possible advantages of men and young men having access to such an immunisation. Has that been part of the discussion at the Commonwealth level? Professor Horvath, you may want to talk about this. There have been a couple of questions raised with individual MPs about why guys are not getting it as well.

Ms Halton—This comes down to what the company applied for in terms of the subsidy applying to the vaccine. As you know, we have now an approach with vaccines where we take a vaccine through the same cost-benefit test to demonstrate its cost effectiveness. The company did not seek funding in relation to young men. So, in a way, this is an academic discussion. It would ultimately come down to the company deciding that there was a cost-benefit case to be made. I am not aware that they have suggested to us that they might be going to do that.

Senator MOORE—Has there been any general discussion about the public health benefits?

Ms Halton—We are aware of the commentary in relation to this issue. You would be hard-pressed not to be aware of it.

Senator MOORE—So as the company made the application based on access to women, that is what the government has considered?

Ms Halton—Yes. As you would be aware, we had quite extensive discussions via the PBAC in relation to a cost-effectiveness approach for different groups. That is why we have ended up with this package as it now is constructed, with the three different groups.

Proceedings suspended from 10.35 am to 10.52 am

Senator MOORE—The program implementation cost for Gardasil is expensive, at $103.5 million. How does that compare with other immunisation programs? Can you make a comparison with other immunisation programs?

Ms Bryant—The immunisation program is a cost-shared program with the states, so we would not necessarily be aware of all the implementation costs that all the states and territories carry. So it is difficult to make direct comparisons. I can say that the implementation costs for this program that the Commonwealth is funding are higher than for other programs, and that flows in part from the fact that this is a three-dose vaccine. Most other things are a single dose. So, of its nature, it is intrinsically more expensive, simply for that reason.

Senator MOORE—Have Health and Ageing, or your unit, been involved in producing information that can be used by people to promote the system—say, information sheets that senators and members can use in newsletters and that kind of thing?

Ms Bryant—Yes. There is an overall communication strategy, which we have worked on jointly with the communications branch in the department.

Senator MOORE—Your unit has worked closely with your communications branch?

Ms Bryant—Yes, our unit works jointly with the communications branch in the department to develop that material.

Senator MOORE—Is the department aware of which members of parliament have promoted Gardasil in their newsletters? Do you get that information?

Ms Bryant—No, I am not aware of that.

Senator MOORE—Do you have any assessment process as to whether the information that goes out in things like newsletters and senators' and members' papers is appropriate or accurate?

Ms Bryant—We provide brochures and material which we go to some lengths to ensure are accurate and consistent with the product information, the known facts et cetera. We test those with the audiences and so on. So our material that we supply has been subject to thorough testing and assessment and so on. As I said, we are not aware of what material senators or others may issue, nor indeed how they have used material or whether they—

Senator MOORE—None has been brought to your attention?

Ms Bryant—None has been brought to my attention.

Senator MOORE—And no information that has gone out from senators or members about this has been drawn to the attention of the department as a whole, Ms Halton?

Ms Halton—No.

Senator MOORE—Have there been any complaints, either to you or through your much-discussed complaints line, about Gardasil or promotion that has been done?

Ms Halton—I am not aware of any complaints.

Senator MOORE—Has CSL been involved with any of the discussions around the promotional material or the information material that the department has put out?

Ms Bryant—The department developed its own promotional material, through the communications unit and so on, and subjected it to testing. Before its release, as part of the process, we made copies of our material available to CSL as part of our checking process to ensure that there was nothing factually incorrect from the company's point of view. But we did not develop our material jointly with them.

Senator MOORE—In the line budget for this particular process is there an advertising component or a community awareness component for this campaign?

Ms Bryant—There is funding for communication and awareness raising, yes.

Senator MOORE—The communications unit is now coming to the table?

Ms Bryant—Indeed.

Ms Van Veen—There is funding for the communications component to support the program over two financial years, totalling $8.6 million.

Senator MOORE—Have you got a program planned for that?

Ms Van Veen—I have an indicative plan. Given that the campaign is currently running, and we have processed some bills but not all of those bills, we have a phase of activity occurring as we speak—

Senator MOORE—For 2006-07?

Ms Van Veen—That is right. I do not have the split over the next year's budget, but the media component is totalling approximately $6.18 million across two years.

Senator MOORE—What has been allocated so far this year?

Ms Van Veen—There is $190,000 for research, $325,000 for creative, $450,000 for public relations and the web component, $600,000 for information resources—

Senator MOORE—What is an information resource?

Ms Van Veen—Booklets, fact sheets—

Senator MOORE—Printed materials.

Ms Van Veen—That is right. There is $200,000 for campaign support—covering phone lines and additional costs associated there—$50,000 for NESB materials and strategies, and the media figure which I gave you already.

Senator MOORE—Is there any particular component for Indigenous campaigning?

Ms Van Veen—Yes. We have not detailed that specifically in the budget—

Senator MOORE—Can we get details from you as to whether these components were outsourced and to whom?

Ms Van Veen—Yes.

Senator MOORE—I will not take time going through all that. If we could get a brief from you as quickly as possible about those figures, as I know that we always do try. The figures you have given me: are they for 2006-07?

Ms Van Veen—Yes, but the media runs across two years. So I can actually give you those figures in the brief.

Senator MOORE—Could you tell us which company has those particular components, and details of Indigenous strategy would be good as well. The particular need there is something we talked about at a previous time. That would be lovely. Just to clarify: at this stage there is no plan to have a mass rollout for anyone outside the school age years?

Ms Bryant—There is the catch-up program for the 18- to 26-year-olds.

Senator MOORE—But for anyone who wants to have the vaccine, is there any plan for a mass rollout?

Ms Bryant—No. There is the 18 to 26 program through GPs and so on, where women in that age group can have the vaccine. In any case, the vaccine is not approved for use outside the specified age range that the government has funded under the immunisation program.

Senator MOORE—Fine. That's it. Thank you.

Senator LUNDY—I would like to ask some questions about the Building a Healthy, Active Australia program. How many grants were issued under the Healthy School Communities program?

Ms Bryant—Approximately 7,000, I am advised.

Senator LUNDY—What was the monetary value of the grants allocated under this program?

Ms Bryant—Do you want the value of each individual grant or the total?

Senator LUNDY—Just the total.

Ms Bryant—The amount spent was $10.3 million.

Senator LUNDY—Was there any unspent funding in this Healthy School Communities program when it closed in December 2006?

Ms Bryant—There was $3.9 million.

Senator LUNDY—Where has that unspent $3.9 million funding been reallocated to?

Ms McDonald—There are plans to look at where there was good practice across the schools that received those grants and to then distribute information to schools across Australia to help them initiate activities based on those good practice activities—so, an evaluation program.

Senator LUNDY—Is that $3.9 million going to facilitate that exercise?

Ms McDonald—That is the proposal at this point in time.

Senator LUNDY—How much was spent in each year of the grant program's operation? If it was $10.3 million—how much in 2004-05 and 2005-06?

Ms McDonald—I am sorry, I do not have that level of detail at this point in time.

Senator LUNDY—Do you have a list of the breakdown of grants?

Ms McDonald—In each year? No, sorry, not with me today.

Senator LUNDY—What about the grants to each school?

Ms McDonald—The grant program was based on a $1,500 grant to each school. There were some schools that got less than that and there was also a GST component built into the total calculation. The grant itself was $1,500 to most schools.

Senator LUNDY—Do you have a list of the schools that got it?

Ms McDonald—Yes, we can do that. I understand that most local members have already received lists of the schools in their electorates that received those grants.

Senator LUNDY—It will not be any problem providing it to the committee then?

Ms McDonald—No, it will not.

Senator LUNDY—It would be good if that could be provided today. Could you also find out today what was the spend in each of the financial years of the program? I am interested in that.

Ms McDonald—Certainly.

Senator LUNDY—I am aware that in February 2006 only $760,000 of the funds had been allocated to schools, so I am presuming that means that over $9 million was allocated between February and December 2006. Is that true?

Ms McDonald—Let me check the details that I have here. The allocation that I have for the 2005-06 financial year was $10 million.

Senator LUNDY—If at February 2006 only $760,000 was spent, that means that between February and the end of June over $9 million was allocated.

Ms McDonald—The allocation for that financial year was $10 million. I cannot clarify that that was how much was actually spent, but that was the primary period in which those grants were distributed.

Ms Halton—That was to do with the school year. Because it was an allocation to schools, at the beginning of the school year invitations went out. It was about the school year.

Senator LUNDY—Do you have any document that would describe what you are going to do with the $3.9 million underspend?

Ms McDonald—There is a proposal being considered internally within the department at the moment, but that has not been released at this stage.

Ms Halton—And that will be a decision for the government. The government will have to decide.

Senator LUNDY—So you have not decided yet but there is a proposal?

Ms Halton—Yes.

Senator LUNDY—You mentioned that that would relate to evaluation. Did the program have an allocation for evaluation of its effectiveness planned prior to be underspend?

Ms McDonald—Not specifically allocated within the budget allocation.

Senator LUNDY—Why not? Do you not evaluate things you spend money on?

Ms McDonald—There was process evaluation built into the departmental funding for that. However, given that this was a $1,500 grant to schools, from the information we were able to collect back from schools it was quite difficult to do a sophisticated analysis of the actual outcome other than the fact that the money was spent on the project that it was allocated to.

Senator LUNDY—So now you might decide to spend some money on evaluating whether those projects were in fact effective?

Ms Bryant—We are documenting and disseminating best practice so that we can encourage the take-up of the most productive ideas.

Senator LUNDY—Why was there an underspend?

Ms Bryant—It was about the number of schools that applied.

Ms Halton—Basically the schools were all invited to apply. Some of them chose not to. That is a question for them. As has been indicated, the trick now is to actually disseminate what we regard as being the best practice examples of what they actually used the money for. I think a number of the people at this table, you included, could probably cite what we know a number of the ACT schools did with it. Essentially it was a matter for schools whether they chose to participate.

Senator LUNDY—What proportion of primary schools accessed the $1,500 grant?

Ms McDonald—My understanding is that the 7,000 represents about 70 per cent of all eligible schools. That was across both primary and secondary.

Senator LUNDY—Were any applications for the funding received after the closing date?

Ms McDonald—No, there was quite a considerable amount of notice given that, until the end of the school year in 2006, applications would be received. We have had no further applications. However, there was other information about new programs which would have impacted on that.

Senator LUNDY—What is your analysis of why only 70 per cent of schools accessed the program?

Ms McDonald—We have not done any specific analysis of that. I presume that timing was an issue for some schools. There would have been other opportunities for funding. The size of the grant and how that fit in with the activities they were planning could also have been a factor. There are a number of reasons that have been postulated, but I do not think we could make any specific comment on why that happened.

Senator LUNDY—The government is going to fund a $10.6 million survey on nutrition. When did the work on the national nutrition and physical activity survey commence?

Ms McDonald—I think it probably would be appropriate to say that work on that has already commenced.

Senator LUNDY—That is what I asked: when did it commence?

Ms McDonald—In the context of consideration of the budget. This is also an issue that has been under debate for some years. There has been quite a bit of thinking about how this would happen. It flows on from the current activity in relation to a children's survey. So a lot of the planning for the children's survey, which is actually underway at the moment, will inform the adults' and additional surveys funded in this year's budget.

Senator LUNDY—So when can the Australian public expect results from the survey to be released?

Ms Bryant—The survey announced in the budget will be conducted in the field in 2009 and therefore the results will be released roughly 12 months later.

Senator LUNDY—So it will be in 2010. Why will it take until 2009 before the survey is actually conducted?

Ms Bryant—There is quite a lead-up process, as you would be aware, with things like the census and ABS surveys and so on, where the instruments have to be designed and field tested. So there is an extensive lead-up process to making sure you get valid data in the field when you ultimately go out.

Senator LUNDY—I am sure. How much has been expended on the national survey so far?

Ms Bryant—The funding for the survey does not commence until the 2007-08 year, so we have not expended the budget—

Senator LUNDY—Do you have a notional allocation against it or a preparatory effort within the department?

Ms Bryant—The budget funding was announced in the budget context; we do not give the break-up of the forward estimates period.

Senator LUNDY—So there is nothing in the current financial year that is assigned to that.

Ms Bryant—No. There is nothing in the 2006-07 financial year on this specific survey. We are expending money on the children's survey.

Senator LUNDY—How many people will the survey canvass?

Ms Bryant—Around 14,000.

Senator LUNDY—How many of those will be children?

Ms Bryant—The survey announced in the budget is an adult survey, so it covers adults aged 17 years and over. It is not sampling children.

Senator LUNDY—How many children does the children's survey that is underway survey?

Ms Bryant—It is 4,000.

Senator LUNDY—When are the results of that expected to be in the public domain?

Ms Bryant—We will get the results at the end of 2007. It would be a little while after that, but I would imagine in 2008.

Senator LUNDY—When is that survey in the field?

Ms Bryant—It is currently in the field.

Senator LUNDY—How regularly will national nutrition surveys be conducted? What was provided for in this budget for the survey to be done again—or is it for a one-off survey?

Ms Bryant—The funding is ongoing, so it is for a rolling program of surveys. At this stage, part of our early implementation work will be consultation with state and territory governments about the type of information that they are interested in from the survey, from those with the capability of conducting the survey and so on. We will certainly do that main survey in 2009, and we envisage that we will repeat it at an interval of five years plus, but in the interim there may be surveys of subpopulation groups—for example, Indigenous people that we particularly want to target in the intervening periods. So it will be a repeated and regular survey.

Senator LUNDY—Is that the same for the children's survey?

Ms Bryant—The children's survey will be part of the ongoing program.

Senator LUNDY—So you will combine them; you will do both children and adults in the subsequent rounds of survey.

Ms Bryant—We will look at children again. I do not think we have made a decision about whether we will do it as a combined instrument or whether we will continue to do them separately on a rolling cycle. Both will be repeated.

Ms Halton—That is essentially a methodological issue for the Australian Bureau of Statistics to give us some advice on: the question of whether you are best to pick up children together with adults in the same sampling methodology. I think it is just a technical question that needs to be answered.

Senator LUNDY—Given that we have to wait till 2010 for the results of this survey—and this is one for the minister—why has it taken the government so long to commence the survey? Why has it taken the Howard government so long to make the appropriate allocation to permit this survey to occur? Particularly now that we will not see the results of the children's one until, realistically, 2008 and we will not see the one announced in the budget till 2010, why has it taken so long?

Senator Mason—I did not think there had been any delays.

Senator LUNDY—I beg your pardon?

Senator Mason—I did not think there had been undue delay.

Senator LUNDY—Well, it has been discussed for quite some time, and the point was made in the public debate about the desperate necessity of such a survey.

Senator Mason—I take notice of your question.

Senator LUNDY—Thank you. And I note that you did not answer. I turn to the CSIRO Wellbeing Plan for Children. Why was the development of a book focusing on healthy eating and physical activity announced by the minister for education rather than the minister for health?

Ms Halton—Perhaps I could give some context to this. You probably are aware that it was announced that there was a ministerial task force looking at this whole area. A number of ministers participated under the chairmanship of Minister Abbott. The range of measures announced in the budget included initiatives across a number of portfolios. In this particular case—given that the initiative is being administered and, obviously, delivered by the CSIRO, which is in the education portfolio—I think you will see there are references to it in various places, but that is why you will see it in Ms Bishop's announcement.

Senator LUNDY—Right; thank you. Where will the funding for this plan come from—the Department of Health or the CSIRO?

Ms Halton—It was part of the allocation of funding to the issue as a whole. It is appropriated to the department of education.

Senator LUNDY—The CSIRO particularly, or the department of education?

Ms Halton—I cannot talk to the structure of their appropriations, but what I can tell you is that it is in that portfolio. So it is not that it is appropriated to us and then we hand it to them. There was the one process of considering all the initiatives, but the money has been appropriated to them.

Ms Bryant—Could I add to that? Of the $3 million allocation, $2 million goes to the DEST portfolio and $1 million comes to the health portfolio. Our $1 million goes to updating some of the underpinning scientific resources like the dietary guidelines.

Ms Halton—But the doing their bit is with them—is with the DEST portfolio.

Senator LUNDY—Yes; thank you for that. You mentioned the ministerial task force on this issue. How did the department of health become aware of this project? I presume the answer to that is, 'Through the ministerial task force'. But to what extent was this policy

driven through health and the needs of children's health, as opposed to from the CSIRO—or, indeed, DEST or the minister?

Ms Halton—Well, here you are coming to respective views about who is running what. I am sure that if you ask the education portfolio they will tell you that it was all their idea and they are in charge! And if you ask us we will say the same thing. It is fair to say that there was, amongst the ministers, a discussion about the range of things that could be done, children's health being one of them, and from that emerged a number of ideas. So it would be unfair of me to say ownership is vested in any one department. I think 'collaborative effort' would be the right way to describe it.

Senator LUNDY—I have a couple of questions about the CSIRO funding, but we have not yet established whether the $2 million going to DEST goes to DEST or, indeed, the CSIRO. Are you able to shed any light on this, given that it is not your portfolio?

Ms Halton—You would have to go next door; they are just in there, Senator.

Senator LUNDY—Okay. From the health department's perspective, is it appropriate to call a book aimed at children's wellbeing a 'diet book'?

Ms Bryant—We do not call it a 'diet book'.

Senator LUNDY—What is it called? The first one was called the CSIRO Total Wellbeing Diet. Is this the CSIRO children's wellbeing diet?

Ms Bryant—It will be called the 'wellbeing plan'.

Senator LUNDY—The 'wellbeing plan for children'—and is that because the view is that 'diet' is an inappropriate term when dealing with children's nutrition and wellbeing?

Ms Bryant—Yes.

Senator LUNDY—Good!

Ms Bryant—The emphasis is not on diet or dieting.

Senator LUNDY—Good; that is the correct answer, as far as I am concerned!

Ms Halton—Of course, Senator, if I were to get one of my nutritionists up here they would say to you that we all have a diet and it is appropriate that our diet is appropriate. It depends on whether it is a verb or a noun.

Senator LUNDY—Indeed. Another correct answer! Given that the department is aware of the issue of growing eating disorders amongst children and adolescents—and I am sure that you are as familiar with this disturbing statistic as I am—has any assessment been done on the possible negative impact from promoting a wellbeing plan aimed at children, albeit not a diet book aimed at children?

Ms J McDonald—In the initial discussions that we have had with the CSIRO in the last couple of weeks, they have been very sensitive to the issue around eating disorders. In terms of the input into that book, we will not only ensure that the information and research that we have will be based on our usual nutrition issues but also seek advice around how to handle that issue in the way the book is presented. It is absolutely clear that this is not about weight loss. Everything in it will be focused on healthy eating and physical activity.

Senator LUNDY—In the original announcement the impression was certainly given that a CSIRO diet book for children was going to be prepared. Is it now acknowledged by the department and the government that the connotation of the word 'diet' is completely inappropriate to use in association with anything to do with the wellbeing of children?

Ms Halton—I actually did not see that as a focus. I think that may have been in some of the media reporting.

Senator LUNDY—I think that is right. But because we are dealing with perceptions and negative connotations, it still has validity in the public debate as a point to make.

Ms Halton—But you used the language 'Do you now acknowledge?' and I think it is important to understand that, all the way through the process, we have actually been very conscious of a need for a level of care about language in this area. I think you are rightly pointing to what is an easy misconception to be generated in the community. We have to find ways of making sure that the language is as clear as possible. But I do not think there has been a change—which was the implication in your question—in our understanding of the need for great care in this area. And I am absolutely confident that the CSIRO is very aware of that as well.

Ms Bryant—In our documentation, we have always been at some pains to ensure that that is reflected.

Senator LUNDY—In your recommendations?

Ms Bryant—In our documentation we have always been careful about the language that we have used around this and how it is described and expressed. We have never linked it with the concept of diet, dieting or any of those things.

Ms Halton—But you are quite right to say that, in some of the media reporting after the budget, there seemed to be a shorthand used in some of the press reports.

Senator LUNDY—I suppose in defence of the media reports, because the CSIRO diet is the CSIRO diet, there was a natural link drawn.

Ms Halton—Yes, you can see how it has happened—absolutely. It has always been clear, from the initial discussions, in decisions and in the material that has been put out—that this about a plan and wellbeing.

Senator LUNDY—Are you able to provide the committee with any of that material that can reassure us that that has been the department's position?

Ms Halton—No. Obviously, we do not release bits of policy material that goes to advising government.

Senator LUNDY—Has there been any correspondence to the CSIRO expressing this view that could be provided to the committee?

Ms Bryant—There are the fact sheets issued in the budget context and so on.

Ms Halton—We will get you some of the material that goes to this issue.

Senator LUNDY—Sure, but could you take on notice to provide any correspondence between the department and the CSIRO and/or DEST that does not constitute policy advice and therefore falls within the realm of things we are able to ask for?

Ms Halton—Sure.

Senator Mason—Senator Lundy, you are right to highlight the sensitivity of the language. It is not something that I particularly thought about.

Ms Halton—It is a real issue.

Senator LUNDY—Thanks. I would now like to go to newspaper reports of early April that flagged—

CHAIR—Senator Lundy, before we leave that subject, I think Senator Stott Despoja had a question in that general area.

Senator STOTT DESPOJA—I will wait until pregnancy counselling. I might put my questions on notice in relation to that. Thank you, Chair, for remembering us.

Senator LUNDY—There were some newspaper reports in early April that flagged the education minister's plan to weigh year 5 children. Was the department of health consulted about this plan, particularly since, later, it was dismissed by the Prime Minister as being too prescriptive? What is the department of health's knowledge about a plan to weigh, measure and assess the height, weight, body mass index, BMI, and level of fitness of year 5 students?

Ms Halton—I am aware of that. I think that issue was discussed by the education ministers a month or two ago. I am aware that there had been a proposal. I do not know where it originally came from; I think it was probably from an academic expert, but it would take some level of forensic analysis to work out whose idea it was in the first place. I am aware that was a debate around a year 5 physical assessment. I know there was discussion by the education ministers as to whether this was something that should be part of the regular testing arrangements. I do not think there was universal support for it.

Senator LUNDY—But I understand there was a discussion paper released by the minister, outlining the proposal of this new testing regime.

Ms Halton—Yes.

Senator LUNDY—Can you confirm that?

Ms Halton—I am told that; I have not seen that piece of paper. We can certainly go and inquire whether it was actually released. I have heard it said that there was a piece of paper. I have not seen it, so I can neither confirm nor otherwise.

Senator LUNDY—Can I take it from that that you were not consulted in its drafting?

Ms Halton—We were consulted about the idea that was in the public arena in relation to testing. We provided policy advice in that context, but obviously we cannot comment about what happened in the debate when it got into the education ministers' arena. But we were party to the policy process, yes.

Senator LUNDY—What is the department's view on the health benefit of conducting such a test?

Ms Halton—Now you are asking us for a policy opinion.

Senator LUNDY—Did you determine a position as a department on that particular proposal?

Ms Halton—We did, but it would be inappropriate for me to say what advice I gave in relation to that matter.

Senator LUNDY—So will it go anywhere? Is it still a live proposal under consideration?

Ms Halton—You would have to ask Education that in relation to whether or not they think that the state education portfolios have a particular interest, recognising that it was an initiative to be delivered in an education setting.

Senator LUNDY—What involvement does the department now have with that type of proposal, given—I am making the reasonable assumption—that any such effort would have to involve the department of health intimately?

Ms Halton—Certainly to the extent that, if it looks like there is going to be support for it, it would be my expectation that we would be consulted in some detail, yes.

Senator LUNDY—And you have not been?

Ms Halton—My understanding is that the state ministers indicated a lack of support, and I am not aware that it has been pursued since that time.

Senator LUNDY—So in your considered opinion it is not currently under active consideration by the minister for education?

Ms Halton—I could never be seen to be speaking for the minister for education.

Senator LUNDY—But you are not aware of it?

Ms Halton—We are not aware of it.

Senator LUNDY—Minister, I suspect you would not be able to shed any light on this, but feel free to jump in if you can.

Senator Mason—I will where appropriate.

Senator LUNDY—Thank you very much.

CHAIR—Talking of jumping in, I am going to jump in soon and give someone else a go. Do you have many more questions?

Senator LUNDY—Just a couple more. The government will provide $11.7 million over four years for one-off grants to organisations for physical activity initiatives. Have the criteria for the distribution of these grants for physical activity projects been developed yet?

Ms Bryant—The guidelines for the program are currently being developed. We expect the program will be advertised in late July or early August and therefore the guidelines will be available before then. But they are not available at the moment. There is a focus on adults in general. Indicatively, grants will be available for between $200,000 and half a million dollars for up to two years.

Senator LUNDY—If you average out the amount that they can apply for at, say $350,000, how many organisations can receive grants? Sorry, I do not have my calculator here.

Ms Bryant—Nor do I.

Senator LUNDY—We will find out. What are the predicted outcomes of this program? What are you hoping to achieve, and have you built an evaluation structure into these grants?

Ms McDonald—There is no specific planning at this stage for suballocations of money within it. There is not a specific budget allocation for evaluation but, with grants of this size, it would be expected that there would be evaluation components both at the local and program levels. The issue to be addressed is encouraging additional physical activity for people in the adult age group. We know that is when people stop being active, particularly younger adults and older adults. It is aimed at community programs, so that people can have affordable and accessible opportunities within their communities.

Senator LUNDY—I know that you are still working on the guidelines, but will you have key performance indicators, such as hours of physical activity per week that have been increased? Is that the idea?

Ms McDonald—That level of detail has not been considered. I think that would be fairly difficult for us to measure in a program sense but, depending on what sorts of programs we are evaluating, we will target the performance indicators to the programs themselves.

Senator LUNDY—I have a very important question for you. Is the aim of this program to increase the physical activity of the people it is targeting for the period of the application of the grant, or is the aim of this program to change their behaviour for the long term?

Ms McDonald—Our aim would be to look at behaviour change and sustainable behaviour change over time. Hopefully some of these projects will be able to continue beyond the funding period.

Senator LUNDY—Given my experience in community development, a minimum of three years is required to even consider changing behaviours, and then a plan is required for an ongoing investment to ensure the program does not just stop.

Senator Mason—Sorry, how many years?

Senator LUNDY—At least three years, and current thinking says that if you are looking at attitudinal behaviour or change, you are looking at five-year programs to have a solid impact in the community and really change behaviour.

Senator Mason—Right through high school, in fact?

Senator LUNDY—No. We are talking about adult community—

Senator Mason—I am talking about in the context of doing it right through high school.

Senator LUNDY—No, the context of this is adult-based program. It is geared at adults where there is, I presume, a perceived drop-off in physical activity in their behaviour. Can you comment on that and how you have reached the conclusion that a two-year program will be effective in achieving those aims?

Ms Bryant—At this stage we are managing a budget allocation, and decisions about ongoing funding are things we will have to come to a little down the track. But, certainly, as Ms McDonald said, a lot of the type of initiative that you see funded through this program—and they include things like healthy walking groups and so on—are things that perhaps need

an injection of seed funding to get them going but are activities that are quite capable of being sustained in the longer term.

Senator LUNDY—Has the department based your funding decision for this program on proven best practice in health promotion? Two years implies that you have not.

Ms Halton—It is not a departmental decision; it is a decision of government in relation to the funding that has been allocated by the budget.

Senator LUNDY—Has the department provided the government with information on best practice health promotion models?

Ms Halton—You are asking me to give you information about policy advice that was provided, and I cannot.

Senator LUNDY—I just want to know whether to blame them or to blame you.

Senator Mason—You can blame me, Senator Lundy. That is fine. I am following your questioning. Your argument is that two years is insufficient to change behaviour.

Senator LUNDY—I am making the assertion that two years of program funding of this nature is not proven best practice in health promotion and that a longer period is recognised as being necessary. So my question—which I know you will not be able to answer, but I will give it a shot—is: did the government ignore the department's advice on proven best practice in health promotion funding in only allocating funding for two years for this project?

Senator Mason—I am not aware of that, and I am not aware that three years is the optimum amount of—

Senator LUNDY—I am not saying three years either but, based on some very limited knowledge that I have, I would expect that three years would be the absolute minimum and that five years is recognised as the necessary minimum amount. Even then, if you are looking at changing behaviours with these programs, the concept of seed funding is not necessarily considered as being the right approach to this—ongoing investment is what is required.

Ms Halton—The decision as it was announced does not preclude ongoing funding, but that was the decision the government took about the allocation in the first instance.

Senator LUNDY—For the second half of the year of the grants in operation, they will be worrying about applying for the next year's funding, which is part of why it is not such great practice.

Senator Mason—Perhaps we might argue that we are also hopeful that people take personal responsibility—

Senator LUNDY—Yes. This is of course where it all comes back to for the Howard government, isn't it Senator Mason?

Senator Mason—I think personal responsibility is very important.

Senator LUNDY—You don't think that the government should take any responsibility at all for promoting health in the community, do you?

Senator Mason—No, we do.

Senator LUNDY—You do because you are funding this, but you keep coming back to that as a backstop. It is very interesting.

Senator Mason—I think the Labor Party believes in personal responsibility as well.

Senator LUNDY—We are interested in health promotion Senator Mason. There is a point at which, if you are going to do public policy, it is always wise to do proven best practice public policy otherwise you can end up doing a bit of damage.

Senator Mason—I agree. But we are not sure where the three-year—

Senator LUNDY—I am not saying that three years is optimal. I am saying that best practice is a longer term investment if you are hoping for any attitudinal changes. I asked the question 'what is the aim of this program?' The answer was 'to change behaviour', not to get people moving more during the period of the function of the grant. It is about testing your aim against—

CHAIR—We need to move to questions and we might be able to come back to those issues you are raising in a little while.

Ms Halton—I should make an observation on the purpose of the program. Programs have multiple purposes one of which is just to get people moving, so I think we need to understand that.

Senator LUNDY—I asked the question before I proceeded down that path. I do have a few more questions but they will come later on.

Senator STOTT DESPOJA—I want to turn to the issue of pregnancy counselling, in particular the government's helpline, and if we have time, the MBS item number. I begin by acknowledging the assistance the department has given a number of us with questions and advice and in providing informative briefings. That has been greatly appreciated and has helped us in our understanding of what has been happening. There are some issues I want to get on record today and some that build on the discussions we have had. I am sure my colleagues have plenty of questions as well. How many calls has the helpline has received? Media reports around 17 May suggested about 68 calls. Is that able to be confirmed publicly?

Ms Bryant—As at 29 May, 93 calls had been answered by the helpline.

Senator STOTT DESPOJA—Obviously there has been some discussion about whether that is a large number of calls. We are talking about very early days and a lack of, or minimal, advertising, which I will get to. On record, is there anything to which you or the department attribute that relatively small number of calls in the first month? Or do you not consider it a small number of calls?

Ms Bryant—It goes to the things you have already spoken of. It is very early days. Awareness and passage of time might see some growth in that number.

Senator STOTT DESPOJA—When the tenderers were invited to apply and were requested to indicate pricing for service activity, what was the anticipated number of calls per month? My understanding is that the levels of service requested were 1,000-1,500, 1,500-3,000 and 3,000-plus. Does that indicate that the department was expecting around 3,000 calls

a month to the helpline—again with the proviso that it will be different from the early stages? Is that the anticipated number of calls?

Ms Koukari—There had been some modelling on the possible number of calls, but we clearly were not certain of the take-up rate for the helpline. The reason we set a minimum number of calls was so that we could ensure that there was the capacity and the infrastructure available to support a good, functioning helpline.

Senator STOTT DESPOJA—You said 'a minimum number of calls'. Are you saying that the 1,000, the lower end of the spectrum, was an anticipated minimum number of calls?

Ms Koukari—No. It was simply to ensure that there was capacity within the organisation to support a helpline at a national level.

Senator STOTT DESPOJA—Have you costed or did you anticipate the cost of each call to the service? I know that is obviously an interesting calculation to make in advance. Would you care to also make a calculation now as to what each call, based on that figure, is costing the service?

Ms Koukari—We were not in the position to determine what we would expect to be a cost per call until we had the tenders in with a price for the overall tender, but I can certainly tell you the cost per call that we are having now, given the reasonably low take-up in the first month. The cost per call at the moment is $445, excluding GST.

Senator STOTT DESPOJA—Obviously you would presume that that figure would be reduced as, obviously, logically, the number of calls to the service increases.

Ms Koukari—That is right, yes.

Senator STOTT DESPOJA—And you do anticipate an increase in the number of calls to the service?

Ms Koukari—Yes.

Ms Halton—Senator, as you have rightly pointed out, the advertising arrangements for this have not actually kicked in yet. My expectation has always been that we would have a very slow start. Actually that has probably been a good thing: it means that people can get settled in in terms of the service delivery arrangements. But as that advertising comes online—and we have talked in the past about this being quite narrowcast; it will not be the mass advertising that we have with some of our health promotion approaches—that approach will target the places, and the people, therefore, who we think may want to use the service, and I would therefore expect to see the numbers go up. As you quite rightly say, then the average cost will come down quite significantly.

Senator STOTT DESPOJA—We might explore advertising in more detail. Ms Halton, you have just talked about targeted advertising. Maybe I will go back a step. First of all, has the advertising campaign commenced in any form?

Ms Van Veen—It has not commenced. It commences next week, at the start of June. We have in place a range of elements that will roll out over the month of June in an ongoing capacity. As Ms Halton said, we are looking at targeted advertising. That is, convenience advertising—which is on the backs of toilet doors—posters and wallet cards in doctors

surgeries, pharmacies, counselling services, educational settings, family planning clinics and Aboriginal medical services. So there is a range of settings where we can find our target audience. As well, there are other activities there—*Yellow Pages* advertising, *White Pages*, Google search marketing et cetera.

Senator STOTT DESPOJA—There are lots of questions there. First of all, when you say 'June', do you mean 1 June—that is, this Friday?

Ms Van Veen—Yes, 1 June.

Senator STOTT DESPOJA—So this week?

Ms Van Veen—Yes.

Senator STOTT DESPOJA—When you talk about wallet cards and other forms of advertising—pictures on the backs of toilet doors, or statements—have you got examples that you can table for the committee?

Ms Van Veen—I can certainly provide those. I do not have them with me today, but we would be happy to provide those.

Senator STOTT DESPOJA—I would be very curious to have a look at those. The original budgeted amount for advertising was $2.4 million over four years—is that correct? Is that on track, still? Is that still the amount that the department has for advertising of this service? I am assuming I am right about the $2.4 million; I am happy to be corrected.

Ms Van Veen—I have $2.5 million.

Senator STOTT DESPOJA—It is climbing; it has climbed in 20 seconds. My apologies.

Ms Van Veen—Certainly the intention at this stage is that the funding we have in place will rollout ongoing advertising. I do not have the splits over the future years, but that is the intention.

Senator STOTT DESPOJA—And what about the money that has already been spent?

Ms Van Veen—I can give you some of those costs. As at 1 May not a lot of funds have gone out the door given that a lot of the bills would literally be arriving in the next month or so.

Senator STOTT DESPOJA—I understand.

Ms Van Veen—Do you want to know what we have covered to date?

Senator STOTT DESPOJA—Anything you can provide would be great. My colleagues might have questions on this as well.

Ms Van Veen—For research there has been $99,000 spent. For the actual development and testing of the products there has been about $7,000 spent on creative design for print materials. The rest of the costs really have not come in at this stage.

Senator STOTT DESPOJA—Who has been responsible for the creative design of those materials?

Ms Van Veen—We have had The Furnace creative advertising agency for the convenience advertising. We did have some early design work done on publications through creative design and ma@d Communication to look at some different design options.

Senator STOTT DESPOJA—Is the department responsible for overseeing and authorising through the government those designs? I am wondering what involvement if any McKesson have as the successful tenderer for the service and the running of the service. Are they involved in any of those creative decisions?

Ms Van Veen—No.

Senator STOTT DESPOJA—I was not sure that they would be. I turn now to the location of and places where the wallet cards and the advertising will be made available. You have mentioned counselling services, GPs, education facilities, family planning clinics, Indigenous services et cetera. When you say 'educational' facilities does that mean schools and universities?

Ms Van Veen—Yes.

Senator STOTT DESPOJA—I am interested in what is on the advertising. Obviously my specific interest relates to transparency in up-front information. Are you able to indicate, either in the form of tabling information or telling us now, the nature and the composition of either the wallet cards or the advertising material? If you can tell us now then I can ask you specifically about it. Otherwise you could probably pre-empt the questions I am going to ask in relation to the nature of that advertising and what it specifies.

Ms Van Veen—The advertising provides a national pregnancy support helpline. It offers nonjudgmental support for unplanned pregnancy and provides details around the free call arrangements. It is predominantly focused on those key aspects of information. I am not sure whether we can provide you with this today, but we will get you copies of the wallet card and the other elements.

Senator STOTT DESPOJA—In relation to the provision of referrals, is there any statement on the advertising that explains that no referrals or generic referrals are provided by this service?

Ms Van Veen—No. There is no reference to that.

Senator STOTT DESPOJA—So there is no statement that indicates what referrals are provided or more specifically that referrals are not provided?

Ms Van Veen—There is no statement.

Senator STOTT DESPOJA—I might put more questions on notice on that. Unless colleagues want to pursue the advertising issue, I am quite happy to move on to some privacy concerns. I have raised these issues with you publicly and privately. Let us start positively with some privacy questions. Senator Mason, this is your area of specialty, isn't it?

Senator Mason—Not any more.

Senator STOTT DESPOJA—It has been confirmed to us, and publicly as well, and I want to go through some of the issues in relation to privacy in terms of the helpline. The calls to the service are recorded, are they not?

Ms Koukari—That is correct.

Senator STOTT DESPOJA—And it has been confirmed that that information will be held for a period of seven years, is that correct?

Ms Koukari—That is correct.

Senator STOTT DESPOJA—One thing I was curious about, and I acknowledge that we did explore this in some of our discussions, was the seven-year period. Was there a rationale for seven years? I understand that both the tape of the call and the file that relates to the person who calls the service will be saved for seven years. Is there a rationale for the seven-year period?

Ms Bryant—All of the material is covered by general privacy legislation. In addition, there is medical records legislation at a state and territory level. The detail of it does vary, I am informed, from state to state. McKesson aims to meet the longest requirement, the longest period, so it basically goes for the state which has the lengthiest requirement, and that is a requirement to maintain records for seven years in respect of adults and 25 years for a child, which is seven years from the age of 18.

Senator STOTT DESPOJA—What is the rationale for McKesson maintaining this documentation or, indeed, recording phone calls?

Ms Bryant—They keep written records and audio records—both considered to be medical records, as they contain personal health information provided in the context of a health service. The written record is essentially to ensure that there is a case history for future counselling sessions to enable continuity of care should the individual choose to call back or whatever, and to provide a record should there be any complaints about the quality of the counselling provided. The audio record essentially serves a similar purpose, and it can be used for quality and training purposes. For example, they could ultimately be subpoenaed in the case of a coronial inquest or something if there were a very unfortunate event. They exist for the same purposes; it is a written record, plus it is for the purposes of quality and training.

Senator STOTT DESPOJA—These calls are, of course, on an opt-out basis, so men and women can opt out of having their call recorded.

Ms Bryant—That is right. All callers are notified in a message at the start of the call that the call will be recorded unless they request that it is not recorded.

Senator STOTT DESPOJA—Do we know why the opt-out provision was supported over an opt-in provision? Was that a consideration of either McKesson or the department?

Ms Bryant—I think that in general it is a fairly standard practice across these types of lines for other services. Some of them are gambling services or whatever else; it is a fairly standard provision. It is also there for gambling or health lines that they provide more generally.

Senator STOTT DESPOJA—Could you take that on notice and provide some examples of other health lines that assume people will opt out, as opposed to opt in, on having their sensitive discussions recorded and kept for a minimum period of seven years? I am not talking about gambling hotlines; I obviously know that is an example that has been provided by both McKesson and the department. You have explained that these records are subject to

various privacy legislation, medical records legislation and the NPPs. If it is a medical record, presumably people can ask for the return of that medical record or for access to view that medical record.

Ms Bryant—As I understand that—and, if necessary, I will get some more details from my colleagues—people can ask to access records. In the main, records would not simply be handed over to the individual, because they have to be preserved. Were an individual to draw attention to some fact that they considered to be in error, my understanding is that original record is not altered in substance; it is recorded as an addendum.

Senator STOTT DESPOJA—This gets to the heart of some of the queries I had. We have established that people can access their record and that the record cannot be returned to the individual.

Ms Bryant—My understanding is that it cannot be destroyed or deleted.

Ms Koukari—That is right.

Senator STOTT DESPOJA—It cannot be destroyed at the caller's request—the client's request ?

Ms Koukari—No, because it is covered by the legislation.

Senator STOTT DESPOJA—Remembering that we are dealing with a number of pieces of legislation and regulation, if that record constitutes a medical record can it be transferred to their GP, at the request of the caller?

Ms Bryant—I understand—and this is a fact I will need to check on—that if, for example, a GP ceases practice, they can transfer details of medical tests or whatever to another GP, at the individual's request, but the doctor's own patient notes are required to be archived; they cannot be transferred. That is a fact about medical legislation on which I will need to confirm the facts for you.

Senator STOTT DESPOJA—I guess this goes back to conversations and queries I have had earlier about why these requests are subject to medical records and privacy law as opposed to either general privacy law, state and territory privacy law or, as Senator Mason would know, the National Privacy Principles. I want to know if people have the opportunity to access—and, indeed, correct or amend—information held about them that they deem to be incorrect. Obviously, there are different standards and regulations and law for medical records, as well as for other general types of information.

Ms Bryant—My understanding is that they are medical records because they contain personal health information provided in the context of a health service. So they are captured by the medical records legislation. As I understand it, the process is that the individual can access the record and they can correct the record by way of an addendum to the record.

Senator STOTT DESPOJA—Who has access to those records—that identified information about the individual? Is it only McKesson, as well as the individual?

Ms Bryant—It is only McKesson, as well as the individual. The department has no access to the individual records. We only have aggregated data.

Ms Koukari—That is correct. In fact, only certain individuals within McKesson have access to the records. For example, even the IT people do not have access to individual records.

Senator STOTT DESPOJA—That information is obviously maintained and owned by McKesson, not the department?

Ms Koukari—That is correct.

Senator STOTT DESPOJA—In the event of a different tenderer operating the helpline, that information would be maintained by McKesson and would not go to the new operator?

Ms Koukari—That is correct.

Senator STOTT DESPOJA—Do you envisage that there would be no additional information derived from those records? There is no reason the department would request information that relates to those records?

Ms Bryant—No. As we have discussed on previous occasions, we get aggregated data about the number of calls and the duration of calls, and I think we can get a break-up of which state or territory the calls come from—the sorts of things that inform the design and adequacy of the service—but we get nothing at all about the individual calls.

Senator STOTT DESPOJA—During additional estimates in February, the department stated that, under the contract, McKesson is required to ensure the confidentiality of client information through a data security plan and a privacy protocol. Perhaps you could give us a detailed account as to what is involved in the data security plan and the privacy protocol for McKesson.

Ms Bryant—We can give you that; it is quite extensive information. It may be more helpful to provide you with the privacy protocol.

Senator STOTT DESPOJA—Okay. I might then come back to that. As you can see, I am still grappling not just with what they use to ensure they are responsible for the privacy of this information but how this operates in relation to medical records and other privacy law. I am trying to work out how McKesson manages its responsibilities—that is, its Commonwealth privacy obligations, performed under contract—versus its general privacy obligations under the National Privacy Principles. I am not confident that I have worked that out. I am happy for that to be taken on notice. You are telling me that all this information is dealt with under medical records, but I think there are other privacy obligations for which McKesson is responsible, and I am not quite sure where that all lines up.

Ms Bryant—My understanding is that the privacy protocol complies with the general privacy principles. The medical records legislation goes a step further than the general privacy principles because of the requirement to retain documents, recordings and so on for a period of time. They are not inconsistent; my understanding is that the medical records provisions simply go further. We do have the privacy protocol here, and we are happy to give that to you. Our contract with McKesson required them to outline the privacy protocol so that we could be satisfied that they were adhering to privacy requirements under legislation.

Senator STOTT DESPOJA—Okay, I might have a look at the protocol.

Ms Halton—We will copy that for you at the break, and we will table it.

Senator STOTT DESPOJA—And the data security plan?

Ms Koukari—Yes, we have that as well.

Senator STOTT DESPOJA—Fantastic—lots of reading ahead! I want to ask about the funding of the pregnancy helpline and related matters. Or does anyone want to go back to advertising and other issues? I want to ask you about one of the media articles in relation to the initial operation of the helpline. I am not sure if you want to respond to this, but it was reported that one caller, in response to asking for additional information on abortion, or termination, was asked to google the word 'abortion'. Is there a policy on googling in relation to referrals?

Ms Bryant—I am not aware of that particular example but, in terms of referrals generally, the helpline provides generic information on where clients can find information about services they wish to contact. We do not refer them to any particular service for a number of reasons, including the fact that there are wide discrepancies in the quality of available services and there is no effective way for the helpline provider to ensure that clients are being referred to safe and appropriate services—not to mention the idea of channelling people to particular services and disadvantaging competitors. There are myriad reasons why the service does not refer, but it does give people generic information about where they can find the particular information they are seeking. It might suggest that they try the Yellow Pages under 'Medical practitioners'—and googling is consistent with that sort of generic referral.

Ms Koukari—In fact, rather than necessarily making suggestions, what they do is support the client to explore options that they would be comfortable in taking. They talk about some other ways they can address the problem and some of the sources of information. That is part of the non-directive counselling process of empowering the individual to make decisions.

Senator STOTT DESPOJA—This question might seem a bit like deja vu. We have had some of these discussions, but I think it is important that they are on record and public so that people who have queries about the service understand what you mean by 'generic'. Obviously, that is a broad-ranging definition of what constitutes 'generic' for the purposes of this helpline, but there are obviously government agencies you will refer people to, or at least advise them of their existence.

Ms Bryant—Yes. If, for example, one of the considerations raised by an individual in their decision-making process is their financial circumstances, their housing circumstances or whatever else, the helpline can say to people that Centrelink exists as a service where, for example, you get some assistance with financial counselling or, indeed, income support if their circumstances warrant it. So the helpline can advise people of the existence of government services of that nature and draw them to their attention.

Senator STOTT DESPOJA—And generic referrals to GPs are obviously acceptable.

Ms Koukari—But even the references to Centrelink are reasonably generic, in the sense that they can only refer them to Centrelink. They cannot say, 'Your local office is on X street' or whatever.

Senator BARNETT—I have a general question. In terms of the announcement last year and the funding, could I seek clarification or confirmation from the department's perspective, firstly, in terms of the set-up of the helpline. Is that on track in accordance with the announcement last year? Secondly, in terms of the procedures to set up the helpline, are they on track in accordance with the objectives set out in last year's announcement?

Ms Bryant—Given the start date of May, expenditure is on track. Given that the helpline is now in operation, the procedures, protocols, contractual arrangements and all of those processes are in place.

Ms Koukari—And we fully expended and finalised the contract for the training materials—which was the other aspect of the pregnancy helpline tender process.

Senator BARNETT—So that has been completed.

Ms Koukari—It has indeed.

Senator STOTT DESPOJA—Hence the forensic questioning of how it is operating. Could I ask a question in relation to funding of AFPSS—it is Pregnancy Help these days, is it not? At the last estimates when we discussed this organisation, my understanding was that we were not sure if they were going to receive funding next financial year, and certainly they sound unsure as to whether or not they are getting funding in the next financial year. I am wondering if you can provide any updates as to whether or not their funding will run out.

Ms Bryant—We have had discussions with that particular organisation in terms of their 2006-07 contract and reorienting it, given they are no longer providing helpline services on a 1300 number.

Senator STOTT DESPOJA—They have got a recorded message, haven't they? I do not know—I have not checked it.

Ms Bryant—I have not personally checked it either, but our discussions with them have been about reorienting their service. They are concentrating on providing more local referral to their affiliated services on the ground and so on. In terms of 2007-08, we are to put advice to the minister shortly on funding for the range of organisations that provide family planning services—and they are one of six. So those funding decisions will be put to the minister shortly. I will not comment on the nature of our advice to him, obviously.

Senator STOTT DESPOJA—So at the moment they are still in receipt of government funds for the duration of this financial year, are they not?

Ms Bryant—They are.

Senator STOTT DESPOJA—Even though their service is providing, as I understand it, a recorded message that, as you quite rightly point out, refers to more state based services. So as I understand it, the only national directly Commonwealth funded service that provides pregnancy counselling—I dial 5 or whatever it may be in my home state, and I go through to 'birth line'—is providing a recorded message. Is that the case?

Ms Koukari—No. The affiliate organisations, the state based organisations, do not receive any Commonwealth government funding.

Senator STOTT DESPOJA—No, sorry; I understand the umbrella arrangement. Who gets the money? Pregnancy Help Australia or AFPSS?

Ms Bryant—That is the organisation that is funded by the Australian government, yes.

Senator STOTT DESPOJA—To provide a national service—presumably the national service that has been advertised, where you ring up—but that national service is now a recorded message, because it does not provide that national direct counselling service anymore. It is being funded by government to provide a service that it does not provide—

Ms Bryant—We have amended their funding contract because they cannot provide—and we do not want them to provide—a national telephone helpline because the government is funding the national helpline. Whilst we are maintaining funding, we have varied their contract so that—

Senator STOTT DESPOJA—So they are getting no money?

Ms Bryant—We are not funding them for a telephone helpline currently.

Senator STOTT DESPOJA—Are they being funded at all right now?

Ms Bryant—Yes, they are.

Senator STOTT DESPOJA—What are they being funded for, if they are not being funded for a hotline?

Ms Koukari—They are funded for a range of training activities relating to the provision of practical parenting support services.

Senator STOTT DESPOJA—And that training does not apply to their affiliate services? Who is being trained?

Ms Koukari—There is still the national organisation for their affiliate organisations; they just no longer provide the counselling arm of the work. Their work is now mainly around providing the practical parenting support services.

Senator STOTT DESPOJA—To whom?

Ms Koukari—They are training their affiliate organisations to be able to provide the practical parenting support services.

Ms Bryant—We do not directly fund any state based services, but we fund the national body—

Senator STOTT DESPOJA—You fund them and they provide the training to the affiliate services?

Ms Bryant—The affiliated services do benefit to the extent that their counsellors are trained by the national peak body. We do not directly fund any of those affiliates.

Senator STOTT DESPOJA—I understand that. I recognise that distinction. I am not suggesting that you are giving money to an affiliate such as Birthline, for example, but the money that the government does provide is going to that service, which is using that money to train people in order to train their affiliates. So there is a very strong argument that there is a benefit available or a benefit derived as opposed to a direct financial benefit. Once again, is the government comfortable that various organisations—for example, the affiliates, in my

home state, Birthline—satisfy the non-directive definitions that we have discussed repeatedly and on the basis of which the government provides money for pregnancy counselling in Australia?

Senator MOORE—Has a contract been negotiated and signed with the new expectations?

Ms Koukari—We have drafted a contract variation which is currently with the organisation.

Senator MOORE—But when did the change happen?

Ms Koukari—The change happened at the end of last year?

Senator MOORE—So the contract to change what they were contracted to do has not been formally signed, even though their arrangements have changed?

Ms Bryant—That is with them, but they have not signed it and returned it to us.

Senator MOORE—But their money stream has been amended?

Ms Bryant—I do not believe their final payments have been made, and clearly we cannot make their final payments unless they sign and return their contract.

Senator WEBBER—When was the last time they received a payment from the government?

Ms Bryant—I would have to take that on notice.

Senator WEBBER—If you would. I would be disturbed if they were getting paid to deliver a service that you have just told me they have not been delivering for some months now.

Senator STOTT DESPOJA—Originally they were entitled to $250,000 per annum, but was there not an additional increase of $50,000 last year?

Ms Bryant—Their funding for 2006-07 was $337,702, GST exclusive.

Senator WEBBER—How is that paid? Is it paid quarterly?

Ms Koukari—It is paid quarterly.

Senator WEBBER—And they stopped delivering the original service last year?

Ms Koukari—We had a range of discussions with the organisation to talk with them about how they could reorient their service because we were setting up this new national helpline. It takes time for any organisation to do that level of reorientation of their services and to position itself for change.

Senator MOORE—Is it common for services to change and a contract that truly reflects what the services are not to be signed?

Ms Bryant—The first little while—the early part of the year—was taken up with discussions and so on with the organisation. At that point, it was perhaps not unreasonable—given that we were engaged in a process of ongoing discussion with them—that we would have continued to fund them. But their final payments and so on are obviously contingent on the contract variation being in place. We will be looking to see that they have achieved the

sort of revised business plan and structure—the reoriented service—that will carry them into the future.

Senator MOORE—Is there any legal liability in terms of a change of contract in the middle of a term where the new contract has not been agreed to and signed by the parties to it?

Ms Bryant—I would have to seek some advice on that. There was a valid contract in place at the start of the year, which is the basis on which we—

Senator MOORE—And the term of the contract was?

Ms Bryant—To the end of June 2007.

Ms Koukari—This financial year.

Ms Bryant—All contracts contain a provision which allows the parties to vary them.

Ms Halton—With mutual agreement.

Senator MOORE—But I am concerned if there is not mutual agreement. The organisation had a contract for 12 months, there was a change in the expectations for the relationship between that organisation and the government and no new contract has been signed between those two parties. I am wondering where that fits legally. Once again, my understanding of contracts is that contracts are negotiated and signed before—

Ms Halton—Let us be clear about this: we have had an exchange with them in which the change was discussed and agreed.

Senator MOORE—Verbally agreed.

Ms Halton—Yes. There is documentation about that, because we have extensive notes about that exchange. Yes, that potentially could cause a problem if that were ever disputed. We can get some legal advice if you would like us to—

Senator MOORE—That would be useful.

Ms Halton—but my understanding is that that forms the basis of an agreement to vary.

Senator MOORE—In principle.

Ms Halton—It probably would form a contract, because it was a verbal exchange in which offer and acceptance has occurred.

Ms Bryant—The written confirmation of it has been provided to the organisation.

Senator MOORE—You just ain't got the signatures yet.

Ms Halton—In effect, we have an agreement. The issue is the exchange of paper that confirms that, but there is actually an agreement.

Senator STOTT DESPOJA—I have a question on the funding issue. My colleagues have asked me to confirm reports that the Family Planning Program, which is within the newly developed gender and reproductive health section, is funding the Foundation for Human Development. Can someone confirm that for me?

Ms Bryant—The Foundation for Human Development is funded by the department.

Senator STOTT DESPOJA—The Foundation for Human Development funded to do what?

Ms Koukari—To provide practical parenting support.

Senator STOTT DESPOJA—Could you elaborate on 'practical parenting support'?

Ms Koukari—The Foundation for Human Development provides practical parenting support in a number of ways. It is based in New South Wales and provides people with advice on where they can go to find financial or accommodation support or other support for their family situation and wellbeing. They also provide other practical support, such as baby clothes and baby items—those types of things.

Senator STOTT DESPOJA—How much money do they get?

Ms Bryant—$56,100.

Senator STOTT DESPOJA—And what is their relationship with the New South Wales Right to Life organisation?

Ms Bryant—My understanding is that they are a subordinate affiliate of the Right to Life foundation.

Senator STOTT DESPOJA—So they are an arm of the Right to Life organisation?

Ms Bryant—That is my understanding.

Senator STOTT DESPOJA—I noticed, on the New South Wales Right to Life website, the Foundation for Human Development—which is funded, obviously, by the department to the tune which you just outlined—state:

Abortion is really another form of oppression of the weak by those more powerful.

Ms Halton—Sorry?

Senator STOTT DESPOJA—It is okay; that was the statement. I have more statements, Ms Halton! I understand that they are funded to provide practical parenting and they do that in the way that has just been described. But I am just wondering how statements such as that tie in with the government's or the department's definition of non-directive counselling.

Ms Koukari—They are not funded to provide counselling.

Ms Halton—They are not funded to provide non-directive counselling.

Senator MOORE—So what is their contract?

Senator STOTT DESPOJA—They are strongly related activities. So that is the distinction?

Ms Halton—They are to provide practical parenting.

Senator STOTT DESPOJA—Does the department endorse that statement? Does it have a view on that statement on the website of the organisation, an arm of which the department pays to provide practical parenting?

Ms Halton—That is not for us to endorse or otherwise. We have a contract with them to provide a particular service and that service is provided.

Senator STOTT DESPOJA—Okay.

Ms Halton—But it is not to provide non-directive counselling.

Senator STOTT DESPOJA—I have questions on the MBS item number but I suspect that a few people—maybe some of my non-Labor colleagues—might like a go. Otherwise I can keep going!

CHAIR—Senator McLucas, do you have a question?

Senator McLUCAS—I would like to have five minutes before we break simply to place on notice a series of questions that I hope the department might be able to deal with over lunch. They are still in outcome 1, but if I could just quarantine five minutes that would be appreciated.

CHAIR—Okay, and we have other people with questions.

Senator PATTERSON—I wish to foreshadow a series of questions that I will be asking the NHMRC. I could put on notice my questions to the NHMRC so that when they appear tomorrow they will have the answers rather than telling me they will take them on notice. So there will be a series of questions after lunch which I hope will be passed on to the NHMRC so that they come fully armed with their answers.

CHAIR—Okay. And there are other questions—

Senator POLLEY—Are we going to finish outcome 1 at lunchtime?

CHAIR—No.

Senator POLLEY—I have some questions on outcome 1.

CHAIR—The suggestion has been made to me that we will continue after lunch for about an hour or so with outcome 1, to deal particularly with issues relating to advertising—

Senator McLUCAS—And the TGA.

CHAIR—And the TGA. You may have more questions. We might have to spill over on this issue as well after lunch.

Ms Halton—Did you say advertising?

CHAIR—Advertising, yes. Senator Moore has a number of questions about the advertising budget of the department.

Ms Halton—Righto.

CHAIR—It seems to me as if we are going to need to go beyond the lunch break with issues in outcome 1. I am in the committee's hands, but we may need more than an hour after lunch at this rate. Senator McLucas, you might want to put your questions on notice now; I think we have not got time to embark on a whole new area of questioning.

Senator McLUCAS—It is a foreshadowing.

CHAIR—Okay.

Ms Halton—And I have to table for you the lapsings from that question you asked. So we will table that.

Senator McLUCAS—Fantastic; thank you.

Senator STOTT DESPOJA—And I will put those questions on notice if that makes it easier.

CHAIR—Okay.

Senator McLUCAS—After lunch, I would like it if we could have a list, for the department and any agency of the department, of what sum, as a total figure, was spent or will be spent on advertising campaigns in the current financial year and in the next financial year. So that is for programs that are afoot, completed or proposed. I would like it if you could identify each campaign by its name and say what sum was spent on each individual campaign for those two years. I would also like an indication of the purpose of the advertising campaign and then a breakdown of each budget, including campaign costs, market and other research, creative costs, preproduction, production and media purchasing.

Ms Halton—I might not be able to get that level of detail by after lunch. I can get the macro stuff. But let me see what we can do.

Senator McLUCAS—That is for the whole range of media, like TV, radio, newspapers—

Ms Halton—I know, and that is now into a level of disaggregation. We will see what we can do.

Senator McLUCAS—On what dates were individual campaigns referred to the Ministerial Committee on Government Communications for approval and on what dates were the necessary approvals granted? For campaigns that have already been completed, on what dates did the campaigns start and on what dates did they finish? For campaigns currently in progress, on what dates did the campaigns start and on what dates is it proposed that they be completed? For campaigns that are completed, what market research, opinion polling or evaluation was conducted following their completion? Has any cost-benefit analysis been done to assess the return from that investment?

Ms Halton—This is going to a level of detail I can guarantee you I will not be able to get by just after lunch.

Senator McLUCAS—But let us put it on the record now and then get it as soon as we can.

Ms Halton—That is fine. We will do what we can do. I accept that there is a level of interest in campaigns just at the moment, but remember that the majority of what we do is actually public health related.

Senator McLUCAS—There is no criticism inherent in asking these questions; I want to make that clear.

Ms Halton—I guess my point is, in terms of the cost-benefit analysis, we might be able to give you some more generic examples of the kind of cost-benefit analysis we have had of a number of campaigns, but I have not got a hope of getting it on a campaign-by-campaign basis between now and the end of lunch.

Senator McLUCAS—I understand that. And what the cost-benefit analysis being done on advertising the cervical cancer drug, for example—I know that this is one that you cannot do because we have not completed the program—might be and the take-up. But, if there is no formal evaluation as part of the whole proposal, then there is not and that is fine.

Ms Halton—We will see what we can do.

Senator McLUCAS—For each campaign, could we have the successful tenderer for the advertising and, if different, the market research. And could you outline the tender process, including the number of tenders received and the time line from when invitation to tender was issued through to the issue of the tender, including the date on which submissions closed, the date on which the decision on the successful tenderer was made and on what basis the tender was given. I have a final question, which is slightly different: is there still a PR consultant hired by DOHA to work in communications on the Opal fuel rollout? If so, when was that contract originally meant to end? What services are currently being provided and at what expense?

Ms Halton—As I said, given the complexity of some of those things, I will absolutely be gobsmacked if we can answer all of that in an hour's time.

Senator McLUCAS—Make her gobsmacked; I want to see what that looks like!

Ms Halton—We can get you the headlines, the name of the campaign and what it is worth. All of that will not be a problem, but, when we get down to when it went to MCGC and when it came out, that is probably going to require going through files. But let us see what we can do.

Senator McLUCAS—Could we get this by the end of tomorrow night, for example?

Ms Halton—Assuming that the people who could answer the questions are not sitting here and they can go back and do it, possibly. We will do our best.

Senator McLUCAS—Thank you very much.

Senator Mason—Mr Chairman, I want to flag something to the committee. I have a very short meeting at 3.30 this afternoon that I have really got to attend. It would be for about 10 or 15 minutes, so I seek the committee's indulgence.

Senator McLUCAS—I would not make comment on that, Senator Mason, given your predecessor's nonattendance at these hearings.

Ms Halton—That is why I suggested he should tell you about his absence.

Senator Mason—I promise to be back as soon I can.

CHAIR—You have leave, Minister.

Proceedings suspended from 12.30 pm to 1.34 pm

CHAIR—Good afternoon. The committee will now resume its hearings into the health and ageing portfolio. We were deeply engrossed in outcome 1 before lunch, and we still have some way to go with it yet. Let us kick off straightaway on that.

Senator NETTLE—I want to ask about the manual for the pregnancy counselling hotline. In the last estimates I asked whether or not that would be made public. There was an article in the *Canberra Times* at the time when the pregnancy counselling hotline opened which said that the department did not intend to issue the manual publicly but it understood that the document had been distributed to MPs concerned about the hotline. As a result of seeing that article, my office contacted the Department of Health and Ageing to see whether that was in

fact the case and whether it was possible for me to get a copy of the manual. I subsequently contacted the department again. On both occasions I have been told that somebody would get back to me about that. I raise it here because I am still waiting to hear whether I am able to get a copy of the manual.

Ms Halton—I am sorry, but I am not aware of any correspondence from you to me on that subject, so I do not know whom they have contacted. The manual has not been distributed. A number of people who expressed an interest have had a briefing from the committee who assisted in the preparation of it, but it is not publicly available.

Senator NETTLE—That is what I understood, because that is what it says in the article: it is not publicly available. But it did indicate that the document had been distributed to MPs. You say that is not the case.

Ms Halton—No.

Senator NETTLE—On seeing the comment in media saying that the manual had been distributed, I contacted the department.

Ms Halton—Who did you contact?

Senator NETTLE—My office contacted the department. I think they were put through to the publications section.

Ms Halton—In future, senator, with any of those sorts of contacts it is better that someone ring my office.

Senator NETTLE—I am not sure where it started, but I know that they were put through to publications. That section did not know what they were talking about, and I am still waiting to hear back about it.

Ms Halton—That would be because whoever it was obviously does not understand what the particular subject matter is. But, no, it is not available publicly and it has not been distributed to senators or members.

Senator NETTLE—You were saying that private briefings have been given?

Ms Halton—Before the launch of the hotline a number of people who had expressed a particular interest received a briefing from the chair of the expert committee who advised on the preparation of the manual; that did occur.

Senator NETTLE—You said it was for a number of people who had expressed an interest. What do I have to do? Do I have to say, 'Hi! I am interested in the hotline'? I would have thought that was reasonably obvious.

Ms Halton—A number of senators from this committee asked specifically for a briefing, which we provided.

Senator NETTLE—Perhaps I need to talk to you if I want a briefing, do I?

Ms Halton—They expressed an interest here and we said we would follow that up. For the particular ones who made that approach, we followed that up and gave them that briefing. If you would like a briefing, we—

Senator NETTLE—Could I be added to the list. If you are contacting people who are interested in the hotline, I would like a briefing.

Ms Halton—If you would like a briefing, we can give you a briefing.

Senator POLLEY—I too would like to be added to the list.

Ms Halton—We can so do.

Senator STOTT DESPOJA—I will put most of my questions on notice in relation to the MBS item number, but that is what I am interested in at the moment. The 2006-07 budget papers allocated over four years $35.6 million over the Medicare item number for general practitioners and qualified allied health professionals to conduct independent and non-directive pregnancy counselling. I could not find much more information on that in the 2007-08 budget papers. Could you give us an idea of how many health professionals have taken part, for example, in the online training that was referred to as part of that original package.

Mr Eccles—At 30 April this year there were 350 health professionals registered—so they have undertaken and finished their training and registered with Medicare Australia—and there are around 800 practitioners currently enrolled in training with their respective colleges. So that is 800 on top of the 350.

Senator STOTT DESPOJA—Does that meet your expectations or what you anticipated?

Mr Eccles—It is roughly in line with them. I do not think we had any set targets for this. It is about right.

Senator STOTT DESPOJA—I might jump around on some of these issues and fill in the gaps with questions on notice. How many people have claimed the rebate that is now available?

Mr Eccles—As at 1 May there were 1,009 claims against the item.

Senator STOTT DESPOJA—My understanding is that GPs have to spend a 20-minute period of time with a pregnant woman to receive the $64.30, compared with the allied health professionals who, I understand, spend 30 minutes and who receive $55. Is there a differentiation there that you want to explain to us?

Mr Eccles—I think that is fairly standard for the way we describe these types of items in the schedule. The rebate level is benchmarked against other like items, and the descriptions are quite similar in that way.

Senator STOTT DESPOJA—For the 1,009 figure that you gave me, can you give me a breakdown of the cost so far to Medicare for both GPs and specialists in accessing the rebate for pregnancy counselling? How much has that cost?

Mr Eccles—The total for the 1,009 items equates to $66,890.05.

Senator STOTT DESPOJA—You got that 5c in there.

Mr Eccles—Yes, we are detail focused.

Senator STOTT DESPOJA—What is the criteria for deciding whether or not an item number is required? How did the department determine that the item numbers were needed by

GPs and health professionals? What led to that? What assessment or evaluation led to the decision to provide—

Mr Eccles—Do you want me to talk in generalities?

Senator STOTT DESPOJA—Yes.

Mr Eccles—There is a very wide range of health activity covered by the Medicare Benefits Schedule. Generally, new items are created when there is a belief that there would be a benefit from having a particular item relating to an activity, so that the practitioners can understand what might be some of the appropriate ways to deliver the service.

Senator STOTT DESPOJA—I might go back to the issue of training and the online training versus expertise. Social workers and psychologists have to undertake a three-year online training and assessment module to qualify in order to use the item numbers. Was there a particular rationale that led to this approach? How did you reach the decision to use that approach? For example, why isn't the pregnancy training similar to the Australian Psychological Society quality professional development?

Mr Eccles—Mr Andreatta might correct me, but I recall—we are going back several months to when this was in its design phase—that the basis was that we spoke with the professional bodies to understand what was the best way to deliver the sort of education required to their particular constituents, their members.

Senator STOTT DESPOJA—The professional bodies being?

Mr Eccles—The relevant colleges—the RACGP or the College of Psychologists. We spoke with them about what sort of module they would recommend to us to deliver the training.

Senator STOTT DESPOJA—Was that their recommendation or was that a result of the feedback?

Mr Eccles—That was a result of the consultations we had with them.

Senator STOTT DESPOJA—I have one more question in relation to McKesson and the helpline issue. Again, it relates to a question in additional estimates in February. I understand the department had written to, or was in the process of writing to, McKesson's seeking advice in response to an article written in the *Sydney Morning Herald* on 3 February this year which raised concerns about the activities of McKesson's. Did the department receive a response to that particular written request and would the department provide us with a copy of the response from McKesson?

Ms Bryant—We did receive a response and I think, subject to discussion with McKesson's, we could provide you with their response to us. From recollection, it was in relation to—

Senator STOTT DESPOJA—Medical files.

Ms Bryant—It was an allegation about private health insurance firms.

Ms Halton—It was disputed quite vigorously by McKesson's, as I recall. We will ring McKesson's and see whether they would be comfortable with us releasing that letter to you.

Senator STOTT DESPOJA—Okay.

Ms Halton—I am sure they will not have any problem with us paraphrasing it but we will obviously do them the courtesy of checking—we could probably make that call today—and, if so, we will provide it.

Senator STOTT DESPOJA—I put on the record that they have been extremely helpful in their dealings with all of us thus far, and that has been appreciated, so if you are happy to pursue that.

Ms Halton—Yes.

Senator STOTT DESPOJA—I would like to clarify for the record—given that Senator Nettle raised the issue of the manual—that the Carolyn Chisholm Society's and Centrecare's involvement in the manual was confined to that process, to the development of the manual. That was the extent of their involvement in the process, was it not?

Ms Bryant—That is right. They provided input specifically to that process and they have not been involved in any other aspects of the service. It was input to the manual—to that process and that process only.

Senator STOTT DESPOJA—Thank you.

Senator BARNETT—I have some questions regarding the registration of the drug RU486.

Senator McLUCAS—That is a issue for the TGA, which I am going to ask questions of in a minute.

CHAIR—We were talking about doing the TGA in this session.

Senator McLUCAS—Yes.

Ms Halton—I thought we were doing the TGA at the end of this program, which is what we normally do.

Senator BARNETT—I have questions for the TGA on RU486, and questions on Medicare funding of abortion.

Ms Halton—Medicare funding for abortion is not under this item, it is under the medical benefits program, which is item 3.

Senator McLUCAS—That is later, towards dinner.

Senator BARNETT—I will take advice from the chair as to when you are looking at questions for TGA and the RU486.

CHAIR—Let us deal with other questions and then we will call the TGA and deal with all the TGA issues at the same time.

Ms Halton—Yes, if we can finish Ms Bryant's part of program 1 now.

CHAIR—Are there other questions that might be applicable to these witnesses?

Senator McLUCAS—I do not have any further questions on the pregnancy helpline. My next questions go back to advertising. Then I have a brief series of questions on the ice strategy and some questions to the AIHW and then the TGA, all in 50 minutes.

Senator MOORE—Senator Lundy has some questions on the drugs strategy.

Senator McLUCAS—Yes, when we are doing the ice stuff there are other questions on drugs too.

Senator BARNETT—Are we hoping to get this done by 2.30 pm?

Senator McLUCAS—Yes, we always remain in hope. In terms of the questions that I foreshadowed before lunch, can you update the committee on how we are going? I recognise that you will not be able to answer them right now, but could you explain when you can.

Ms Van Veen—I can take you through a program of campaigns in terms of what is currently running, the funding that is expected in this year, what is allocated in next year and what has occurred already in this financial year, as well as what is in development. There is a lot of detail that we will have to pull together for you because we have a number of health promotion campaigns. In some instances there is a rolling program that has been occurring in these areas—tobacco, drugs, immunisation—as well as community awareness raising around legislation and programs. I can take you through that.

I have some information about spends but, given the bills are paid by different policy areas in the department, I am not going to be able to give you all of that detail. But I know that people certainly were listening to all of the questions that you raised and all of the information that you are after and we will get you that information. It would be the same thing with respect to the MCGC dates. Given the number of campaigns that we have, we would not have that information for you today.

Senator McLUCAS—Rather than read out all the different campaigns, is it possible to collate a document that answers all of those questions that we have raised?

Ms Van Veen—That is being done, but I do not have that with me now.

Senator McLUCAS—Rather than use the committee's time now, if it is going to happen in a short period of time—like in the next day or so—I am happy for that to happen.

Ms Halton—In the next two days we can give you a piece of paper that goes through those broad areas. I do not think we can get you every minute detail that you asked for, because there was a lot of information in that question. As has just been said, this goes across a whole raft of areas, because these health promotion campaigns go to a series of different subjects. I am happy to give you what I have got by the end of tomorrow, and then we will just give you the rest when it is available.

Senator McLUCAS—That would be terrific. I am very happy with that. I would like to ask you about one potential future campaign. Is the government planning an advertising campaign on obesity or healthy lifestyle.

Ms Van Veen—Under the Australian Better Health Initiative, which is a COAG funded initiative, there is indeed a campaign being designed. This is in keeping with the February 2006 COAG announcement of funding to promote good health and reduce the burden of chronic disease. The department is working with state and territory governments on what is defined as a rolling series of social marketing campaigns to address those very issues. So, yes, there is a campaign being designed.

Senator McLUCAS—Will that be included in the program that you provide us?

Ms Van Veen—Yes.

Senator McLUCAS—When is it proposed to run?

Ms Van Veen—We are in the development stage. A launch date has not been set. I think we are in the toughest part of the ballpark in terms of the challenge of the message that we are tackling here. We are developing it carefully, based on market research as well as expert advice. There is not a date set for it at this stage because it is in the early stages of development.

Senator McLUCAS—I am no advertising specialist, but when you say 'early stages of development', have you done any market testing of the proposed campaign?

Ms Van Veen—Not as yet.

Senator McLUCAS—So it is still in that what they call the creative stage?

Ms Van Veen—Yes, absolutely.

Senator McLUCAS—What sorts of thematics are being developed as part of that creative stage?

Ms Van Veen—We are actually in the tender process at the moment. I am not at liberty to discuss that because it is a competitive tender. We have had campaigns at state and territory levels around what people need to do. We need to make this personally relevant to get through on the question of why they need to do it. We need to look at what is going to motivate people to take action and how this can talk to particular members of the Australian population. It really is in the early stages. We do not have themes, so to speak.

Senator McLUCAS—But it is a very individual message?

Ms Van Veen—Yes.

Senator McLUCAS—You said you were in the tender process at the moment. Is it a tender for the creative stage or the—

Ms Van Veen—It is for a series of consultants, a creative advertising agency, a public relations company and specialist communications consultants to address Indigenous populations as well as non-English speaking backgrounds.

Senator McLUCAS—I recognise that you said you do not have a time for the campaign set in stone yet, but if you are in tender for those sorts of support services now, when would you imagine that the rollout of the campaign would occur?

Ms Van Veen—I would expect it before the end of the calendar year. Obviously we are moving rapidly into the second half. Because we have a process of refinement to go through, I cannot tell you if it is going to take two or three processes of concept testing to refine those concepts. Whatever we do, we must make sure that it is going to work effectively with the intended audiences.

Senator McLUCAS—When do these tenders close?

Ms Van Veen—They have closed.

Senator McLUCAS—When do you expect to make decisions about—

Ms Van Veen—In June we should see the appointment.

Senator McLUCAS—And you will appoint a series of personnel.

Ms Van Veen—Yes.

Senator McLUCAS—How long does the creative one run for?

Ms Van Veen—I would expect that, given that there is funding over several years for this, it would be a three- or four-year contract.

Senator McLUCAS—It will be a rolling contract.

Ms Van Veen—Yes.

Senator McLUCAS—Well, the work will be rolling and changing.

Ms Van Veen—Potentially, depending on performance, yes.

Senator McLUCAS—In the documentation that you will provide to us, will the Medicare electronic payments system be included?

Senator BARNETT—Have you finished on the obesity questions?

Senator McLUCAS—On advertising.

Senator BARNETT—Because I have a follow-up question to your question, if that is okay.

Senator McLUCAS—Sure.

CHAIR—Yes.

Ms Halton—Electronic claiming is Human Services. It is germane to us, but that would be running specifically out of Human Services.

Senator BARNETT—You have been referring to the funding for the anti-obesity initiatives out of the better health COAG initiatives. I assume that that is the $200-odd million that has been agreed at state and federal level?

Ms Van Veen—Yes.

Senator BARNETT—Can you provide a breakdown of the funding by the states to that initiative in terms of each individual state and territory?

Ms Van Veen—For just the campaign or for all of the—

Senator BARNETT—I would like it overall, firstly, and, secondly, for the campaign. I am happy for you to take it on notice.

Ms Van Veen—Thank you.

Senator BARNETT—Do you have full support from the states and territories for the campaign? Are they all in agreement and supportive of the campaign?

Ms Van Veen—Yes. We have a campaign reference group with every state and territory on it. We have had a number of face-to-face meetings. We have regular teleconferences. Certainly they have supported all of the work that has occurred to date.

Ms Bryant—The contribution to the campaign is about $19.8 million from the Australian government, with the balance of about $10 million made up of contributions from the states and territories. They are all contributing except Victoria, which is contributing funding towards related health messages in the tobacco area, particularly given its contribution to chronic disease and so on.

Senator BARNETT—So they are not contributing to the anti-obesity initiative like every other state and territory?

Ms Bryant—The ABI initiative, in part, is to promote good health but also to reduce the burden of disease. The Victorians have chosen to allocate their funding to the chronic disease end of the spectrum in terms of tobacco and reducing—

Senator BARNETT—We know about chronic disease. We know the different contributions that are made to chronic disease, and tobacco is one very major, significant one. Obesity is another. So you are advising this committee that Victoria is not making contributions to the anti-obesity initiative and advertising campaign.

Ms Bryant—That is correct.

Senator BARNETT—You have said that $19.8 million is contributed by the Australian government and $10 million by the states and territories. I thought the agreement at COAG was on a dollar for dollar basis—about $100 million each—so why would this be on a $2 for $1 basis?

Ms Bryant—The balance in the health campaign is made up at the state and territory level of local area health promotion activity.

Ms Halton—But not all of the initiatives under ABI are shared 50-50. There are some items under ABI which are basically 100 per cent Commonwealth, there are some things that are 100 per cent state and there are some things that are mixed. For example, we have an MBS item, which is by definition 100 per cent Commonwealth. There is not a strict 50-50 split on every item.

Senator BARNETT—Are you able to provide a breakdown of the contributions from the states and territories out of the $200-odd million, which is $100 million each? Then, if you are advising that there are different contributions to different parts of the overall initiative, could you provide a breakdown of those contributions?

Ms Halton—This is as it was announced by COAG. So basically it has not changed. But, if you would like us to provide you with that detail again, we can.

Ms Bryant—The original ABI announcement by COAG was $500 million, and that is $250 million in Commonwealth investment and $250 million by the states and territories.

Senator BARNETT—All right. Could you break it down? You have talked about the campaign—$19.8 million and $10 million. Will you break that down and provide the state and territory contributions, which Victoria is not contributing to?

Ms Bryant—They are contributing their proportionate share of the dollars to other activities.

Senator BARNETT—Overall, but to the antiobesity campaign?

Ms Bryant—They are not contributing to the antiobesity campaign.

Senator BARNETT—So could you give us a breakdown of the other states and territories?

Ms Bryant—New South Wales is $4.36 million; Victoria is zero; Queensland, $2.67 million; WA, $1.3 million; South Australia, $1 million; Tasmania, $0.16 million; ACT, $0.21 million; and Northern Territory, $0.20 million.

Senator BARNETT—Is that broken down on a population share basis, or on what basis?

Ms Bryant—It is the AHMAC cost-shared formula. It is population based.

[2.03 pm]

Australian Institute of Health and Welfare

Senator ALLISON—I would like to ask some questions on outcome 1. Does the AIHW monitor the cost or affordability of dental treatment to Australians on an ongoing basis?

Dr Allbon—The AIHW has a collaborating unit which is situated at the University of Adelaide. It is the Dental Statistics and Research Unit. That unit is responsible for a considerable amount of monitoring. It puts out regular reports, usually based on surveys that it has done of the dental health of either children or adults. It does telephone based surveys but also surveys that involve practitioners actually checking the teeth of representative samples across the country. So certainly through that mechanism the status of the teeth of the nation is monitored. In our regular monitoring reports on health expenditure we do cover costs. That collaborative unit covers cost as well.

Senator McLUCAS—And the cost data is collected by the surveys and speaking with practitioners?

Dr Allbon—No, the cost data is produced in health expenditure reports that we produce. If you would like some further information on that I can ask John Goss, who is our expert on that subject, to come and talk to you on that score.

Senator McLUCAS—That would be great. Thank you.

Mr Goss—The numbers we publish in *Health expenditure Australia* every year, and we list separately the different sorts of dental expenditure. So there is expenditure, of course, by the Australian government in supporting dental services, which was $450 million in 2004-05. There is expenditure by the local, state and territory governments, and that was $503 million in 2004-05. There is also funding for dental services which comes from private health insurance and from people paying out of their own pockets. I can also give you a breakdown of the overall Australian government expenditure if you like.

Senator McLUCAS—Just before you go to that, is the contribution from individuals and private health insurers something you can quantify as well?

Mr Goss—Yes, that is something we quantify. There are two components to it. There is the 30 per cent subsidy by the Australian government for private health insurance which ends up in dental services, and that came to $368 million in 2004-05, and the actual amount which flows from the private health insurance funds in 2004-05 was $701 million.

Senator McLUCAS—And private copayments from individuals?

Mr Goss—Yes, private copayments—out of people's own pockets—is $3.4 billion.

Senator MOORE—Where do you get that figure? I can understand how you get figures that people claim back, because that is through the system, but how do you get the private copayments?

Mr Goss—The private copayments figure is sourced from data from the national accounts data of the Australian Bureau of Statistics. They in turn derive it from Australian tax office data and private industry surveys.

Senator MOORE—I would like to talk later about that.

Senator McLUCAS—Does the AIHW trace the rate at which Australians forgo dental treatment because of cost?

Dr Allbon—The Dental Statistics and Research Unit at the University of Adelaide does, through its surveys, ask questions. They are self-report questions on the extent to which people felt that they did not go to a dentist because of the cost involved.

Senator McLUCAS—And what does that data show?

Dr Allbon—The 2004-06 survey, which has just been reported, *Australia's dental generations*, says that that figure is about 21 per cent for adults.

Senator McLUCAS—Twenty-one per cent of adults do not go to the dentist because they cannot afford it?

Dr Allbon—Because they believe the cost is a barrier, yes. But, as I say, it is a self-report figure.

Senator McLUCAS—How statistically reliable is that, then, as a self-reporting figure? I am not a statistician either, believe it or not.

Dr Allbon—Self-report figures always have an element of give and take around them, but on this basis I think it is a pretty useful figure to use. It is the best that there is, and it appears to have been reasonably consistent over time in terms of the way it has been collected. So I think it is a pretty reliable figure.

Senator McLUCAS—It seems obvious, but these things are not necessarily that way. Would you imagine that that group of people—the 20 per cent of the Australian adult population who are not attending dentists—are generally in the lower socioeconomic groups?

Dr Allbon—There is some specific evidence about the interrelationships between socioeconomic status and dental health care. They certainly do demonstrate that, particularly, for the Indigenous population, for people who are not in cities and for men that the rate of non-attendance is greater, yes.

Senator McLUCAS—That is interesting.

Ms Halton—It goes back to that conversation about needles earlier.

Senator McLUCAS—Needles and healthy blokes, yes.

Dr Allbon—I think it has something to do with the same phenomena.

Senator McLUCAS—You mentioned that figure of 21 per cent of adults not attending because of costs. Do we have a figure for children?

Dr Allbon—No, we do not have a comparable figure for children. The 2004-06 survey was for adults only. We are very aware that the majority of children—it is in the 80 to 90 per cent range, but I can check that figure for you—do attend because they have access to school dental services. A much higher percentage of children do attend because some states and territories, not all, offer it as a free service.

Senator McLUCAS—If you have any further information on that, it would be useful.

Dr Allbon—In relation to children?

Senator McLUCAS—Yes, in relation to children's attendance and whether or not the cost is an inhibitor of children attending. If you could provide the committee with anything at a later stage, that would be terrific.

Dr Allbon—If there is anything further, yes, certainly.

Senator McLUCAS—I understand your report on oral health talks about the number of people who do not attend because of cost. Does the AIHW do work in other areas of health where people are not attending or not continuing with a regime of treatment because of cost issues?

Dr Allbon—I will have to consult my colleagues. We are not aware of anything.

Senator McLUCAS—Dental is different because of the higher private co-payment required.

Dr Allbon—That area of work is done by our collaborating unit. We are not doing anything in any other area that would give you any further answer to that.

Senator McLUCAS—That is all I have on AIHW.

ACTING CHAIR (Senator Moore)—Subject to Senator Allison coming back, we will go to the general drug issues. Senator Polley and Senator Lundy have some questions on drug strategies and then we will see what happens. We are getting there, Senator Barnett.

Senator POLLEY—My first question is: how much input did the department have in the government's development of its ice policy?

Ms Halton—A significant input.

Senator POLLEY—Can you outline the process for us as to what consultation there was?

Ms Halton—Actually, there was a discussion amongst secretaries, as it happens, about a number of issues in relation to this particular problem. From that was formed ultimately an IDC. Then obviously there was a process of providing advice to government, but we chaired that process.

Senator POLLEY—Was the government's policy revised after 16 April this year after the Labor Party announced its policy? Did the department provide further advice on ice to the government after that date?

Ms Halton—No.

Senator POLLEY—Has there been any research done into the different strategies that are being put in place? For instance, Queensland has the register system in pharmacies for pseudoephedrine material that is sold over the counter.

Ms Halton—As you know, Project STOP was rolled out first in Queensland but it will have broader application. This is something we have been working on with people at that end. Ms Hart can give you more detail, but we are particularly aware of what is going on in Queensland.

Senator POLLEY—Are there any other states that have that process in place? Can you outline what is happening?

Ms Hart—There is actually a national approach to looking at interventions around the control of the diversion of precursor chemicals that are used to make ice and amphetamine drugs. There is a Commonwealth, state and territory working group which is jointly run by the Minister for Ageing, Christopher Pyne, who has the responsibility for drugs, and the justice minister. That includes law enforcement agencies, health departments at the federal and state level, and the pharmaceutical and chemical industries. They have a number of initiatives including, as the secretary mentioned, Project STOP, which is a real time database that tracks the illegitimate purchase of pseudoephedrine based medications at pharmacy outlets. That was originally a Queensland based project and it has now been rolled out nationally. The national roll-out was launched on 2 April. It will be progressively taken up in all states and territories.

Senator POLLEY—What sort of money has been allocated and how much has been expended thus far for Project STOP?

Ms Hart—I understand that $5.4 million has been committed through the Attorney-General's Department—because that is another department I do not have available to me the figures for how much has been expended under the initiative, but I am sure we would be able to find that out for you.

Senator POLLEY—If you could take that on notice for me, that would be really good. Could I have a breakdown of the expenditure state by state as to how you are allocating the funds?

Ms Hart—I can pursue that through the Attorney-General's Department for you.

Senator POLLEY—Could you also take it on notice to provide any other useful material that has been used that perhaps would be beneficial for the committee to have?

Ms Hart—Yes, I will take that on notice. We do have some information about the rescheduling of pseudoephedrine based medications which has been an important part of dealing with the illegitimate diversion and use of those in illicit drug production. I can provide you with some information on that as well.

Senator POLLEY—Thank you.

Senator LUNDY—I would like to ask some questions about the National Illicit Drug Strategy in relation to the Illicit Drug Diversion Initiative. I understand there was an announcement in the budget to extend the grants available under that particular initiative. Is that the case?

Ms Hart—My understanding is that the current program has been extended to run until June 2008. We are in the process of formalising that through finishing Commonwealth-state agreements with each of the states and territories, except Queensland where we have an agreement in place.

Senator LUNDY—What is the total investment by the Commonwealth government in the Illicit Drug Diversion Initiative?

Ms Hart—So far we have invested $340 million in the program.

Senator LUNDY—Over how many years?

Ms Hart—The program commenced in 1999. That was when the original framework was put together.

Senator LUNDY—What proportion of that $340 million is expended on the Community Partnerships Initiative?

Ms Hart—The Community Partnerships Initiative is actually a separate program, and I have some figures on that. The Community Partnerships Initiative is really focused on small community grants, as the name suggests. It is focusing on community based activities that deal with local prevention and early intervention initiatives. The most recent round announced in April by Minister Pyne was for $5.2 million. Prior to that, we have invested $17 million in the Community Partnerships Initiative since 1997.

Senator LUNDY—Can you describe the aims of that community partnerships program?

Ms Hart—It is a program that aims to prevent and address the harm caused by drugs through projects that establish and build on community identified priorities and partnerships. It is quite a diverse program because it ranges across metropolitan, rural and remote areas. It depends very much on what the community issue is and how arrangements within the community might support an intervention. Hence it has a very broad variety of activities that are funded under it.

Senator LUNDY—What sorts of community groups could be funded under that initiative in order to put in place harm reduction and diversion programs?

Ms Hart—I have a list of the latest round, which would give you a more detailed idea. To characterise those: they are youth groups, multicultural education centres, Indigenous councils, disability and information lines, some of the culturally and linguistically diverse community groups, some church based youth groups and some existing drug and alcohol charitable and church based organisations. I can provide a list of the latest round if you would find that helpful.

Senator LUNDY—Are any sporting organisations eligible for funding or have any been funded in the past?

Ms Hart—They would be eligible. I do not have in front of me a list which would indicate which specific organisations we may have funded in the past. It is quite a large program. We funded over 250 services. I would need to check back on that. Potentially they could be eligible.

Ms Halton—If I can go a bit further on that front: when this initiative was originally agreed at COAG, which is where it came from, there was explicit discussion about the kinds of activities that the states and territories wanted to think about and could be done by way of diversion. Sporting activities were explicitly discussed as being potentially quite legitimate uses. As Ms Hart says, in terms of the list of who has actually received funding, it is not immediately evident. But there is no prohibition; on the contrary, it is quite consistent with the objectives that you might want to use sporting activities as a diversion.

Senator LUNDY—Going back to the Illicit Drug Diversion Initiative: I note on the website that the aims of that particular program are to increase the education, counselling and referral services through community based programs and support the diversion of illicit drug users from the criminal justice system into education and treatment, including the establishment of assessment services and additional treatment places. That list then evokes the reference to the Community Partnerships Initiative as a way of trying to achieve these objectives. Given the current debate and the government's position about the AFL, and armed with the knowledge that the AFL policy is informed by best practice on the diversion and handling of drug and alcohol problems, could you tell me whether the AFL would be eligible for funding under the Community Partnerships Initiative for their initiative to try to prevent drug taking within that particular sport? If so, how would they go about applying?

Ms Hart—Not within the sport. Obviously the focus is on small, often not very well-resourced community groups to do something locally. That tends to be the heartland of the Community Partnerships Initiative.

Senator LUNDY—So because the AFL is well resourced they would not be eligible, or is their program not suitable?

Ms Halton—Let us be clear, Senator. This is actually about providing community intervention in relation to drug-taking behaviour. This could be any specialist organisation in relation to a defined and discrete target group. These programs tend to be for particular geographic areas or what have you. If the AFL came in and said they wanted to run a drugs related program and they had the appropriate expertise and facilities and support from all the relevant players in Frankston, for example, they would be considered along with everyone else.

Senator LUNDY—Thank you for that. The point has been made by Professor Jon Currie, Director of Addiction Medicine at St Vincent's Hospital, and two of his colleagues, Dr Yvonne Bonomo and Dr Martin Lloyd-Jones, that the AFL's out-of-competition illicit drugs policy conforms with best practice as described in the federal government's Illicit Drug Diversion Initiative and indeed its broader policy. I am wondering whether the health department or anyone within this division was consulted by the minister before they made their statements last week in relation to their criticism of the AFL's out-of-competition illicit drugs policy?

Ms Hart—In response to that, we would not be in a position to comment on policy. In relation to illicit drug testing within sport, you would appreciate that that is principally the responsibility of Senator Brandis as the Minister for Arts and Sport.

Senator LUNDY—No, it is not, because this policy is outside of the wider code. Any application of the sports related regulations with respect to drug testing is very much within the realm of this kind of initiative. There is not a legal obligation on that organisation, being the only organisation to have adopted that kind of policy in the sports portfolio per se. That is why I am directing these questions specifically to the health department. In addition, I do not want to know what you told Mr Pyne but if you told him anything.

Ms Halton—We will not comment on whether or what we told him.

Senator LUNDY—On whether or not you provided any advice?

Ms Halton—It is not appropriate that we provide an indication of advice.

Senator LUNDY—I would think it is appropriate to find out whether or not you provided any advice, albeit I accept it is not within your province to tell me what that advice was. Can you tell me whether you provided any advice to Christopher Pyne on this issue prior to his statement regarding the AFL's drug policy?

Ms Halton—We give Minister Pyne a range of advice on a range of subjects constantly in relation to his portfolio matters.

Senator LUNDY—Let me ask you a statement of fact. Does the AFL's out-of-competition illicit drugs policy comply with or conform with the types of policies that are advocated and specifically funded by the Howard government under its Illicit Drug Diversion Initiative and have you done that assessment? I put to you that it does comply with best practice. This is exactly the kind of program you would find for a community organisation seeking to achieve the same objectives.

Ms Bryant—I think you could argue that there is broad consistency with the Illicit Drug Diversion Initiative in the sense that the purpose of the diversion initiative is to intervene early in young people's drug use and give them incentives to address their drug use problem, particularly before they incur a criminal record, and to provide avenues to divert them into education, assessment and treatment. There is then an issue of whether you think the incentive is strong enough, whether you do not think it is strong enough et cetera. There is a broad level of consistency to the extent I have outlined.

Senator LUNDY—Thank you very much. I think the issue here is that there was very strong advocacy from the minister that these offenders within the AFL's policy ought to be directed immediately into the justice system as opposed to diverted from the justice system, as it explicitly states is a goal of this particular initiative. Perhaps you could take on notice whether the AFL's efforts in their own football-playing community to stamp out illicit drug use—which is clearly the aim of their policy, and it not only serves their own employees, the playing community, but sets an example to all players of AFL; it deploys that broader message to the AFL community—would be eligible for funding under the Community Partnerships Initiative. I understand they have not applied, but I am keen to get a clear understanding whether they would be eligible under the criteria if they did apply.

Ms Halton—We can give you a statement of eligibility criteria for that program. That I would be happy to do. In terms of whether any individual organisational body who applies would be eligible, we would not be in a position to make that assessment because it would be

a matter for that organisation to come to us directly seeking clarification. They would have to provide us with certain information. But, as to who would be eligible in terms of the way we state the eligibility for that program, we would be happy to give you that information.

Senator LUNDY—Thank you very much. Just going back to my questions about the advice you provided to the minister, I am not precluded from asking for explanations about when and how policies were adopted. So I ask you again: what role did the department play in the preparation of the Howard government's policy as expressed in their critique of the AFL out-of-competition illicit drugs policy?

Ms Halton—I am not aware of such a policy, Senator. You are quite right: we can be asked questions if they are around matters in relation to the development of a policy. I am not aware of the development of such a policy. I understand there has been a debate about ideas and issues, but it has not been put to us that there is a change in the policy framework in which we are operating.

Senator LUNDY—That clarifies it. So I can take from that that there has been no policy change in the area of the Illicit Drug Diversion Initiative that would have given effect to Minister Brandis's and Mr Pyne's expressions of the policy as it relates to the AFL.

Senator BARNETT—Chair, Senator Lundy is putting an interpretation on an answer which may be her interpretation. It may not be the interpretation of Ministers Brandis or Pyne. I just draw that to the attention of the committee.

Ms Halton—I was going to say that I cannot make a comment about that. All I can say to you is that the policy framework relating to this program continues. That is the only comment I can make on that.

Senator Mason—Senator, did you take the opportunity to ask Senator Brandis about this?

Senator LUNDY—Yes.

Senator Mason—I am sure you enjoyed the moment.

Senator LUNDY—The conversation degenerated.

Senator Mason—We will not explore that then, will we?

Senator MOORE—Ms Halton, I would like to clarify where Cancer Australia fits.

Ms Halton—Cancer Australia comes under outcome 10. Senator, you asked a question about the disaggregation of the budget and how it fits—what is health, what is portfolio et cetera. We have a typed up list which we will table. Senator Moore was interested in our reconciliation action plan. I have that to table. So I table both of those.

CHAIR—We will now go to questions for the Therapeutic Goods Administration and then we will come back to general questions.

Senator McLUCAS—I want to go to the sale in February 2002 of the TGA building in Symonston. Could you explain to the committee how the sale was managed?

Ms Halton—The sale of a building is not really a matter for us; it is really a matter for the Department of Finance and Administration.

Dr Graham—The building was sold in 2002 and the sale was organised by the Department of Finance and Administration.

Senator McLUCAS—What role did the TGA play in that process?

Dr Graham—A neutral role in the sense that DOFA was fulfilling government policy about divestment of government buildings.

Senator McLUCAS—So it sort of happened to you?

Dr Graham—It was a purpose-built building for the Therapeutic Goods Administration in the first place, yes.

Senator McLUCAS—When was it first built?

Dr Graham—It was opened in 1992.

Ms Halton—The planning and construction of it happened in the late eighties—and the only reason I know that is that I was on the steering committee which got to look at all of the floor plans when I was in the department of finance looking after the public purse to make sure we did not spend too much on it.

Senator McLUCAS—So it was built in 1992?

Ms Halton—And was completed.

Senator McLUCAS—So it was completed and opened in 1992, and 10 years later the government decided to sell it. That is a policy decision of government. What role did the TGA play in that? Were you consulted through the sale process?

Dr Graham—My understanding is that we understood that the negotiations were going on, but it was something that was dealt with by the Department of Finance and Administration. We were the occupants of the building. That was primarily our role.

Senator McLUCAS—You may not be able to help me with this, Dr Graham, but would the TGA have had on its books at the time of the sale, in 2002, a valuation of the building? I do not know if you were showing the building as an asset on the TGA's books at that time.

Dr Graham—I cannot really help you there. We may have. There certainly was a value done of the building when it was first built and by that stage it was 10 years old. At that point a lease was entered into and we continued on from there.

Senator McLUCAS—It would be useful for me to know what the value of the asset was showing on the TGA's books at 2002.

Ms Halton—We will have to take some technical advice on that. The question of what was a book value, which might have been used on a depreciated basis, as in what might have been showing in any accounts, may not be the same as a market valuation.

Senator McLUCAS—A real value.

Ms Halton—Yes, exactly. I think I will have to get the accountants to have a look at this issue. When the government moved to cost recovery and accrual accounting, I think there were varying approaches taken to how these assets were shown on balance sheets. I would not want to mislead you in terms of the value that may be there, so I think we will have a look at it and come back to you on notice.

Senator McLUCAS—Let me phrase the question differently. I am trying to find out whether DOHA or TGA understood in a real sense the value of the property at 2002.

Ms Halton—That is fine.

Senator McLUCAS—What shows on the accounts may be a different figure.

Ms Halton—I suspect the answer to that, but when my CFO is around I will ask him. I suspect that we would not have had a market value showing on any balance sheet.

Senator McLUCAS—Sure, but it may have been in other documentation rather than the accounts.

Ms Halton—To be quite honest, I would be surprised if it was. I will get the CFO to see what we have got.

Senator McLUCAS—My next questions go to the sale process, so you may want to defer them to DOFA. I understand that there was only one unqualified tender. Is that something you can comment on?

Dr Graham—No.

Ms Halton—We cannot deal with any of these questions.

Senator McLUCAS—That is fine. I understand that. From TGA's perspective how does the lease arrangement work?

Dr Graham—We now have a 15-year lease which started in 2002 and at the end of that 15 years there is a five-year option.

Senator McLUCAS—What are the rent and rent review arrangements?

Dr Graham—There was a rent agreement established at the start of the lease, of course. That is indexed by three per cent per annum or CPI, whichever is larger. Every three years there is an opportunity for either party to have a valuation of that rent compared to comparable properties to see if there is an adjustment to the rent. That occurred in 2005, when we brought in a valuer to look at comparable properties and there was an adjustment to the rent.

Senator McLUCAS—When you say 'we brought in a valuer' are you saying TGA did or—

Dr Graham—The owners of the property in fact initiated that part of the lease and there was mutual agreement about bringing in a valuer to determine what was the fair price. So it did increase above the rent that we were paying but not as substantially as the owner of the building would have liked.

Senator McLUCAS—Can you provide details of the rent since you have been paying rent, since 2002?

Dr Graham—This is in the public domain. In 2005-06 the rent was $3.77 million. Then the review clause was initiated. At the end of that process the rent increased by $0.881 million. The rent at this point in time is $4.654 million. As I said, that rent is then increased by CPI or by three per cent, whichever is the larger, each year.

Senator McLUCAS—Did you compare that quite large rental increase with other similar properties?

Dr Graham—Yes. That was the role of the independent valuer who compared the TGA building—well, it is very hard to compare a purpose-built building—to other properties in Canberra of a similar commercial quality. The outcome was that increase in rent.

Senator McLUCAS—I understand that was a 15.6 per cent increase.

Dr Graham—It would have been of that order. It was over and above the three per cent that we would have anticipated anyway.

Senator McLUCAS—That turns out to be about $900,000. Was that budgeted for from the accounts of the TGA?

Dr Graham—No. Certainly in our forward estimates we budget for the three per cent or the CPI. That level of increase was not budgeted for. It was presented to the industry because we were under cost recovery. By tightening our belt we reduced the impact on the industry quite substantially, but there was a flow-on effect which was taken into account in the next round of fees and charges.

Senator McLUCAS—What proportion of that $900,000 has been passed on to your constituents, for want of a better word?

Dr Graham—It is probably a little hard to untangle, but at the end of the last financial year the direct impact of the $0.881 million was substantially less than that. I have not got the figure because we found savings elsewhere internally to increase efficiency. But it is true to say that some of that could not be absorbed and we did pass it on in terms of negotiating the next round of fees and charges.

Senator McLUCAS—So what is the increase in fees and charges? When you say 'the next round', is that 2006-07 or 2007-08?

Dr Graham—This current financial year, 2006-07. When we do the round of fees and charges, normally they would increase by CPI unless for whatever reason—and it might be the number of products coming into the market or other activity that the TGA is dealing with—there may be a need to increase or, in some cases, decrease the rate of fees and charges in a particular industry sector. But the government policy is that we are under 100 per cent cost recovery for the activities we provide.

Senator McLUCAS—And so the increase in fees and charges in 2006-07 is CPI plus what?

Dr Graham—In some areas the increase was more than CPI but in other areas—I have a clearer memory of what we are negotiating for the next year at this point of time. There are some industry areas where we have not increased the charges, for instance, because we have recouped enough in terms of the charges from the previous year to not necessitate an indexation increase for the next year. So what we do is divide the revenue of the TGA into the industry sectors, and each sector should be self-supporting. Where we are over-recovering we adjust the fees down. Where we might be under-recovering, we adjust the fees up and we do that in discussion with the industry.

Senator McLUCAS—That is the broad policy of managing full cost recovery, Dr Graham. What I am trying to get to is what increases have been passed on to the industry and therefore to consumers as a result of the increase in the rental on the property at Symonston.

Dr Graham—I would probably need to take that on notice. As I said, it was substantially less because, as you can understand, we had this exact discussion with the industry and parts of the industry had a concern about the size of the increase. We demonstrated to them that by belt tightening within TGA we had lessened the impact on them. So it was a shared pain between the industry and the regulator about that unexpected increase, but as I said I can—

Senator McLUCAS—I suppose I want to know how much was the belt tightened and what did that equal in dollars.

Dr Graham—As I said, I would need to take that on notice to give you that breakdown because there are other variables that impact on the final outcome of the revenue that comes into the TGA and the expenses we pay out. What I would need to do is to untangle some of that to show the impact of the rental increase.

Senator McLUCAS—And that will be on the 2006-07 fees and charges—the pricing regime, if we want to call it that?

Dr Graham—Yes, the increase occurred in 2005-06 so the impact is 2006-07.

Senator McLUCAS—Could you look at the increases in fees and charges in that year and try to attribute a portion of them to the increase in rental—

Dr Graham—I will do that.

Senator McLUCAS—In terms of the next rent review process, when will that take place?

Dr Graham—In three years time from 2005-06.

Senator McLUCAS—In 2008-09.

Dr Graham—Yes.

Senator McLUCAS—Do you have any crystal balls at your place to work out what is going to happen?

Dr Graham—I think it will not be as large as the last increase, because in a way what that reflected was that the rent was under the current market value, and that was a catch-up. It is a little hard to predict but all things being equal, although there is a tight commercial property market in Canberra at the moment, with more commercial property coming into the market I would expect that the impact would be much less.

Senator McLUCAS—I suppose that goes back to my original question about what the value of the property was when it was sold.

Dr Graham—There is the value of the property and the value of the rent.

Senator McLUCAS—Yes, and its comparison with other properties given the difficulties. There is not another TGA building in Canberra that I have noticed.

Dr Graham—Yes. As I said, I cannot give you the background to those factors, but I would say that in 2005-06 there was a fairly substantial catch-up to current market rates

which I would not expect in the next round. I would not expect the need for it in the next round.

Senator McLUCAS—On notice, Dr Graham, I wonder if you could provide—and I have already asked this question—what rate the fees and charges to the industry increased in 2005-06 and then in 2006-07.

Dr Graham—All right.

Senator McLUCAS—What sort of work have you done for fees and charges in 2007-08?

Dr Graham—All right.

Senator McLUCAS—What have you done to this point, though?

Dr Graham—Oh, you would like to know?

Senator McLUCAS—Yes. I dare say that you have to set them yet.

Dr Graham—The normal procedure each year is that we have a meeting with each of the industry sectors. In some sectors there might be more than one industry association. We show them the documentation on our predictions for the future, and a lot of that is driven by the number of units of work that are going through and the cost per unit. They have the opportunity to indicate to us what they think the future level of activity may be, and we come to a mutual understanding of what increase in fees and charges might be needed.

At that point in time we present the outcomes of those discussions to the parliamentary secretary and we go through making a regulation for the fees and charges next year. We are at that process now. We are taking those draft regulations through the process to the Executive Council to be signed. As I said, this year there have been some areas where the fees have not been increased at all, although the normal expectation with that would be that they increase by indexation—CPI. In fact, it is a wage-CPI combination increase. Because we have overrecovered, if you like, in that short period of time, we have put that back into the industry.

Senator McLUCAS—Is it possible to compare fees and charges over time? I dare say that the charges may have changed given the nature of your business.

Dr Graham—We can do that.

Senator McLUCAS—Is that published information?

Dr Graham—That is public information, because there is a schedule of fees and charges that the industry pays.

Senator McLUCAS—Yes.

Dr Graham—The difference between fees and charges is that the fees pay for the premarket activities—those activities that are paid by the customer, if you like—for a particular service whereas with the postmarket, the charges are a cost that is averaged across the industry. So what we are trying to do is balance out the premarket activity against the postmarket activity and, therefore, the balance of fees and charges changes over time.

Senator McLUCAS—Yes.

Dr Graham—So it is not quite comparing a trend in fees—comparing apples to apples—because some of it might be passed over to charges or, in fact, passed back again.

Senator McLUCAS—Is it possible to extrapolate? I will not ask you to do this over time completely, but could you have a look at the 2002 fees and charges and then describe them in 2007 dollars? Is that something that you could do?

Dr Graham—Yes, we can certainly do that. As I said, there is going to be qualifiers around how you interpret that.

Senator McLUCAS—Absolutely, I understand that. But if you could do that, that would be helpful.

Ms Halton—The only concern I have about that, Senator, is that because fees are escalated via a composite index comprising cost of living and wage increases, if you just take the 2002 dollars and express them in 2007, that implies an escalator, like a non-funded GDP escalator—

Senator McLUCAS—So which wage cost index is used?

Dr Graham—It is a cost index. I have not got the exact one, but it is a mixture of CPI and the wage index.

Senator McLUCAS—You would be able to proportion—

Dr Graham—For this year, I am not sure if it is fifty-fifty. It is 50 per cent of the ABS wage cost and 50 per cent CPI—an equal index.

Senator McLUCAS—But you would have that fifty-fifty wage cost index over time?

Dr Graham—Yes.

Senator McLUCAS—That would not have changed, I would imagine**.**

Dr Graham—Yes.

Ms Halton—So, in terms of taking 2002 prices, instead of just expressing those in 2007 dollars, which implies a non-funded GDP escalator, it would better to inflate that by the index. So as long as you understand—

Senator McLUCAS—I understand that. That is a more accurate figure.

Ms Halton—That is fine.

Dr Graham—I may not give you all the fees and charges, because there is a list of pages. I will take some representative ones and indicate how they trended.

Senator McLUCAS—I would start with the most common ones.

Ms Halton—Yes.

Senator McLUCAS—Thank you. I did have some questions about black boxes, but I might put them—

Ms Halton—That would be transport, surely.

Senator McLUCAS—They will go on notice.

Senator BARNETT—I want to refer to the *Canberra Times* article of 15 April. It is headed 'Abortion pill close: freely available in months'. It says that Australian women could be using the abortion pill RU486 within months once a European drug company applies to be

the first to register it with the Therapeutic Goods Administration. Has the TGA received an application for the registration of RU486? If so, who is the applicant and for what purpose are they wishing to use RU486?

Dr Graham—The short answer is no, we have not received an application. There has been what perhaps you could call an expression of interest—a very tentative approach. That was a while ago. But we have not received an application.

Senator BARNETT—How long ago would that expression of interest have been made and from whom did it come?

Dr Graham—That information would be commercial-in-confidence, but it would have been about six months ago as a guesstimate.

Senator BARNETT—If an application is made, is it required that it be used jointly with another drug, such as mifepristone? If that is the case, is there an application by the manufacturer of that drug for it to be used and for such a purpose?

Dr Hammett—If a sponsor of a particular medication wishes to use another medication in conjunction for a particular treatment then normally, if they were routinely used in conjunction, the application would include data related to both of those medications.

Senator BARNETT—So does that mean that in any application regarding the joint use of those two drugs all of that information would be included in the application and reviewed accordingly by the TGA?

Dr Hammett—If the sponsor was applying for the use of that particular product within an indication that said it must be used with another product then we would expect data related to the use of both products. However, if the sponsor was requesting an indication that applied only to the use of a single product then we would review the data of that single product.

Senator BARNETT—What if this other product is already legally available? You would still require details in terms of the safety and efficacy of the use of both products together?

Dr Hammett—It would depend on the specifics of the indication that was requested by the sponsor. Let me make this clear: if a sponsor—a hypothetical sponsor—wanted to use mifepristone for termination of pregnancy and they made no reference to the use of another product, we would not expect data from them on the use of another product. If, however, they wished to use mifepristone in conjunction with another product as the routine treatment for termination of pregnancy then we would expect data related to the use of both products.

Senator BARNETT—And you would review the safety and efficacy with respect to that data that you have been supplied with by the applicant?

Dr Hammett—For any application for registration of a product, we would review the safety and efficacy data as it pertains to that application.

Senator BARNETT—Yes. I think I am with you. In terms of assessing any application for the registration of RU486, I just want to clarify what the TGA actually do in terms of the process. So you review the data on safety and efficacy issues. Do you only review data given to you by the applicant or can you review data that is in, say, the public domain or in other places that you might find it?

Dr Hammett—We routinely review data that is in the public domain. In any application for registration of a medication, we require the sponsor to produce information that they may have obtained through scientific trials, or that may be available in scientific literature or in the public domain. We require them to produce all of that data and we would review all of that data. This, of course, is all very hypothetical at this stage. We have no sponsor for mifepristone who has made an application for registration of that product in this country. I guess we can keep talking about how the TGA would routinely register any drug, but at present it is a hypothetical conversation in regard to mifepristone.

Senator BARNETT—Sure, but what is not hypothetical is that there are changing health impacts and safety concerns and issues raised from time to time around the world—not just in Australia—with respect to the use of RU486. So what I am asking is: do you keep up to date with the latest evidence and research that is available and do you use that up-to-date information in the review of any application?

Dr Hammett—For products that are included on the Australian Register of Therapeutic Goods—so registered medicines in this country—we routinely require the sponsors of those medicines to provide us with regular updates about safety and side effects that may become available anywhere in the world. So that information is routinely reviewed by the TGA. We do not routinely review information about products that are not registered in Australia. Clearly, there are medications that are available around the world that are not available in Australia, and the resources that are available to the TGA would not allow us to cast a fishing net on every single medication in the world.

Dr Graham—But in general, if a company comes across data that might indicate that there is a concern about a particular use of its product, or if we come across that information through our contacts with, say, the FDA or other organisations, either party can initiate a review of that product to change its product labelling, the product information, or how it is used to take into account that concern.

Senator BARNETT—And this really is the crux, Dr Graham: if you receive information from a third party, in terms of the evidence on safety and related matters, are you at liberty to use that information in your assessment of any application that may come before you with respect to RU486?

Dr Graham—If we came across information that was scientifically valid, we would no doubt take that up with the sponsor concerned and we would discuss the need to respond to that information. We would also perhaps use our expert committee—in the case of prescription drugs, it is the Australian Drug Evaluation Committee—which brings a separate perspective to an area of concern. It is very hard to generalise, but certainly information that was substantive would not be ignored.

Senator BARNETT—Thank you.

CHAIR—Are there any other questions? Senator Allison has questions on the TGA.

Senator ALLISON—Yes, I do. I wanted to ask about the recent court ruling in favour of Mr Jim Salim. Can the department indicate what the implications of that case are for the department?

Dr Graham—I will give a little bit of background, because I think there needs to be a bit of context for understanding the outcome of the court case. A number of charges have been made against Pan or ex-staff members of Pan Laboratories. In October 2004 Pan itself and also one of its employees, a Mr—

Senator ALLISON—Sorry, Dr Graham, I am familiar with that. I am not sure whether everybody else needs to know it. But if there is a prepared statement, maybe you could just provide it to the committee.

Dr Graham—It is not prepared.

Senator ALLISON—My questions are directly related to the findings of the court case.

Dr Graham—Yes, and I was just giving the flow of where this has come from and putting it into a context. So there have been a number of charges made—

Senator ALLISON—I am wondering whether we need to do that; that is all.

Dr Graham—All right. I will just explain that, of those charges, Pan pleaded guilty to the charges under the Therapeutic Goods Act and the New South Wales Crimes Act and was fined a total of $3 million. One employee has pleaded guilty and was also convicted. One of those charges related to this matter, and that charge was made in October 2004 about the destruction of evidence. It turned on a point of law. The judge interpreted that offence as requiring the prosecution to prove beyond reasonable doubt that at the time Mr Salim sought the destruction of the evidence he not only knew that the evidence being destroyed would or could be used in a judicial proceeding but that it would be used in a federal judicial proceedings. So it was a very fine matter of law. That is under appeal at the moment.

Senator ALLISON—So are you suggesting there are no implications from the finding of the judge in this matter?

Dr Graham—As I am pointing out, it is under appeal so it is very hard for me to make a further statement than that, although it was on a point of law that the decision was made by the judge.

Senator ALLISON—So when was the decision made to go to appeal?

Dr Graham—Very recently, because the decision for acquittal was made very recently too.

Senator ALLISON—Can you tell me precisely when the appeal was?

Dr Graham—I would have said in the last two or three weeks.

Senator ALLISON—Could we have that document—I was not aware of the appeal—which gives the background?

Dr Graham—This is just a sheet of information. I can give you parts of the document if you like. I can prepare something for you.

Senator ALLISON—If you can give the committee what you were about to read to us which we said we did not need, that might be useful in the light of there being an appeal.

Ms Halton—Yes, Senator, we can give you that.

Senator ALLISON—I want to ask about the Commonwealth program National Mindframe Media Initiative.

Ms Halton—So this is a mental health question—Mindframe—which is not under this program of mental health?

Senator ALLISON—It could possibly be dealt with under mental health or, I understand, it could also be outcome 1.

Ms Halton—Mental health is not under outcome 1. Mental health is under outcome 11, so I am just not quite sure—

Senator ALLISON—I want to ask about suicide related matters, which is not really mental health.

Ms Halton—That is program 11, which at the moment is scheduled for tomorrow at 2.30 pm. It is tomorrow afternoonish, Senator.

Senator ALLISON—Okay. Then I will go to questions about the tobacco advertising act. It has been brought to my attention that British American Tobacco Australia has begun a project that is said to be about reducing cigarette butt littering across Australia. Is the department familiar with this project?

Ms Hart—I am sorry, Senator; I think I only caught half of your question. Would you mind repeating it?

Senator ALLISON—I will ask it again. British American Tobacco Australia has set up what it calls a Butt Littering Trust and from that trust there is advertising currently running and a campaign which is said to be about reducing littering of butts. Are you familiar with this project?

Ms Hart—I have heard mention of it, but I do not think we are formally aware of it. You would appreciate that under the Tobacco Advertising Prohibition Act there are certain statutory limitations on our power to regulate advertisements that relate to tobacco products.

Senator ALLISON—Does this mean you are not investigating the matter? What does this mean in relation to my question?

Ms Hart—In relation to your question it means it has not been brought to our attention as a matter that we would investigate under the TAP Act.

Senator ALLISON—All right. I formally bring that to your attention. I will give you a photocopy of two of the advertisements which do not advertise the tobacco company but certainly portray smoking and cigarettes in what I would regard as, in style terms, an attractive manner. So from what you know, would this be of interest to the department under the act?

Ms Hart—We would need to look at the ads in detail and take some legal advice. I have not looked at them closely, but I would be happy if you referred them to us for us to pursue it.

Senator ALLISON—I will do that. I will hand them over now to you. With regard to the Indigenous tobacco control campaign, what is the most recent data the department has on smoking rates for Indigenous Australians?

Ms Hart—We would need to provide those to you. Unfortunately, I do not have those at my fingertips at the moment, but I can get hold of them for you.

Senator ALLISON—What are the most recent figures? When were they last collected? What do we have access to by way of the most recent?

Ms Hart—I think that the most recent information would be available through the National Drug Strategy Household Survey, which was conducted in 2004 in the field. With regard to the sampling of Indigenous people, I am aware that we have some other information sources that provide data on Indigenous smoking rates. I just do not have them to hand at the moment.

Senator ALLISON—Are you able to inform the committee about trends?

Ms Hart—I would not like to do so without having those numbers in front of me, but we can certainly get hold of them for you and let you know what the data shows in terms of time, series and trends.

Senator ALLISON—Okay, and if you could also provide a comparison with non-Indigenous Australian smoking rates in the same period. Are you collecting data next year from Indigenous communities? Is that what you said?

Ms Hart—We will be collecting the next round. The household survey is conducted once every three years, and the next round of that is in the field and being worked on at the moment. I need to confirm with you what sample size of Indigenous people is available as part of the routine that is—

Senator ALLISON—And, if you would, the plan for the next survey in Indigenous communities specifically. What proportion of the tobacco control funding is allocated to Indigenous smoking?

Ms Hart—We have a range of initiatives. I would need to compile that for you. We have some funding that is provided across all substance types for Indigenous communities and we have a number of Indigenous specific projects. I do not have an aggregated figure of that, but once again I could provide that.

Senator ALLISON—Are any of those projects to do with training Indigenous health workers in Quit programs?

Ms Hart—Yes. We have some work that is being done particularly focusing on smoking amongst Indigenous women who are pregnant. I have some information on that. We also have a program that is being funded under the Indigenous Communities Initiative. It is some general funding that is being rolled out with the Perth based National Drug Research Institute in some metropolitan and rural and remote communities, and the focus is broadly across substances. A number of our Indigenous activities tend to be broadly based across a number of substances, including smoking, alcohol and illicit drugs.

Senator ALLISON—So this is one project in WA?

Ms Hart—Yes, there is a project in WA. As I mentioned, we have some other initiatives and I can certainly compile some information for you on those. I do not have that information easily available to me just at the moment.

Senator ALLISON—With this program in the one area, is that a pilot program? What is the purpose of it being just in that area?

Ms Hart—We have a number of programs that are focused on particular communities. Generally there is a much larger range of program funding available through OATSIH, through the Indigenous area of the department that has some larger substance abuse programs. In my area, through the national Drug Strategy Branch, we have some smaller pools of money that attempt to look at culturally appropriate programs. Some of those first started off as pilot programs. If the evaluation demonstrates that they are suitable for national rollout, we then consider whether there is scope for further funding.

Senator ALLISON—And what stage is that evaluation at?

Ms Hart—The project I just referred to was approved, I think from memory, about the middle of last year, so it is in the process of being rolled out. My understanding is that it is funded for a number of years and we would then be looking at an evaluation of it.

Senator ALLISON—If it is evaluated and shown to be successful, is this rolled out more broadly? What is the strategy?

Ms Hart—As you will have noticed, we have confirmed some funding for Indigenous communities. So there would be potential, if the evaluation shows that it is a workable model and that it is a successful intervention, for it to be considered and renewed if the data held up.

Senator ALLISON—There were calls recently for there to be an Indigenous tobacco control strategy. Does the department intend to develop one?

Ms Hart—As you would appreciate, we have a general tobacco control strategy. We have some specific projects that are focused on Indigenous communities and Indigenous people but within the Drug Strategy Branch we do not have a specific Indigenous tobacco control strategy.

Senator ALLISON—Why is that?

Ms Hart—The process of deciding on and developing priority strategies is done jointly by the Australian government and state and territory governments through the Ministerial Council on Drug Strategy, and there has not been a decision taken through that body to develop an Indigenous specific tobacco strategy.

Senator ALLISON—When was the last time Indigenous tobacco control was on the agenda of that meeting?

Ms Hart—I am afraid I do not know off the top of my head. I would need to go back and look through their meeting papers to determine that.

Senator ALLISON—I am surprised there is no strategy. I would have thought that this was one of the more pressing preventive health and possible preventive health programs within Indigenous communities. Is this not a priority for the department?

Ms Hart—I did not mean to suggest that it was not a priority for the department. I am talking only in terms of funding and initiatives available under my program. I think it would be important for programs available in the substance use area of OATSIH to also address the question. I was just relating it to Drug Strategy Branch funding, for which I have a responsibility.

Senator ALLISON—If I ask them, are they going to say that it is your department; you have the responsibility, not them?

Ms Hart—That is another program area within the department but we work closely with them. Obviously, specific strategies focused on Indigenous people are also run through their program areas.

Senator ALLISON—Has the department provided any advice to the government or to other parts of the department about Indigenous smoking?

Ms Halton—If I can make an observation, there has been a focus on Indigenous smoking. There have been a number of conversations about ways to tackle Indigenous smoking. You raised a question earlier about, for example, tackling Indigenous health workers. That is something we have done some work on, through the Office for Aboriginal and Torres Strait Islander Health.

The question of our approach to smoking more broadly, and picking up what you might describe as pockets of the Australian population who currently show much higher rates of smoking than other pockets, I think is an area which will warrant some consideration, particularly as our smoking rate has come down so significantly. We are now looking at the need to target particular subpopulations. As Ms Hart has indicated, this area as yet in terms of generic smoking programs has not come up. The immediate priority is looking at young people. But the reality is that there will have to be a number of quite specifically targeted pieces of work looking at those subpopulations whose smoking rates are higher than the average population's smoking rate.

Senator ALLISON—I would have thought there would have to be as well, but it does not sound as if there is a national strategy. Are we working towards one?

Ms Halton—No, there is not yet; that is exactly right. But in terms of—

Senator ALLISON—So when will we have one?

Ms Halton—That is a bit like how long is a piece of string.

Senator ALLISON—Is it?

Ms Halton—Yes. Essentially the question of where we go next on smoking is a matter which has to be considered using a range of these other bodies. We do not do this unilaterally. So it is a question of talking with the states; it is a question of talking with the relevant councils et cetera. But in terms of whether this issue needs to be focused on in the not-too-distant future, yes, it does.

Senator ALLISON—Will it be on the next ministerial council agenda?

Ms Halton—I think it is not currently slated for the next ministerial council agenda. Will it be a matter of discussion in the not-too-distant future? Yes. I cannot say to you that it will be on the next ministerial council meeting, but in the foreseeable future, yes, it will be discussed.

Senator ALLISON—When is that next meeting?

Ms Hart—The next meeting of the ministerial council is in November this year. I was talking about the household survey, which my area looks after, but in terms of data I have just had some brought to my attention regarding the National Aboriginal and Torres Strait Islander

Health Survey, which is conducted every six years by the ABS. I have some information here—several points—about some trend data in Indigenous populations.

Senator ALLISON—Which is saying what?

Ms Hart—Half of the adult Indigenous population aged 18 and over are currently daily smokers, and that is about twice the age standardised rate for non-Indigenous adults.

Senator ALLISON—And is it better or worse, in terms of the percentage, than previous surveys? You can take that on notice.

Ms Hart—I will need to take that on notice. There is some other trend data but it is quite a large report so I would not want to misquote it.

Ms Halton—When we started looking at this issue, which we did a couple of years ago now, one of the things we decided to do in the first instance was tackle Aboriginal health workers as role models in the community. I have a personal sense that Aboriginal health workers have a smoking rate of nearly 100 per cent. That is probably unfair but there seems to be a very high rate of smoking amongst Aboriginal health workers. We have done some specific work tackling that particular population as a way into some of these communities. As Ms Hart indicated and I think we all understand, smoking rates for Indigenous people are very high. The question of how and when we are going to tackle that issue has not been resolved but it will have to be tackled.

Senator ALLISON—We know they are very high. My questions are: are they higher than they were? Does that indicate that our programs, whatever they are, are failing? And shouldn't there be a national strategy to look at this question?

Ms Halton—Yes, and you are asking me now for a policy opinion. What I can say to you is that we have done work in this space, particularly around health workers as a starting point. This issue will be discussed because in terms of how we are tackling smoking we do have to have a population-wide approach. We are, however, starting to tackle subpopulations. Young people are a particular focus at the moment, and you will know about the advertisements we have been running in relation to young people. This is an obvious early starter in terms of some of those other subpopulations.

Senator ALLISON—We have known the smoking rate among Indigenous communities has been very, very high—more than twice as much as non-Indigenous communities—for a very long time.

Ms Bryant—Senator, if I can just go to your question of trends. I am advised that the health performance framework that the department has shows no statistically significant level of change in the incidence of smoking in Indigenous populations over 10 years. They are fairly static.

Senator ALLISON—They stay the same but the non-Indigenous population has gone down—

Ms Bryant—That is a reasonable interpretation.

Senator ALLISON—indicating there may be a need for greater effort in this area. I have another couple of questions on tobacco. Has the department done any work on what appears to be a growing availability of tobacco products online?

Ms Hart—Yes, we have. We are aware of the advertising and sale of tobacco products over the internet, and the department is concerned that that may well weaken our policy on tobacco control and the mechanisms of tobacco control. In fact at the ministerial council meeting earlier this month a decision was taken about an option for amending the TAP Act, the Tobacco Advertising Prohibition Act, to try to capture sales to smokers under 18 years and also to restrict advertising of tobacco products on the internet.

Senator ALLISON—So when can we expect that legislation?

Ms Hart—We will give its development priority. As I said, the decision was taken only a few weeks ago now. We will need to draft a regulatory scheme and go through the process of producing a regulatory impact statement and tabling the regulations, but it is a priority. It is an area that we have been looking at a mechanism through our act and also in concert with state and territory acts that deal with point-of-sale legislation to see if we can restrict those sales.

Senator ALLISON—Are you also looking at progress in this area overseas?

Ms Hart—We have to some extent had a look at that. The difficulty for the Australian government in this area is the legislative competence under the Constitution to regulate, so consequently we have to work in the legislative framework of constitutional power between the Commonwealth and the states and territories.

Senator ALLISON—I understand that in the United States 33 state attorneys-general have joined to put in place legislation that would ban the sale and delivery of online tobacco products. They have also involved leading credit card companies and overnight delivery services. Is that something you are considering at present?

Ms Hart—There has been discussion amongst state and territory health departments about the issue of proof of age at point of delivery. The capacity to regulate that is covered by state and territory acts. At the moment, my understanding is that Western Australia requires a driver's licence or proof of age on point of delivery when something has been ordered online. The ministerial council has recommended that other states and territories look at a similar model, so that could act as a complement to the proposed regulatory changes the Commonwealth is making under the TAP Act.

Senator ALLISON—When tobacco comes in from overseas through online orders, do people avoid paying the tax?

Ms Hart—I am not sure I could answer that. That would be a question for Customs.

Senator ALLISON—How do the forward estimates on tobacco control expenditure for the next four years compare with the actual expenditure on tobacco control for 2004-05? Are you able to provide those figures?

Ms Hart—I do not have those to hand but we could easily provide them to you.

Senator ALLISON—That is all I have.

Senator MOORE—I have one question which I believe is in this outcome and it follows from a question asked by Senator Allison about the sexual health survey of students by La Trobe University. Senator Allison asked that question both here and on notice and got a response back from the department which said that the survey was not being funded in the last financial year but the department may reconsider the request for funding for the survey in the next financial year. We have now hit the next financial year and I want an update.

Ms Bryant—We have reconsidered that issue and we will be able to fund the survey in 2007-08.

Senator MOORE—Lovely. Have people been advised of that?

Ms Bryant—I have been told my language was not quite precise.

Ms Halton—I do not want this to be misunderstood. It has not been 'reconsidered'. I think we said it was under consideration and funding has been provided.

Senator MOORE—The wording was—and this is the magic of these things—'While funding was not available in 2006-07, the department will reconsider the request for funding for the survey in the new financial year.'

Ms Halton—Exactly. So the question was: when was funding going to be available? There is funding available in this year. I do not want it to be misinterpreted that we had rejected it, period, and we have now reconsidered the rejection.

Senator MOORE—So the survey for high school students will now be funded for La Trobe University?

Ms Bryant—Yes. The people in the organisation have been informed, as in we have asked them for a current quote to undertake the work, so they are aware of it.

Senator ALLISON—When will the funding actually flow to the program?

Ms Bryant—We envisage it will be in 2007-08.

Senator ALLISON—Which end of 2007-08?

Ms Bryant—That is to be resolved depending on the timing of the survey and the advice and material we get back from the organisation.

Senator ALLISON—Has La Trobe University been informed of this?

Ms Bryant—Yes, we have had discussions with La Trobe University.

Senator ALLISON—What were the other priorities that stopped funding of this program on its five-year anniversary, as it were?

Ms Bryant—We have a funding allocation that funds a large number of initiatives—

Ms Halton—Which is regularly oversubscribed. It is one of the problems with this particular bucket— everybody wants something out of it.

Ms Bryant—There would be several dozen—

Ms Halton—Dozens.

Senator ALLISON—Several dozen more important than this study?

Ms Bryant—That is right.

Ms Halton—Regrettably, yes.

Senator ALLISON—Is it possible to provide a list of those?

Ms Halton—No.

Ms Bryant—It would be difficult for us. We have some ongoing initiatives, some single year initiatives and so on. We can have a look at what we could provide but it is not as straightforward as a simple list.

Ms Halton—No.

Ms Bryant—This has come out of what we would call bill No. 1: base appropriation.

CHAIR—If there are no further questions in outcome 1, we will break for a little while. We are about two hours behind on the program that we have published. I guess there goes any chance of an early mark, which some of us were looking forward to. We might need to consider whether there is any need to truncate or apportion time for the rest of the evening. I will leave that to senators on my right to think about.

Senator McLUCAS—Just before Senator Allison leaves, I wonder whether we could aim to continue the list of outcomes but truncate the time.

CHAIR—So the outcomes in the order that they appear in this program—

Senator McLUCAS—So we try to finish Wednesday on Wednesday and Thursday on Thursday.

CHAIR—I am happy to be an ogre and cut off questioning.

Senator McLUCAS—I would like you to be more bullish.

CHAIR—Okay.

Proceedings suspended from 3.32 pm to 3.48 pm

CHAIR—The estimates committee hearings of the community affairs committee will now resume. I think our minister is on the leave that we have allocated him, so he is excused. We are on outcome 3, access to medical services, and questions from Senator McLucas.

Senator McLUCAS—Going to the collection of Medicare statistics: GP consultation numbers are presented in the reports disaggregated by five-year age groups; is that correct?

Ms Halton—Which report are you talking about, Senator?

Senator McLUCAS—The MBS group statistics report.

Ms Halton—Yes.

Senator McLUCAS—Is that the smallest age cohort that they provide?

Ms Morris—Yes.

Senator McLUCAS—So they are not collected by age, so to speak?

Ms Morris—No.

Senator McLUCAS—But you know the age of the client?

Ms Morris—That is the smallest level of disaggregation we go down to.

Senator McLUCAS—Right; so you could not say the GP rates for five-year-olds are X, Y or Z?

Ms Halton—You could but we do not. So we do not ever publish anything other than in those five-year cohorts. That has been the standard for as long as I can remember.

Senator McLUCAS—So you could say—

Ms Halton—We could.

Senator McLUCAS—You could, but you do not publish them.

Ms Halton—We do not.

Senator McLUCAS—Are they provided to the minister on an age basis?

Ms Halton—No.

Senator McLUCAS—Just by the five-year cohorts?

Ms Halton—Yes.

Senator McLUCAS—Okay. With regard to the last published data by electorate, when was that?

Ms Morris—That was released on 5 April 2007.

Senator McLUCAS—Do you have that data with you?

Ms Morris—I will have bits of that data with me, but it was a fairly large release. So I have some data with me.

Senator McLUCAS—Is it on the website?

Ms Morris—Yes.

Senator McLUCAS—So that was data for what financial year?

Ms Morris—For 2005-06 and 2004-05 too. It was the release of data by electorate for 2005-06.

Senator McLUCAS—And that was on 5 April?

Ms Morris—Yes, and it is publicly available on the Medicare Australia website. Sorry; it is calendar year. Sorry, Senator, I forgot it has safety net data in it which is calendar year.

Senator McLUCAS—So that is for the 2006 calendar year?

Ms Morris—Yes.

Senator McLUCAS—And the previous release, was that for a calendar year or a financial year?

Ms Morris—It would have been for a calendar year.

Senator McLUCAS—Okay. If we cannot find that, we might come back to that.

Ms Halton—You can get the URL.

Senator McLUCAS—That would be good.

Ms Halton—If you want it, we will give it to you.

Senator McLUCAS—That would be fabulous. Thank you. Does the website also indicate a disaggregation by age?

Ms Morris—No.

Senator McLUCAS—But you do collect that data?

Ms Morris—We do, and the quarterly releases of data we look at by age. We disaggregate for over 65-year-olds and for under 16-year-olds by age.

Senator McLUCAS—So the quarterly data has over-65s?

Ms Morris—Yes.

Senator McLUCAS—Under-16s?

Ms Morris—Yes, and under-16s.

Senator McLUCAS—And by profession, by service?

Ms Morris—By non-referred and referred.

Ms Halton—We have put the nurse items in.

Ms Morris—Yes, practice nurse items.

Ms Halton—We have put practice nurse items in separately.

Senator McLUCAS—Are there bulk-billing rates, Ms Morris?

Ms Morris—Yes. Senator, we will get you the URL so you can investigate the data yourself.

Senator McLUCAS—That is for both by electorate and by demographic?

Ms Morris—Yes, what was released in early April.

Ms Halton—It is not by demographic. The material that was released was the electorate data and that basically just gives you the aggregates by electorate. So it does not disaggregate by age.

Senator McLUCAS—Or type of service?

Ms Morris—No. For bulk-billing data, that is released quarterly and that does disaggregate—not by every single age group but by over 65-year-olds and under 16-year-olds and total.

Senator McLUCAS—Does it also disaggregate by rural and remote?

Ms Morris—No, it does not.

Senator McLUCAS—Can we have that data then, please?

Ms Halton—Sorry; what were you asking for, Senator?

Senator McLUCAS—Rural and remote.

Ms Halton—The minister has made a policy decision about what material he will release. This is his decision and that is what he has decided to release in that format.

Senator McLUCAS—So the quarterly data is 65 plus, 16 minus—

Ms Halton—And in between.

Senator McLUCAS—And therefore the bit in between.

Ms Halton—Yes.

Senator McLUCAS—In terms of service provided—

Ms Halton—It is referred and non-referred. In the non-referred you can see the differentiation between the practice nurse items—

Senator McLUCAS—But not, for example, for pathology?

Ms Morris—Yes, we do have pathology. We tend to group services. We do not have every single item or every single specialist, but we group them by type of service. So pathology, I am fairly sure, we do have. Optometry we have. Yes, these are disaggregated by specialist attendances—obstetrics, anaesthetics, pathology, diagnostic imaging, operations, optometry and other. So they are broad groupings.

Senator McLUCAS—But not rural and remote?

Ms Morris—No; we do not disaggregate to that level.

Senator McLUCAS—The minister obviously made a decision that he can have that data but the Australian community cannot. The opposition cannot but he will release it as his will will have it. Parliamentary Secretary, I am glad you are back early. Why do you think it is that the minister can have access to this data but he is not prepared to share it with the rest of the community?

Ms Halton—Senator, the information you are particularly interested in is rural versus other splits—is that correct?

Senator McLUCAS—The minister, in a press release in May this year, talked about disaggregated data and identified that the rate of GP bulk-billing in rural and remote areas is increasing—that bald statement. There is no point of reference for that. Has it increased by 0.01 per cent? It is a useless piece of information without having some point of reference. What we are asking for, Parliamentary Secretary, is to get a copy of the disaggregation by rural and remote areas.

Ms Halton—I will need to take some further advice. My understanding is that there is an annual release of the electorate data.

Senator McLUCAS—Just to clarify: is the electorate data the bulk-billing rate?

Ms Halton—Yes, and safety net data. Then there is the quarterly reporting which goes to the age range utilisation—the figures that Ms Morris has just gone through.

Senator McLUCAS—Is that for bulk-billing again?

Ms Halton—That is correct. I believe that the minister has released to the Parliamentary Library some data which looks at the capital city, other metropolitan and rural and remote split. I think that information has been put in the public arena. It looks to me as if it has been released in response to a request from the Parliamentary Library, so therefore it is in the public domain. That is not part of the quarterly process, but I am having that confirmed. But

this information is in the public domain because it has been given to the Parliamentary Library.

Senator McLUCAS—If that data has been given to the library, could we also request a copy of it?

Ms Halton—Yes. As I said, let me just clarify when this went et cetera.

Senator McLUCAS—Thank you. I misunderstood a question I have here. Going back to figures by electorate, I asked about bulk-billing rates and I did not mean that. I meant to ask about Medicare services and benefits, so it was the total Medicare services and total benefits paid by electorate released for 2004-05. I understand that has not been released for 2005-06?

Ms Morris—The report on government services is published once a year. I am sorry; I cannot tell you when.

Ms Halton—It is the blue and white book, and it is produced in about March.

Ms Morris—It has unreferred GP attendances by RRMA but not by age. It is broken down by RRMA but not broken down beyond that.

Senator McLUCAS—That goes to the rural and remote question. I thought that was answered by Ms Halton's reference to the document that has gone to the library.

Ms Halton—No, that was the services question. The document that has gone to the library is on bulk-billing.

Senator McLUCAS—Right. So we are now going to total medical services and total benefits paid. I understand that it was released for the 2004-05 financial year by electoral division.

Ms Halton—Prior to the minister taking a decision about what he was going to release, there was—and I do not remember whether it was by him or whether it was when Senator Patterson was the minister—one earlier release of data which I think had a number of different things in it. Then the minister took a policy decision on what he was going to release by electorate on an annual basis, and that is what we are now doing.

Senator McLUCAS—I remember that vividly. My understanding was that that was bulk-billing rates. I do not think it was total services.

Ms Halton—I think there was an earlier release of services information. I think there had been a patchwork; there had been a number of things released at different times in the run-up to that period. Then the minister decided that he wanted to regularise what was released, and that is what we now have: we have this annual release of electorate data in terms of bulk-billing.

Senator McLUCAS—Bulk-billing rates only?

Ms Halton—That is right.

Senator McLUCAS—But not total services?

Ms Halton—That is right.

Senator McLUCAS—Ms Halton, would you go back and confirm that is in fact what the minister has said—

Ms Halton—Yes, let us go and look at the history of it.

Senator McLUCAS—My recollection is very clear—that is, that it was totally about bulk-billing rates, which was the political point, and not about total services or total benefits paid. Given that we have data for 2004-05—and I think it is financial year data—I am formally requesting that we have 2005-06 financial year data on total Medicare services and total benefits paid by electorate.

Ms Halton—I think his decision was that what is in the public arena was what he would put in the public arena, but I will come back to you on that.

Senator McLUCAS—Is the 2007 report on government services, which is for 2005, by RRMA and by age?

Ms Morris—It is not by age, just by RRMA.

Senator McLUCAS—When on 11 May 2007 Minister Abbott said:

> The rate in rural and remote areas increased to a record 72.6 per cent,

how would he have defined rural and remote? I dare say it was by RRMA, but by which RRMA?

Ms Morris—RRMAs 3 to 7.

Senator McLUCAS—We will come back to total benefits paid. I turn to questions around the structure of Medicare. Are there any planned changes to the structure of Medicare?

Ms Halton—Meaning what, exactly, Senator?

Senator McLUCAS—The formal structure of the entity.

Ms Halton—Medicare is a program.

Senator McLUCAS—Yes. Are there any planned changes to the structure of Health Services Australia?

Ms Halton—We are not responsible for Health Services Australia.

Senator McLUCAS—I know that.

Ms Halton—It is owned by the Minister for Finance and Administration.

Senator McLUCAS—Are there any plans to transfer assets from Health Services Australia to either Medicare or Medibank Private?

Ms Halton—We cannot answer that question.

Senator McLUCAS—You can answer it in terms of Medicare.

Ms Halton—No. Do you mean Medicare Australia as part of human services?

Senator McLUCAS—You have no knowledge of any proposals in that area?

Ms Halton—We cannot make any comment about it. The minister for finance is the shareholder minister for HSA and the Minister for Human Services is responsible for Medicare Australia. So what is going on in that space is a matter for them.

Senator McLUCAS—Yes, but you have heard of planned changes?

CHAIR—Senator McLucas, I do not think it is appropriate to ask witnesses about areas that are not within their area of responsibility.

Senator McLUCAS—It does affect health service delivery in Australia, and this is the Department of Health and Ageing.

CHAIR—Very indirectly. If you want to know about their responsibilities, you ought to ask the agency concerned.

Ms Halton—HSA is a company. I am not sure about the point.

Senator McLUCAS—It is a government owned company.

Ms Halton—Yes, but it provides a commercial service.

Senator McLUCAS—Yes.

Ms Halton—Principally the department of immigration, as I understand it.

Senator McLUCAS—I beg your pardon?

Ms Halton—Principally to the department of immigration, as I understood it, but Health Services Australia does a lot of migrant medical screening.

Senator McLUCAS—Yes, but it is a health issue. Anyway, we did try in the other committee and that was unsuccessful as well.

Ms Halton—Senator, can I tell you the data? You were asking about the URL.

Senator McLUCAS—Yes, please.

Ms Halton—It is www.health.gov.au/internet/wcms/publishing.mnss/content/electoratereport/index.

Senator Mason—That should be pretty easy to find.

Ms Halton—We perform a research service as well.

Senator McLUCAS—Thank you very much. Could I talk about MRIs. The government announced in the budget that it would provide $17.9 million to improve access to MRI services. This apparently is going to provide an additional three locations in addition to increased support for the Medicare-eligible MRI service in Dubbo. Where will the additional three MRIs be located?

Ms Morris—That decision has not yet been taken, Senator.

Senator McLUCAS—What is the process by which that decision will be arrived at?

Ms Morris—We will put some advice up to the minister based on an analysis of population and doctor numbers, but it will be the minister's decision where they are located.

Senator McLUCAS—So you provide the evidence base and then further decisions are made on that?

Ms Morris—Yes.

Senator McLUCAS—In terms of population, do you have a look at the population where access to MRIs is less and then make recommendations on that basis?

Ms Morris—We look at many factors, Senator. When you look at non-metropolitan areas, you make some trade-offs around those.

Senator McLUCAS—Certainly. It is about access, not numbers.

Ms Morris—Yes

Mr Learmonth—There has to be the population to support a viable throughput, so it is a balance of those things.

Senator McLUCAS—Are there some parameters you can provide the committee in terms of the population element that—

Mr Learmonth—There are not settled parameters about how we do the analysis. It takes into account a range of factors.

Ms Halton—For example, Gulargambone is not going to be big enough.

Senator McLUCAS—No. However, the town next door, which has a population of 30,000, which is 10 million kilometres from Brisbane, probably will.

Mr Learmonth—It is reasonably complex because we do look at catchment areas and make inferences around which particular location might draw patients from what sort of area, and we try to strike that balance between the need and viability.

Prof. Horvath—And simply what the medical establishment there is to feed it. Even if you had a marginal population, if you do not have appropriately skilled people to order the MRIs, then it is not appropriate.

Senator McLUCAS—I understand that. So there are variables such as population and doctor numbers. What other variables are added into those deliberations before advice is provided to the minister?

Ms Halton—Well, presence of another machine.

Senator McLUCAS—Or potential accessibility to another machine?

Ms Halton—Yes. You might have quite a large area that already has one machine but there is not enough access given the size of that population.

Ms Morris—Or there might be an area where prima facie it looks sensible to put something there but there will not be the workforce there to support it or to cope with the patient population.

Senator McLUCAS—So you are going through that process now—

Ms Morris—Yes, Senator.

Senator McLUCAS—of ascertaining the recommendations for the three?

Ms Morris—Yes.

Senator McLUCAS—I seem to get from you that it is not a scientific process really.

Ms Halton—There are a number of what you might describe as scientifically verifiable variables. For example, how many people are there? Draw in the population. Are there medical professionals? Is there already a machine? Yes; no; yes; no. There are this many—draw the map. But at the end of the day it is the combination of all of those which I do not

think you could say you could derive into a statistical mathematical algorithm. You can get to the observable facts and then there is a question of judgement about the combination of those facts.

Mr Learmonth—It would be a little false precision to think that you could rank individual locations in a way that is meaningful.

Senator McLUCAS—That makes it hard to assess whether a decision has been made on the basis of need or other considerations.

Ms Halton—I think you can characterise a series of areas which will all have a claim, some more heavily weighted one way than another way. There are clearly some areas that do not have a claim. They are either not big enough or they do not have enough professionals. So you can rule people out but then, of the ones you are left with, there is an on balance judgement about which ones to go with.

Senator McLUCAS—So how does Launceston feature in that sort of consideration?

Mr Learmonth—We have not done the analysis yet, Senator, to make judgements about any particular example.

Senator McLUCAS—You have not made any analysis?

Mr Learmonth—No.

Senator McLUCAS—So where are we up to in the process? How long does it take? When do you imagine you will have that statistical and population analysis completed?

Ms Morris—We are hoping within the next month, Senator. It is hard to put time frames around it.

Senator McLUCAS—But you would have that advice to the minister by the end of the month?

Ms Morris—We would aim to do that, Senator.

Ms Halton—All other things being equal. It is a bit like our ambition to get all our Senate estimates questions done on time—best endeavours.

Senator McLUCAS—You will do better than FaCSIA.

Ms Halton—There should have been a reward to the department for best performance.

Senator McLUCAS—Your reward was beginning today. That was your reward. Be happy.

Ms Morris—We are working on it, Senator. We will get it done as soon as we can, but who knows what else comes up in my in-tray and my officers' in-tray between now and then.

Senator McLUCAS—All right. So you do not know about Launceston. You have not done an analysis of that?

Ms Halton—No.

Senator McLUCAS—What about Redcliffe, in Queensland?

Mr Learmonth—Senator, we have not done enough analysis to draw judgement on any of them.

Senator McLUCAS—No, but going back to the discussion about population, access to other services, medical professionals in the region—you know where Redcliffe is, I imagine.

Mr Learmonth—Yes.

Senator McLUCAS—How would that rate, given what you have talked about?

Ms Halton—We have not looked.

Mr Learmonth—We have not done an analysis to know how it might compare with some alternative. Whilst we might be able to describe the characteristics of Redcliffe, we do not know how it is placed against the others because we have not done that work to get a sense of relative priorities.

Ms Halton—The one thing it has got is population. So I think we can also tick the population box. But in terms of relative access, we have not done that work yet.

Senator McLUCAS—With regard to your point, Ms Halton, about ruling centres out, you are saying that Redcliffe would not be ruled out because it is reasonably—from a person who comes from Cairns— close to Brisbane.

Ms Halton—Yes.

Senator McLUCAS—But it would not be ruled out on that basis?

Ms Halton—No, not necessarily. The thing you have to remember is that even though you do have facilities in Brisbane, they are already servicing quite a large and growing population.

Senator McLUCAS—I am not trying to make an argument one way or the other; I am trying to—

Mr Learmonth—Access is more than just proximity. It is also about the capacity of what else is in the region. It is quite complicated to determine. There might well be a machine within a reasonable distance at Redcliffe. The question is what capacity does it have in terms of its existing catchment.

Senator McLUCAS—Does Wollongong not have an MRI at the moment?

Ms Halton—It has one.

Senator McLUCAS—It has one already?

Ms Morris—It has one but it has a large population.

Senator McLUCAS—One unfunded or one funded?

Mr Learmonth—Funded.

Senator McLUCAS—But a large capacity?

Mr Learmonth—A large population.

Senator McLUCAS—Thank you. Let us go to the Dubbo machine. Why does Dubbo need extra money? It is sort of in the budget papers. It just says, 'increase in support'.

Ms Halton—That was a viability issue, Senator. This is where there are, again, on balance judgements. There is a reasonable sized population out there, but in terms of making that machine actually viable, they need a small supplement.

Ms Morris—It is to enable them to bulk-bill concessional patients. Without that additional supplement, especially at this setting up stage, they would not—as Ms Halton said—have been able to just carry on financially and bulk-bill concessional patients.

Senator McLUCAS—It would be interesting to look back over time and make a judgement about whether Dubbo actually did fit the criteria of the assessment process.

Ms Morris—There are no clear-set criteria, I think is what we are saying.

Ms Halton—And I think that is the point here. At the end of the day there can be on-margin calls in some of these areas. Geographically, if you have got to go from Dubbo all the way to Sydney, that for the patients is a big issue. We know that in some cases it is probably worth the slight extra investment to provide people at some distance from capitals with a service. But again, they are on-margin issues. This is one of them.

Senator McLUCAS—Could we have a list of the government funded MRI machines?

Ms Halton—Yes. It is on the website.

Senator McLUCAS—It is on the website.

Ms Morris—We will get you the URL for the list of the funded MRIs.

Senator McLUCAS—What is the quantum of the supplement that Dubbo requires?

Ms Morris—The budget measure was for an additional $1.5 million over three years.

Senator McLUCAS—So half a million a year; and you do not just send a cheque; you ensure that people who are concessional are bulk-billed?

Ms Morris—Yes, we are drawing up a contract at present.

Senator McLUCAS—What other MRI machines in Australia are also non-viable?

Ms Halton—This one is not non-viable; let us be clear about that. The issue with this one was about no gap—so bulk-billing arrangements and concessionals. It could be financially viable but it would rely on a level of charging for concessional patients.

Ms Morris—That is exactly right.

Senator McLUCAS—So there are concessional patients in other areas who are being charged a copayment?

Mr Woodley—MRI units have been Medicare eligible since 1998, under a whole range of arrangements. Those that became eligible in 1998 became eligible at a time when there were no conditions attached to patient charging, which made them on a par with almost every other Medicare service. So those services—the 1998 lot—are able to charge according to the market.

Ms Halton—But—

Senator McLUCAS—Was the Dubbo machine always—

Ms Halton—Go with the 'but'.

Senator McLUCAS—Sorry.

Mr Woodley—But, under the range of schemes that have generated extra Medicare eligible MRI units since then, in general there have been conditions attached to that funding, including conditions around patient charging.

Ms Halton—Yes, so when we went out to tender, one of the things we said would be a criteria would be whether or not they would make available bulk-billed services to concessionals. So in terms of considering the merits of the tenders, that was one of the considerations. So that was pretty much what we got.

Senator McLUCAS—When did the Dubbo machine go in?

Mr Woodley—It began providing services—I think it was in December last year.

Senator McLUCAS—Did it have a condition that it would bulk-bill concessionals when that contract was drawn up?

Mr Woodley—The terms that were agreed with the provider in Dubbo were that, yes, it would observe certain patient charging policies.

Senator McLUCAS—So now the provider has come back and said, 'We can't operate because we do not have enough throughput to make it viable.'

Ms Morris—That is the bottom line.

Ms Halton—Yes.

Senator McLUCAS—On the basis of that situation, how many other Medicare-eligible MRIs in Australia are in that position?

Mr Woodley—Which position? Bulk-billing or subsidising?

Senator McLUCAS—Where they do not have enough throughput to make them viable without charging an additional copayment.

Ms Halton—I am not aware of any, Senator, but I cannot say categorically—

Senator McLUCAS—You have not sought that, I dare say.

Ms Morris—No, but the case has not been made on the basis of any others.

Senator McLUCAS—So basically Dubbo is being funded because they have come to you to say, 'We can't do this.'

Mr Learmonth—I think as a general proposition, as the secretary said before, when new MRIs have been offered under other schemes, the patient billing has been part of the criteria. So, if you like, we can leverage the market interest. If there is no depth in that market interest—and there might only be one provider that is willing to provide it in a lineball marginal situation—then we need to look at other strategies.

Senator McLUCAS—Thank you for that. I want to come back to the electorate data. I understand that the website, which we have, does not have the total benefits by electorate, and that is what we are after.

Ms Halton—That is right.

Senator McLUCAS—But it was released for 2004-05; is that right?

Ms Morris—Yes.

Senator McLUCAS—Total benefits?

Ms Morris—Total benefits were released for 2004-05.

Ms Halton—I will have to go back and look at what was released.

Senator McLUCAS—We will come back to that later. Can we go to the professional services review.

Ms Morris—Yes.

Senator McLUCAS—The professional services review, I am advised, has had reduced funding over the forward estimates period. Can you go through what the 2006-07 allocation is?

Ms Morris—Yes.

Senator McLUCAS—And then projected expenditure and then have a look at the forward estimates and we then can talk about it.

Ms Morris—What they got in the budget—the measure relating to the professional services review—is $12.9 million over four years.

Senator McLUCAS—And how much of that is allocated—

Ms Morris—But that is not their sole funding; that is an amount on top of the base level of funding.

Senator McLUCAS—What is the base funding?

Ms Morris—That has not been released. This was in relation to a lapsing measure that was renewed and this is the amount of funding that they got under that lapsing measure.

Senator McLUCAS—That does not show in the lapsing programs list that we got earlier. Is there a written one following that?

Ms Morris—Sorry, I am just clarifying the language that I am using here.

Senator McLUCAS—That will help me as well.

Mr Clout—The number of lapsing programs on the list now, as you can see, is only about 17 or so. A very large number of the lapsing programs in the department have been converted to ongoing programs and are now regarded as ongoing programs in the forward estimates. So this program may have been announced originally as a lapsing program and is now ongoing. So you will find that PSR is not on the list that you have got; it is now an ongoing measure.

Senator McLUCAS—But the end of the question says 'lapsing programs which have been identified as being rephased in the relevant budget documentation are listed at attachment A'.

Mr Clout—That is right.

Senator McLUCAS—Is 'rephased' a word that I am misconstruing?

Mr Clout—'Rephased' means that it is a reprofiling of funding. So funding is moved from one year into other years. PSR will not appear in the list that you have got there, I do not think, because I do not think that it is a lapsing program anymore.

Ms Robertson—The $12.9 million for the PSR that appears in the budget papers has actually been rolled into the base funding for the PSR. It was money that was appropriated for the purpose of implementing legislative changes from, I think, around 1999 and then again in 2002. Since then, the implementation of those changes made has become part of the normal program of the PSR; hence that money going into the base funding.

Senator McLUCAS—Can you give us the quantum of the base funding of PSR?

Ms Robertson—I do not think I have the total funding with me here.

Senator McLUCAS—So how much of the $12.9 million over the four years is allocated in 2007-08?

Ms Morris—It is $6.1 million.

Senator McLUCAS—And in the out years?

Ms Morris—Sorry, I am looking at the wrong piece of paper. It is $3.5 million for 2007-08; $3 million for 2008-09; $3.3 million for 2009-10 and $3.1 million for 2010-11.

Senator McLUCAS—How does that compare to the funding given to PSR in 2006-07? For this particular element, not for base funding.

Ms Morris—For that particular element, I may have to check that. I hope I will be able to get that for you in the course of the afternoon. I do not have it with me.

Senator McLUCAS—While you are looking for that, can you also find out how much of that has been expended or is projected to be expended?

Ms Morris—In this current financial year?

Senator McLUCAS—In this current financial year.

Ms Morris—I will try. We will need to talk to the PSR about that so I am not confident I can actually give you the answer on that today, but I can tell you what the figure is.

Senator McLUCAS—This brief indicates to me that there has been a reduction, and you are saying that is because the legislative changes in 1999 and 2002 have been completed and rolled through.

Ms Morris—That is right. As Mr Clout explained, this was particular funding to implement some changes and the decision has now been taken to roll additional funding into their base.

Senator McLUCAS—Okay. If you can come back with the allocation and the projected actual for this current year—

Ms Morris—If we can get it, yes.

Senator McLUCAS—What threshold was established for the Medicare levy surcharge?

Ms Robertson—I cannot recall. I am sorry, I would have to take that on notice.

Mr Learmonth—That is a Treasury matter.

Senator McLUCAS—So Health and Ageing had nothing to do with setting that threshold?

Mr Learmonth—It is the Treasury portfolio.

Senator McLUCAS—So you had no input into setting the threshold or whether or not it has been indexed?

Ms Halton—It is not for us, no.

Senator McLUCAS—So you have never been consulted about whether it should be indexed or whether the threshold should be changed?

Ms Halton—There might be some informal discussions between officers, but it is not a formal matter for us.

Senator McLUCAS—Have you done any analysis of whether the fact that the threshold has not been indexed over time has impacted on people's take-up of PHI?

Mr Clout—I believe that the Medicare levy thresholds are indexed annually, but rather than appearing as a parameter update I think they appear as a measure annually in the revenue measures of Budget Paper No. 2.

Senator McLUCAS—That is not what I am advised here, Mr Clout. Can you find out for me what the threshold is now?

Mr Clout—I will find a copy of Budget Paper No. 2 somewhere in the room and confirm that for you.

Senator McLUCAS—Thank you. If it is different from that, we might come back to it. We will now go to the package for dental care under the strengthening Medicare program which was first announced in 2004. When it was first introduced, what was the budget allocation for the scheme?

Mr Eccles—Are you are talking about the existing dental item?

Senator McLUCAS—Yes, the current existing three MBS items.

Mr Eccles—It was part of a broader allocation of $162 million to cover the dental and allied health initiative, so it was part of a—

Senator McLUCAS—Excuse me for a minute, Mr Eccles. Please continue.

Mr Eccles—I have been referred to the right page, sorry about that. That interruption was very opportune.

Senator McLUCAS—So it was part of a broader package?

Mr Eccles—Yes, it was part of a broader package called the Medicare allied health and dental care initiative which was $162.6 million over four years.

Senator McLUCAS—And was it disaggregated into years? It started in the 2004-05 budget; is that right?

Mr Eccles—That is right.

Senator McLUCAS—Can you disaggregate that over years, and can you take the dental out of the total program?

Mr Eccles—The cost of the dental items was not separately identified in the budget package.

Senator McLUCAS—I will come back to you if I want you to disaggregate that $162.6 million over the four years.

Mr Eccles—Sure.

Senator McLUCAS—How many people were expected to benefit from the dental component of that?

Mr Eccles—We did not set any targets. It was always expected that, like most of the MBS items, it would be a demand driven program but we did not set any specific targets for uptake.

Senator McLUCAS—How do you evaluate something if you do not set a target?

Mr Eccles—We take into account things like uptake and feedback from the profession—the extent to which the profession is telling us it is meeting the problem that it was designed to remedy. They are the usual processes that we bear in mind when we consider assessing things. As you know, the Medicare Benefits Schedule is a special appropriation and it is not capped, so to speak, and there are no targets set for particular items.

Senator McLUCAS—But if you are changing policy you would, hopefully, have an objective.

Mr Eccles—Absolutely.

Senator McLUCAS—And then you would measure success against that objective.

Mr Eccles—That is right.

Senator McLUCAS—So what was the objective?

Mr Eccles—The objectives were to assist people with chronic and complex conditions and have access to the right form of dental care that would improve the management of those chronic and complex conditions.

Senator McLUCAS—So how do you evaluate that?

Mr Eccles—We evaluate that by talking to the professions and by talking to the stakeholders in this area—and we did that.

Senator McLUCAS—You do not count the number of people who go through the system?

Mr Eccles—I think that comes into it, and certainly we did look at that data when we were contemplating how this item was going.

Senator McLUCAS—It was fairly anecdotal.

Mr Eccles—There is no more formal mechanism than that.

Senator McLUCAS—What details do we have about what kind of chronic conditions people who access dental care under the program had and what numbers of people?

Mr Eccles—We can give you the uptake to 30 April. Are you after the uptake of the dental items?

Senator McLUCAS—Yes.

Mr Eccles—There have been 14,821 items—of the item being utilised.

Senator McLUCAS—Of which item?

Mr Eccles—These are the dental care items for people with chronic and complex conditions.

Senator McLUCAS—So 14,821 events of care have occurred.

Mr Eccles—No, 14,821 services have been provided. I do not know how many follow-up items—

Senator McLUCAS—I understand there were three different Medicare items, the first one being the initial consultation and then some procedural Medicare items.

Mr Eccles—Yes.

Senator McLUCAS—So you are describing the first?

Mr Eccles—No, I am sorry, it is 14,821 total services provided.

Senator McLUCAS—Total periods of care performed.

Mr Eccles—That is exactly right.

Senator McLUCAS—So how many people are we talking about?

Mr Eccles—5,730.

Senator McLUCAS—There have been 5,730 people since 2004?

Mr Eccles—2004-05.

Senator McLUCAS—That is a cumulative figure?

Senator McLUCAS—Yes.

Senator McLUCAS—Some 5,730 people have benefited from that program?

Mr Eccles—That is right.

Senator McLUCAS—That is not very many, is it?

Mr Eccles—I think that is one of the reasons it is being adjusted.

Senator McLUCAS—Has the department done any analysis as to why the take-up was so small?

Mr Eccles—Yes, for the last several months—quite a considerable period of time—we have been speaking with the Australian Dental Association to work out what the impediments may have been to optimal uptake, or higher uptake, and it was on the basis of those discussions that the new package which was announced in the budget was developed.

Senator McLUCAS—And what did those discussions reveal? What are the impediments to take-up?

Mr Eccles—Mr Andreatta will take you through it. I will give the high level and then Mr Andreatta can go into it in a little more detail. It was essentially the rebate level and the number of services that were able to be provided in the calendar year, or in the 12-month period. I think it is also fair to say that since this item was designed we have a much better understanding about how the dental profession works and how the dental profession interfaces with the general practice profession. The consultations, or the discussions throughout this, gave us a much better idea of those issues.

Senator McLUCAS—Just before we move on, regarding the interrelationship between the general practice and dental professions, what are the things that the committee should understand there?

Mr Eccles—I think it is fair to say that this was new. GPs do not have a long track history of referring people to dentists.

Senator McLUCAS—Track history?

Mr Eccles—Track history, track record, past history—and it was particularly new in that area. It is also important to know that our understanding of how dental health impacts on someone's chronic disease is emerging and growing. We know a lot more about how someone's poor oral hygiene or dental health can impact on chronic diseases than we did even a few years ago.

Senator McLUCAS—So you have undertaken a training program with GPs?

Mr Eccles—I think that has certainly been part of this. As the medical profession became aware that this item was available, they have certainly looked into it and there is certainly a lot more information out there being provided to GPs.

Prof. Horvath—Can I just follow up on what Richard was saying. The whole issue of dental health and a whole range of chronic disease and involvement, as Mr Eccles says, is rapidly emerging. A decade ago I do not think there was any appreciation, and now a whole range of diseases that were thought to be not linked are now becoming obviously linked. The colleges are very active in their continuing professional education of general practitioners. Also, the College of Physicians has become involved. So it is moving, it is evolving, and I think we have not got there yet.

Senator McLUCAS—We might talk about what we are doing to get there.

Prof. Horvath—No, I am talking professionally. I think the story has not been told yet.

Senator McLUCAS—That is what I am asking about. We need to talk about how we do that, other than tell GPs to do another thing, which does trouble me. We have to insert that recognition of oral health relating to a whole range of outcomes into the health cycle.

Prof. Horvath—I think there is a lot of research at the moment and various disease groups are looking at oral health—how it impacts across the board. I think there is a lot of learning yet to be done.

Senator McLUCAS—All right. Mr Andreatta, you were going to tell me something.

Mr Andreatta—As Mr Eccles said, the two main issues that came back from the ADA were that the current items were too limited and that their structure did not fit within the way that dentists currently provide their dental services. We designed the items as generic items whereas dentists practise with treatment services for a whole range of different conditions. I guess we learned over time that the structure of our items was not as acceptable as our new measure will now be designed. The second area was inadequate funding. We set a rebate level that was, again, not acceptable to the profession. We did not include things like the supply of dentures, which is an area of real need for those with chronic conditions.

There was some red tape and some administrative issues that we learned about over the course of this measure. The interaction between the GP and the dentist was certainly something new. The claiming arrangements that dentists currently have with their private health funds is different from how they claim with Medicare. So all of those added up to, I guess, a dissatisfaction with the current set of items that were implemented.

Senator McLUCAS—We will come back to that in a moment. Some 5,730 people and a total of 14,821 items; what did that cost the Commonwealth?

Mr Eccles—$1.7 million in benefits paid.

Senator McLUCAS—$1.7 million out of a total program of $162.6 million. I know that other allied health services were in that program. What were the claims on the program from the other allied health services?

Mr Eccles—That might take a couple of minutes to find.

Senator McLUCAS—I want to see what is left in that program.

Mr Eccles—Sure. In the first two years and 10 months of the initiative, there have been 1.517 million services and $70 million in Medicare benefits has been paid.

Senator McLUCAS—And this is—

Mr Eccles—That is for the whole kit and caboodle.

Senator McLUCAS—Is that the whole program?

Mr Eccles—The whole lot, including the 14,000 dental services that are included in those 1.5 million services.

Senator McLUCAS—So that is up to what date?

Mr Eccles—30 April 2007.

Senator McLUCAS—And when does that program end? Is it at the end of this financial year?

Mr Eccles—No, I think it has another year and two months to go. I think it was a four-year program. So we are over halfway.

Senator McLUCAS—When does the program announced in the budget start?

Mr Eccles—November 2007.

Senator McLUCAS—What is the basis for the overlap?

Mr Eccles—The overlap period was the fact that we did not want to sit around any longer and let this dental item continue now. We would rather move forward and fix it regardless of its original anticipated end date.

Senator McLUCAS—Out of that whole program of $162 million, $70 million has been spent, with another 14 months or so to go; is that right?

Mr Eccles—Yes.

Senator McLUCAS—So there will be some funds remaining there.

Mr Eccles—I do not know. It is hard to predict. These items traditionally do ramp up.

Senator McLUCAS—And is that the experience with this particular item?

Mr Eccles—With the dental one, a little bit; but certainly with the other allied items, absolutely. They are on a projection like that.

Senator McLUCAS—So you are predicting, Mr Eccles—and I will hold you to this—

Mr Eccles—I will be here in 12 to 14 months time.

Senator McLUCAS—that $162.6 million will be spent out of this program.

Mr Eccles—We will be right on the button is my prediction. I think we will be very close. There are no alarm bells ringing at all on this one.

Senator McLUCAS—So are you suggesting that there was a higher level of uptake of the allied health component compared to dental? I am sure you would have expected more than $1.7 million to be spent on dental.

Mr Eccles—Yes, we did. It is not a precise science estimating the uptake of these things.

Senator McLUCAS—So how can you be absolutely sure that $162.6 million will be spent on that day?

Mr Eccles—I have a gut feeling on that one. There are no alarms bells ringing. That was the way I clarified it, Senator. There is no reason to think that we are going to miss the mark by much, but it is an imprecise science.

Senator McLUCAS—We need a little more exact science than this, Mr Eccles.

Ms Halton—He is unerringly cheerful and optimistic.

Senator McLUCAS—I understand. I suppose I need the numbers in the columns.

Mr Andreatta—Senator, it might be worth giving you the uptake figures for those 13 allied services with that group and the increase over the last three years. In 2004-06, it was 248,000; in 2005-06, it was 530,000; and, in the first 10 months of this year, it is 738,000. So in total the allied health items certainly are projecting upwards.

Senator McLUCAS—Do you have those disaggregated by type of allied health services?

Mr Andreatta—We do.

Senator McLUCAS—Can you provide that to us?

Mr Andreatta—Sure.

Senator McLUCAS—Not orally.

Mr Eccles—We will take that on notice.

Mr Andreatta—We have the current financial year here. Is that what you are after?

Senator McLUCAS—Yes, that would be fine. Basically, I am trying to look at proportions rather than trends.

Mr Andreatta—Sure.

Senator McLUCAS—Let us go back to the rebate level. The Australian Dental Association said that the rebate level was too low. I dare say that, as part of that, the other side of that coin is that the copayment for the patient was going to be too high. Is that reasonable?

Mr Eccles—I am not sure if we have the information that goes into that level of detail, so I would not really want to answer definitively. That might be one we had best take on notice.

Senator McLUCAS—It sounds logical though.

Mr Eccles—It is not illogical.

Senator McLUCAS—Let us work from that basis. Do you know what the average copayment was for those 5,730 people who had services under these item numbers?

Mr Eccles—The data that is published on this shows an average of $57 out-of-pocket cost per service.

Senator McLUCAS—That is for these funded item numbers.

Mr Eccles—That is right.

Senator McLUCAS—So $57 out-of-pocket cost for each service.

Mr Eccles—That is right.

Senator McLUCAS—Can you give me the split between the first service—I do not know what the item number is—which is the general analysis, and the more procedural item numbers?

Mr Eccles—Sure. The average out-of-pocket cost for the dental assessment was $23 and the average out-of-pocket cost for dental treatment was $77.

Senator McLUCAS—So that is for the other two item numbers.

Mr Eccles—In relation to the other two item numbers, there was $77 in out-of-pocket costs for dental treatment and $514 in out-of-pocket costs for the specialist.

Senator McLUCAS—Let us go through those item numbers then. How many services in that first item number were undertaken?

Mr Eccles—I think that is an important context. There are three items: dental assessment, dental treatment and dental specialist. For dental assessment, there were 2,641 services provided, with $23 being the average out-of-pocket cost. For the second one, there were 3,456 services provided. The average benefit paid was over $195 and the average out-of-pocket cost was $77. Then there were only 35 dental specialist services provided. The average benefit paid was $1,174 and the average out-of-pocket cost was $514.

Senator McLUCAS—That adds up to the 5,700-odd. So from that there were a few people who had two treatments—

Mr Eccles—Absolutely.

Senator McLUCAS—which they are allowed to have.

Mr Eccles—Yes. And those figures are only for the 10 months to April this year. So they are the figures for 2006-07 to date. I do not have the earlier figures.

Senator McLUCAS—Let us go back to the old program. How many GPs referred people to dentists?

Mr Eccles—How many GPs participated? There were 1,393 providers, and I am not sure whether I have that split by GPs and dentists. They are dental providers. I do not have the figures for GPs.

Senator McLUCAS—Do you collect that data?

Mr Eccles—We should be able to get that very easily.

Senator McLUCAS—What I am trying to find out is whether there are some GPs who got it and did a lot of referring and some who did not do anything at all.

Mr Eccles—I think that would be the case.

Senator McLUCAS—Is there a state-by-state breakdown on referring GPs?

Mr Eccles—I would imagine.

Senator McLUCAS—And people who use the program?

Mr Eccles—So you would like by state the number of GPs initiating the treatment and the number of patients being referred?

Senator McLUCAS—Yes, thank you.

Mr Eccles—Got it.

Senator McLUCAS—Let us go to the program in the budget. Could you explain this statement to me, Mr Eccles? 'Eligible patients will be able to claim Medicare benefits for diagnostic dental consultation'—that is the assessment—

Mr Eccles—That is the first treatment, yes.

Senator McLUCAS—'as well as Medicare benefits for a range of dental treatment services up to a maximum of $2,000.'

Mr Eccles—Per calendar year.

Senator McLUCAS—So how will the rebates work?

Mr Eccles—We are still working with the Australian Dental Association. As you would appreciate, we have until 1 November before this kicks off. But we will be talking to them about the best way, within that $2,000 or within that framework, to develop a way to provide rebates that better fit the needs of the people with chronic and complex conditions.

Senator McLUCAS—Going back to the current program, has there been any analysis of the socioeconomic circumstances of the people who are using this service?

Mr Eccles—I do not know if there has been any. I know there has been no economic analysis of the people using these services, but there are some things we know about people who have care plans and who have chronic conditions, and it is that they are at the lower end of the socioeconomic status.

Senator McLUCAS—That is a broader group, of which this is a very small cohort.

Mr Eccles—Absolutely.

Senator McLUCAS—And I think to extrapolate the socioeconomic status of all of those people and apply it to the 5,730—

Mr Eccles—We do not have any information on the socioeconomic status of the 5,700, but we do know that the group that qualifies for this kind of care generally are at that end.

Senator McLUCAS—For different—

Mr Eccles—Different questions, I understand, but the short answer is no.

Senator McLUCAS—Are you concerned by the AIHW evidence earlier today that was that 20 per cent of adults are not using dental services because of the cost of services?

Mr Eccles—The focus of this measure that we are talking about now is on the people with chronic and complex conditions. That is exactly what we are trying to do—to increase the proportion of those people who can access essential dental services.

Senator McLUCAS—There will be a copayment under the new program, though, won't there?

Mr Eccles—It is impossible to say there will not be, but we would like to work with the Dental Association and the usual groups to set rebates at an appropriate level.

Senator McLUCAS—What is the average usage in the first year of attendance at a dentist, given that this cohort with chronic illness have probably not been attending dentists regularly for a long time? What is the average number of attendances and the average type of service that you expect this cohort will require?

Mr Eccles—The first one will be the assessment, obviously. Then it is going to be very much up to the dentists. This is the exact question that we are posing to the ADA at the moment in designing the features of this program.

Senator McLUCAS—Have you talked to the AIHW?

Ms Halton—We have read their publications.

Mr Eccles—We are absolutely aware of them. We speak to the AIHW about a whole range of things but not specifically about the statistics that you referred to today.

Senator McLUCAS—So you do not know how the rebates are going to work yet?

Mr Eccles—No.

Senator McLUCAS—What items of dental care or procedures will be included?

Mr Eccles—That is another thing that we are working through at the moment.

Ms Halton—But we can say categorically that cosmetic items will not be included.

Senator McLUCAS—Who are the dentists who put braces on children?

Mr Eccles—Orthodontists. I know them very well.

Senator McLUCAS—And I have paid a lot of money to them.

Ms Halton—Several swimming pools, I would say, by the sound of it!

Mr Eccles—They are not captured by this.

Senator McLUCAS—No orthodontic work?

Mr Eccles—No, that is not true, but cosmetic treatment is not captured. Essential dental care that relates to someone's condition is the focus.

Senator McLUCAS—I am sure there will be arguments from various orthodontic surgeries about how cosmetic the procedure is, but that is another matter.

Mr Eccles—Exactly.

Ms Halton—You can also differentiate people around this table who are of a certain age where for them it was a far less common procedure.

Senator Mason—My parents are still paying for mine!

Ms Halton—There is a mortgage on his mouth!

Senator McLUCAS—I came from the country and we had no fluoride! Let's not go there. Can we turn to the list of chronic conditions, Mr Eccles.

Mr Eccles—We have information on chronic conditions. The way this works is that it is very much linked to the range of other items about chronic conditions. Mr Andreatta will read out the relevant part of the MBS that covers what a chronic condition is.

Mr Andreatta—This relates to the GP management plans, which are the pathway to these items. The MBS explanatory notes do cover some guidelines on what a chronic medical condition is and give some examples. But it is not a definitive list. It is really then up to the clinician to make a decision on the patient meeting that criteria. It basically says that a chronic medical condition is one that has been or is likely to be present for six months or more, and the examples include asthma, cancer, musculoskeletal conditions and strokes. As I said, that is not a definitive list.

Senator McLUCAS—Is the list on the current program definitive or is it the same?

Mr Eccles—No; it is the same. It is linked to practitioner discretion about chronic disease.

Senator McLUCAS—About what is chronic.

Mr Eccles—That is right.

Senator McLUCAS—That is fine. You did mention earlier that dentures were not included in the current program. Are they going to be included in the new program starting in November?

Mr Eccles—That is something that is still under consideration.

Senator McLUCAS—So it is not yet decided.

Mr Eccles—No.

Senator McLUCAS—How much does it cost to get a set of dentures these days?

Mr Eccles—We are not exactly sure. There are varying quotes. It is something we are talking to the ADA about. We want to get a handle on all these sorts of things. It is just a bit too early to give you a full answer on some of these things.

Ms Halton—There are some horrible mixed metaphors going on here.

Senator McLUCAS—I understand.

Mr Eccles—It is a mouthful!

Ms Halton—He has not been here as long as we have. I am close enough to hit him!

Senator McLUCAS—So you cannot really give me an indication of what you expect the out-of-pocket costs for any patient to be?

Mr Eccles—Not at this stage. The reason the 1 November kick-off was announced was so that we could work on all these matters.

Senator McLUCAS—How can you make a judgement that there will be greater uptake if you cannot—

Mr Eccles—There are some features that are well established and that the minister has announced and talked to. We are confident that the discussions that we have held with the ADA, which have contributed to the design of this, will absolutely improve the uptake. There is potentially no limit on the occasions of service in any given year. The limit is on the announced amount of money, $2,000. Also it is a significant increase in the money that is available. Under the current item, I believe it is around $75 for each of three visits. Now it will be $2,000 in a calendar year. We believe that we have the building blocks for a scheme that will have a much improved uptake.

Senator McLUCAS—So it will support people who can afford a copayment, but if you cannot afford a copayment you still will not get into the scheme?

Mr Eccles—No. The idea is that you will get $2,000 without putting your hand into your pocket.

Ms Halton—The discussions with the ADA are ongoing. They have said to us that they are pretty confident that, with the right benefit level—this is exactly what we are talking to them about—copayments should be limited or nonexistent. They do have some experience of these arrangements.

Senator McLUCAS—Are you negotiating with the ADA to set maximum copayments?

Ms Halton—No, because that is not, as you know, the way Medicare works. In terms of setting in place an arrangement in relation to benefits and what we will pay for what, they have indicated to us that, subject to further discussion, they are hopeful that the profession will be able to offer services without significant copayments and in some cases without copayments.

Senator McLUCAS—Your experience with the current program you are not expecting to change?

Ms Halton—Yes, I am. That is precisely my point.

Senator McLUCAS—Why?

Ms Halton—At the moment the per item benefit in the current program is $75.

Mr Eccles—There is going to be the capacity under the new program for a potential rebate to better fit the complexity of dental treatment.

Ms Halton—There you go with the metaphors again.

Mr Eccles—What was the metaphor?

Ms Halton—'Fit'.

Senator McLUCAS—I got it. So there will potentially be an increase in the rebate to dentists?

Mr Eccles—The minister has mentioned that we do have something to use as a bit of base reference point, and that is the DVA dental schedule, which is almost like a mini schedule for particular dental items. We will be discussing with the ADA the prospect of picking out aspects of that.

Senator McLUCAS—Do you currently track the cost of dentistry under the whole of range of services that are provided in Australia?

Mr Eccles—In primary care we do not.

Ms Halton—Sorry, what was the question?

Senator McLUCAS—Do you track the costs of dentistry to patients? There was that AIHW data that we had before.

Ms Halton—The answer is specifically, no, but in general, yes. Do we keep a vague eye on it? We do because of private health insurance and because we are interested in dental issues and we read the AIHW publications. Certainly via private health insurance we have a particular interest. But obviously we have had no functional interest other than through PHI previously.

Senator McLUCAS—Do you intend to track dentists' charges with this changed program?

Ms Halton—We will track what dentists are charging in relation to these services, yes.

Senator McLUCAS—And how will you do that?

Mr Eccles—The same way that we charge for any MBS item, which is through Medicare.

Senator McLUCAS—So you will see the total charge through the MBS?

Mr Eccles—Exactly.

Senator McLUCAS—And that is how you are currently collecting that average data?

Mr Eccles—That is exactly right.

Senator McLUCAS—So that will be able to be tracked over time.

Mr Eccles—Yes.

Senator McLUCAS—So if there is any increase in prices charged, that will become evident?

Mr Eccles—Absolutely.

Ms Halton—Accepting, Senator, that there is a current baseline of zero because we do not have the total figures now. What we will know is what a co-payment looks like—whether it exists—in relation to the services when they get up and running and then from that baseline forward we will be able to monitor changes. But we do not actually have data at the moment other than through things like the household expenditure survey in terms of what dentists are currently charging if it is not covered by private health insurance or a veterans item. So what we do not know is what the charging may be. In my case, say, if I do not have private health insurance then there is no way, other than through the household expenditure survey, of

working out what I pay for dental services. But once we get these kinds of arrangements in place then we will have a point zero and a point of comparison thereafter.

Senator McLUCAS—I suppose my point, Ms Halton, is that it would be important to have comparative data on charging behaviour of the profession given the changed policy framework in which it will operate.

Ms Halton—Once we have that framework in place, we will be able to compare what they do over time. What we will be able to do is look to see what charging is vis-a-vis what happens, for example, in relation to PHI or veteran charging at the moment. That is the data that we have: veteran charging and PHI arrangements. We do not have data for the general population other than what we get through things like the household expenditure survey.

Senator McLUCAS—With regard to public clinics, what will be the interface between public dental clinics and this program?

Mr Eccles—That is still being worked through.

Senator McLUCAS—What sorts of issues do you have to canvass there?

Mr Eccles—The extent to which the focus of this is, like MBS, on private practitioners. So private practising dentists will be the focus. But we are aware of issues and we are contemplating those things.

Senator McLUCAS—You recognise that low-income people are using—if they can get into them because of the waiting lists—public dental services.

Mr Eccles—This is designed not to—

Ms Halton—This is a supplement.

Mr Eccles—Yes, this is a supplement. It is not to remove all of the pressure on public dental services. That said, there is no doubt that some people on those public waiting lists will access or use this as a channel into dental care.

Senator McLUCAS—If they have got the cash in the pocket to pay the co-payment.

Mr Eccles—One of the drivers—

Senator McLUCAS—They have to have the cash in their pocket to then get the money back.

Ms Halton—No.

Mr Eccles—No. One of the drivers behind the redesign has been the phenomena we have been seeing in terms of out-of-pocket expenses. It is something we are going to look at. There could well be—and I am certainly not going to predict a number—a significant number of people bulk-billed under these arrangements with no out-of-pocket costs.

Senator McLUCAS—I do not know on what basis you say that, Mr Eccles.

Mr Eccles—Discussions with the ADA and others. Those are some of the things that we are working through in trying to work out how we may design a structure within the framework that was announced in the budget.

Senator McLUCAS—Are residents of aged-care facilities are eligible for the current program.

Mr Eccles—Yes.

Senator McLUCAS—How many residents of aged-care facilities took up services under the existing program?

Mr Eccles—We do not have that information.

Senator McLUCAS—You would not be able to get it?

Mr Eccles—I do not think we can get it.

Senator McLUCAS—Is there an element of the proposed scheme that would try to increase access by residents of aged-care facilities to dental services?

Mr Eccles—It is something that we are, again, looking at.

Senator McLUCAS—Is there any way at all that you could count residents of aged-care facilities?

Mr Eccles—I do not know. I do not know enough about the data.

Ms Halton—The only way you would be able to do it is if you actually did a data-matching arrangement, because Medicare Australia pay nursing home benefits or benefits for residents of residential care facilities. But, as you well understand, there are preclusions against data matching of that kind. So whilst it is theoretically possible, I think it would be practically prohibited unless there was an overarching public interest in so doing. You would have to get all sorts of privacy exemptions and then do a kind of de-identified data match.

Senator McLUCAS—You could put all of the 3,000 aged-care facilities into the machine and ask if anyone matched up.

Ms Halton—It is not the facilities; it is actually the residents.

Senator McLUCAS—But they have an address.

Ms Halton—Yes, but it depends on what the address is for the person. They may not actually be showing it as their address for mailing for example. You would have to get the person. You would have to match on person. But frankly, Senator, it would not be worthwhile.

Senator McLUCAS—It is hard enough to get GPs into aged-care facilities. To get them to then refer to a dentist would be pretty hard too.

Ms Halton—That is true.

Senator McLUCAS—What is the rationale for waiting until November?

Mr Eccles—It is ambitious.

Senator McLUCAS—It is ambitious at November?

Mr Eccles—No. We are going to hit November, but there is a lot of work that needs to be done redesigning systems with Medicare Australia and engaging with the ADA. We often use 1 November as a start date because it is the publication of the book. The MBS book gets published a few times a year and 1 November was the most appropriate one following the budget.

Senator McLUCAS—Does it require legislation to be amended?

Mr Eccles—We think so. We are looking at that as well.

Senator McLUCAS—What legislation do you think?

Mr Eccles—It might be the legislation that looks at some of the aspects of the safety net, because the $2,125 is in essence a variation on the safety net.

Senator McLUCAS—Can you explain how that interaction occurs then?

Mr Eccles—We will be able to explain that more once all of the details are sorted. Again, it comes down to the fact that no-one will be paying out-of-pocket expenses for the first $2,125 in any given year—that is, $125 initially and then $2,000 worth of treatment. The framework within which that is going to be administered will be the safety net framework. Even though it has different criteria and different application, it is still going to be administered—I know it is turgid—through the safety net framework and there may need to be some legislative change in order to have the safety net adopt the provisions that are being worked through now.

Senator McLUCAS—Just finally, the program is expected to cost $377 million over four years. How did you come to that figure?

Mr Eccles—The usual ways that we do. We estimate a range of variables in coming up with a figure. Any impact on the MBS still needs to be costed by the department of finance for budget purposes. We did some modelling to estimate the impact that this is going to have on the budget. I do not have the details, but obviously there are assumptions about uptake and the level of rebate that would be paid in any given year.

Senator McLUCAS—When you say that is the usual way you do it, is that the way you did it when you devised the current scheme?

Mr Eccles—Yes, the current scheme was far broader and took into account all of the allied health items and other things.

Senator McLUCAS—And surely had an objective of encouraging many more people to use dentistry.

Mr Eccles—I think that is right. It was as part of a far broader scheme of allied health in general.

Senator McLUCAS—I am just not sure if you can make a bold statement that we are going to spend $377 million over four years on dentistry when there are so many balls in the air.

Mr Eccles—As I said, it is an imprecise science. The MBS is a demand driven program and it has been designed like that so that there is no potential for people to miss out.

Ms Halton—I think the point here is that the previous program was in the context of a broader allied health roll-out. I think as has been indicated in terms of the evidence already given, there were not the detailed discussions with the ADA. We know now a lot about what the barriers were between general practice and the profession and the nature of the services people might need. So this program is a stand-alone design. Yes, there is a process of estimating and those estimates may or may not prove to be accurate, but I think we have a greater level of confidence in relation to these. At the end of the day when we roll it out we

are all going to see what happens, because we have never done this before. But in terms of what we know and what the profession have been telling us, we have some level of confidence that we will have significantly greater take-up.

Senator McLUCAS—Just on some costings, the DVA fee schedule of dental services for prosthetics says that a complete set of maxillary and mandibular dentures costs $1,345. What does it cost in the private sector?

Mr Eccles—I do not have that information.

Senator McLUCAS—Who does?

Mr Eccles—Probably the ADA. I am sure there is a variation in fees. Some would charge maybe close to that and others obviously would charge more. I do not have that information.

Senator McLUCAS—These are the questions I am trying to ask.

Prof. Horvath—It would vary greatly with what type of denture they are talking about. There is a huge range of dentures now being used—from implantables, to removables, to bridges, to porcelains. I think that would be a very difficult thing for us to find an average cost on.

Ms Halton—The reality is that the veterans schedule is a reasonable benchmark in that it has been struck and is used.

Senator McLUCAS—But that is an agreed schedule?

Ms Halton—That is right.

Senator McLUCAS—And the program as it has been rolled out does not have that sort of agreement that the DVA has with dentistry providers.

Ms Halton—As Mr Eccles has already indicated, that is precisely what we are doing at the moment; we are working with the ADA on exactly this issue. The minister will in due course consider that advice precisely to have something which is a basis and which is mutually agreed that we can go forward on.

Senator McLUCAS—The AIHW says that the average hourly rate of private dental care in 2003 was $295. What are the comparable figures today?

Mr Eccles—I am sorry?

Senator McLUCAS—The AIHW said that the average hourly rate—and I hope you are never there that long, but that is the way they measure it—of private dental care in 2003 was $295. What are the comparable figures today?

Mr Eccles—I do not have that information.

Ms Halton—In any event, we would not be using it on an hourly rate, I suspect. It is not the standard way we—

Senator McLUCAS—No, but if we are trying to get some notion of the actual costs, I would have thought we would have had some understanding of what the frequency of visits for anyone with a chronic illness should be and in a very general sense what services they would require. To do that, you would need to know what the hourly rates in a dentist chair are and probably what the cost of a set of dentures is.

Mr Eccles—And that is exactly what we are talking to the ADA about. For example, the ADA were able to let us know that the $125 rebate which is available for the initial assessment was an acceptable rebate for the type of work that needs to be done. When we design the way that this is going to roll out, we are going to be very mindful of talking to the ADA to make sure that we are pegging rebates at the right level.

Senator McLUCAS—Well, let us watch and see. There is a lot to hold you to there, Mr Eccles; you have been giving lots of unequivocal answers.

Mr Eccles—I will be back.

Senator McLUCAS—Thank you very much for your advice and information. Chair, that is all I have on outcome 3.

CHAIR—Are there any other questions on outcome 3?

Ms Halton—I have some extra information, and I am sure it will make Senator Lundy's day and everyone else's because you are all going to get one. I have here the list of schools approved for grants sorted by state as at 22 December 2006. I will table it. I just hope you are all happy with the number of trees I have sacrificed.

Senator McLUCAS—Just for the record, I do not need one.

CHAIR—We might only have a copy made for those who actually asked for them.

Ms Halton—It is too late. They are all over there.

CHAIR—We have got copies already?

Ms Halton—Yes, because we were asked to table it.

CHAIR—Okay. If there are no other questions on outcome 3, I would like to say thank you very much to the officers concerned. Sorry, Mr Clout has something else to provide.

Mr Clout—Senator McLucas asked me earlier about the Medicare levy thresholds. Page 19 of budget paper No. 2 has the Treasury revenue measures descriptions, and there is an item there which says that the government will increase the Medicare low-income thresholds to $16,740 for individuals and $28,247 for families with effect from 1 July 2006. In this measure description, there are a range of other items. It says that the amount of threshold for each dependent child or student will also be increased to $2,594. It explains that this is so the thresholds take into account movements in the CPI. So the indexation happens annually.

Senator McLUCAS—Sorry, Mr Clout, I think we are talking at cross-purposes here and I may be using the wrong language. I am looking at the fact that people who earn over a certain amount of money and do not take out private health insurance pay an increased Medicare levy. That is not what you are talking to me about, is it?

Mr Clout—They are two different things, that is right.

Senator McLUCAS—That is what I was asking about, and I understood the figure was $50,000 and has been $50,000 since its inception.

Mr Clout—That is something I will have to discuss with Treasury and find out.

Senator McLUCAS—My question then was: has the Department of Health and Ageing done any analysis on whether the fact that that threshold has not changed encourages or discourages people from taking out private health insurance?

Mr Clout—I think we will have to come back to you on that one.

Senator McLUCAS—Thank you. Before we start on pharmaceutical services, Ms Halton, you have given me here 'services bulk-billed, total services and percentage, 2005-06, calendar year, electorate', and that is the information that the library has and from the website. But it still does not go to the issue of total Medicare services and benefits by electorate division, which you are going to come back to me on.

Ms Halton—That is right. Ms Morris is going to come back later tonight for whichever one it is—I cannot remember, I think it was rural—and she will try to get to the bottom of what is where—that we actually release—and what we have released in whatever year it was, 2004-05 or 2003-04. So we are trying to get a bit of history of what we have released when and where the bits are that we have released to try to make it a bit more understandable.

Senator McLUCAS—Thank you, that is good.

[5.28 pm]

CHAIR—We now move to outcome 2, Access to pharmaceutical services.

Senator McLUCAS—The first issue goes to the reforms that were announced in January 2005; they were the first tranche of reforms that have occurred to the PBS. The projected savings from those changes at that time—

Ms Huxtable—Sorry, which measure are you speaking about in particular?

Senator McLUCAS—I do not have a name for it. It is called 'reforms', but announced—

Ms Huxtable—Keep going and we will try to identify what it is.

Ms Halton—We have had something like 30 measures of reform on the PBS in the time that I have been in the portfolio. Some of them get implemented at different times; some of them are announced at different times.

Senator McLUCAS—This was projected to save $831 million.

Ms Halton—That is the 12.5 per cent.

Senator McLUCAS—So that is quite significant. Can you explain to the committee what savings have resulted from that measure?

Ms Huxtable—The only complete year since that measure commenced was the 2005-06 year. The measure actually started on 1 August 2005. So it was almost a complete year. The actual savings for 2005-06 were $84 million.

Senator McLUCAS—There was an announcement about $831 million in expected savings—is that going to be achieved?

Ms Huxtable—This is an interesting measure, because it has now really become part of the broader reforms to the PBS which were announced in November of last year. So we are now moving into mandatory price reductions of 25 per cent, two per cent and the 12.5 per cent will also apply. But the costings for that measure do not really have a separate existence

now because they have been drawn into this broader fabric of change within the PBS and you cannot pull it all apart; it is too difficult to do that. But for 2005-06 and 2006-07, the 12.5 per cent measure can be tracked and for 2005-06 we have an outcome. For 2006-07, clearly we have not finished this year as yet.

Senator McLUCAS—Have we got a year to date, or near the amount?

Ms Huxtable—I do not have that and, to be honest, we do not really track it in that way.

Senator McLUCAS—You report quarterly, do you not?

Ms Huxtable—In part because we need to wait until we get a complete set of data and that relies on us getting data through Medicare Australia in regard to scrips and the like. So we do a calculation usually some months after the end of the financial year.

Senator McLUCAS—You do not do it on a quarterly basis? You get some from Medicare Australia monthly or weekly, do you not?

Ms Huxtable—I am not sure, to be honest. It is a little like Medicare; there is a reconciliation that needs to occur. So scrips do not always come within the period and it takes some time for them all to be received in respect to the period.

Senator McLUCAS—But you do not wait until the end of the financial year; you must keep a bit of an eye on it?

Ms Huxtable—We do not really track it as a measure. The PBS is a huge scheme, as you would imagine, and an individual measure like this, it is just part of the general running of the PBS.

Senator McLUCAS—I love it when we talk to PBS people. Eighty-four is just part of it, really.

Ms Huxtable—Yes, a morsel.

Senator MOORE—How do you get the 831 figure?

Ms Huxtable—The 831 figure I do not actually have in front of me so I am just not sure where that figure is coming from, but my recollection of the savings estimate was that it was around $800 million, but that included RPBS as well—the repat scheme—and the revised figure in respect of the PBS only was close to $740 million.

Senator MOORE—And over how many years?

Ms Huxtable—I am sorry, I have forgotten what you said. It was four years over the forward estimates period.

Senator MOORE—And anticipated savings in the first round of changes of around $70 million—or whatever figure we will find out we agree on—and now that has been rolled into the next round of changes, which we have in the bill before us.

Ms Huxtable—That is correct.

Senator MOORE—So there has not been anything else? There has just been the one that came in on 1 August 2005 and now the anticipated piece of legislation, which I think is going before the Senate in the next sittings?

Ms Huxtable—This sittings, I hope.

Senator MOORE—I sense a committee in the wind.

Senator McLUCAS—I want to go then to the bill that is proposed.

Ms Huxtable—I have a very large folder at my feet. If we are going to get into the bill, I will have to retrieve it.

Senator McLUCAS—Yes. I am not totally across how all of these measures will interrelate with each other. I suppose we will just start and then as it becomes evident that we need more clarification we will seek that. What are the figures that the government is relying on to understand these savings that this tranche of reforms will deliver?

Ms Huxtable—I think we provided on notice after the last estimates hearing the savings figures for this measure, so you do not want those. You are not after those in particular but after the assumptions?

Senator McLUCAS—Can we start with the actual savings measure, because I do not have that with me at this time.

Ms Huxtable—The net savings in the forward estimates period, 2007-08 to 2010-2011, is $580 million.

Senator McLUCAS—$518 million?

Ms Huxtable—$580 million.

Senator McLUCAS—Thank you. Are they disaggregated over the forward estimates?

Ms Huxtable—I think when the measures were announced that would have been the case and I am pretty sure we actually gave you those in that question, which I have somewhere embedded in one of these papers. Yes, we did disaggregate it.

Senator McLUCAS—I do not need to have it again.

Ms Huxtable—It is in that question, yes.

Senator McLUCAS—So $580 million over four years is expected to be the savings from this measure.

Ms Huxtable—That is right.

Senator McLUCAS—And what are the assumptions underneath that? How do you come to that figure?

Ms Huxtable—The savings were generated through a process with the department of finance, as is always the case. The data that was used was primarily sourced from the PBS estimates model, which projects activity within the PBS, and the statutory price reductions. As we speak about the reforms we will get into these, but there are a number of required price reductions within the forward estimates period. So in a fairly straightforward way those are factored into what we know about drug utilisation in the forward estimates period and a figure falls out of the bottom. If anything is straightforward in this program, it is a fairly straightforward costing.

Senator McLUCAS—Can we just go through that? The price reductions will deliver what level of saving over the four years?

Ms Huxtable—The gross savings are predominantly from price reductions. There are two pricing mechanisms—there is the mandatory price reductions, which commence 1 August 2008, and then some of the medicines that are in one of the subformularies may become subject to price disclosure arrangements before the end of the forward estimates period. We will get into all the detail of that probably as we go on, but these savings will predominantly be as a result of mandatory price reductions. The gross savings over the period are $1.7 billion and then there is an offsetting amount, which is a package of compensation being returned to the pharmacy because of the impact on pharmacy remuneration of the reforms, and that is $1.1 billion. There is a bit of rounding in this, obviously.

Senator McLUCAS—I am sorry?

Ms Huxtable—$1.1 billion.

Senator McLUCAS—To pharmacy?

Ms Huxtable—Yes.

Senator McLUCAS—For?

Ms Huxtable—To compensate for lost income due to the changes, and the result of that is that net saving of $580 million that I spoke about before.

Senator McLUCAS—Okay. Can you explain to me how the mandatory price reductions work?

Ms Huxtable—To understand how the mandatory price reductions work we probably have to start at the formularies.

Senator McLUCAS—Yes, I have heard about these things.

Ms Huxtable—Yes. So pending the passage of the legislation, from 1 August 2007 the current formularies, the whole list of medicines on the PBS, will be separated into two parts. Single brand medicines, which are medicines where there is only one brand of medicine, will be on F1 and multiple brand medicines will be on F2. The F2 formulary will be split into two parts in the transition phase, which is the four-year period of the pharmacy agreement that remains. The medicines on F2 will be split into F2T, which are medicines where there is a significant level of discount in the system, and F2A, which are medicines where there is less discount.

Senator McLUCAS—Discount to whom?

Ms Huxtable—Discount to pharmacy. Different pricing rules will apply between the formularies. I think I said that multiple brand medicines are in F2. That is correct. There are also a small number of single brand medicines in F2 which are linked within therapeutic groups to a medicine that is a multiple brand medicine.

Senator McLUCAS—I am thinking of therapeutic groups but that is not what you mean by a single brand medicine.

Ms Huxtable—There are six therapeutic groups within the PBS, and we have talked about some of those before.

Senator McLUCAS—Yes.

Ms Huxtable—For example, the statin group. Actually that is not a good example because there are no patents of medicines in there. For example, in the proton-pump inhibitor group, omeprazole is a multiple brand medicine. That is subject to high levels of discounting. Then there are four other PPIs which are single brand medicines which are within that therapeutic group because, in the view of the PBAC, they are interchangeable at a patient level. So the whole therapeutic group sits on the F2 formulary.

Senator MOORE—Is the decision made by PBAC?

Ms Huxtable—No. The criteria for deciding what goes where is in the legislation. So the formula there is a sort of starting formulary, but medicines are put on formularies depending on how they sit against the criteria that is in the legislation. That goes to single brand medicines on F1, multiple brand medicines on F2 and single brand medicines linked to multiple brand medicines on F2.

Senator McLUCAS—Can you give me an example of an F1 medicine, a single brand medicine?

Ms Huxtable—There are many, many examples.

Senator McLUCAS—Something that I might understand.

Ms Huxtable—I will find one that you would be familiar with. Herceptin would be a single brand medicine on F1. There are many.

Senator McLUCAS—Are they medicines that do not have an equivalent? A doctor would have to prescribe that medicine and that medicine alone on the PBS in Australia.

Ms Huxtable—When we talk about medicines we are talking about a molecule really, so it is a self-standing, unique thing. That molecule may have multiple forms and strengths. There may be several brands of each form and strength. So one molecule may turn into something which has many different items on the PBS but the molecule itself is unique. If it is a single brand, it means that there is only one brand of that molecule on the PBS.

Senator McLUCAS—I understand. So where were we?

Ms Huxtable—We were talking about formularies and price reductions.

Senator McLUCAS—Yes.

Ms Huxtable—I think you were asking about the price reductions, and I said that to understand the price reductions you need to start with the formularies.

Senator McLUCAS—Yes.

Ms Huxtable—So, once we have medicines on the PBS split into these two groups and then the subgroups, then we apply the pricing rules. For medicines on F2A, which is those F2 medicines that have lesser levels of discount, there will be a two per cent price reduction on 1 August 2008, another two per cent on 1 August 2009 and another two per cent on 1 August 2010—so a cascading two per cent reduction over three years.

Senator McLUCAS—For F2T?

Ms Huxtable—For F2T there will be a one-off 25 per cent price reduction on 1 August 2008.

Senator McLUCAS—And that is a reduction in price to the pharmacy?

Ms Huxtable—It is a reduction in the approved price to pharmacist, which is the X manufacturer price and the wholesale mark-up—and that is it.

Senator McLUCAS—Currently the pharmacist is—sorry, I am venturing into an area that I do not know.

Ms Huxtable—It is a fascinating area.

Senator McLUCAS—Currently the pharmacist cannot charge a higher price than what is set by government, and some people have a copayment and that all changes according to concessional status.

Ms Huxtable—That is right.

Senator McLUCAS—Does that change?

Ms Huxtable—No. All the fundamentals of how the consumer interfaces with the PBS do not change at all. This is about the price the government pays—reimburses.

Senator McLUCAS—Reimburses to the pharmacy.

Ms Huxtable—That is right.

Senator McLUCAS—Going back to the price reductions in those essentially three subsets—F1, F2T and F2A—what proportion of the savings appear from each of those types?

Ms Huxtable—We do not have it broken down to that degree of specificity. We can look at it and see what we can provide, but I just do not have it.

Senator McLUCAS—You would have done it to achieve the total figure.

Ms Huxtable—Exactly. In terms of what is the relative balance, we did not classify by 10 of these and two of those. It was just a question of where they all fell and what they added up to.

Senator McLUCAS—Can I suggest, Senator Moore, that we leave this level of minutia to our potential inquiry.

Senator MOORE—I think so. This kind of detail we will be exploring at the committee level, I would think. I cannot wait.

Senator McLUCAS—What work has been done to see how these changes will affect the price paid by consumers?

Ms Huxtable—Senator, as I said, these changes are about the price at which government reimburses medicines. The purpose of them is to get much better value for taxpayers and governments from that part of the PBS market where there is genuinely a market operating. We know that, in respect of many of these F2 medicines, the price which the government pays and the price at which they are supplied to pharmacy is quite different. So the government is paying a top dollar price and pharmacy is getting that medicine at a much, much lower price.

Senator McLUCAS—How does that work?

Ms Halton—It is discounting. This whole preform process has been about the fact that there have been significant discounts principally on generic products with competition, hence the F2T—that is, there have been significant terms of trade. This has been about recognising that for what you might describe as the commodity product—that is, the generics—we have paid too much. That was actually being reflected in what you could probably describe as a shadow market operating—that is, the manufacturers, distributors and producers of the product could actually sustain a much lower price. That was being reflected in discounting that was being offered in order to achieve market share.

What that means is that we, as the government, the Australian people, the taxpayers, have paid too much for those products. You would know that the PBS is one of the more complicated of our programs, but this whole reform is designed to get better value for the taxpayer in those products whilst still making sure that we have headroom and the capacity to continue to list innovative products. So the implications in terms of the consumer are actually relatively limited or generate a benefit to the consumer, particularly general patients, because the price of these products will be affected downward. The prices of these products are going to go down, not up.

Senator McLUCAS—So how does it affect brand premiums that consumers sometimes pay?

Ms Huxtable—The brand premium policy is not changed by these arrangements. There are certain conditions where a brand premium can be sought or where a therapeutic group premium can be sought, and those remain unchanged. I would have to say, though, there is one feature of these reforms which I think is relevant in this discussion, and that is that for the first time there will be a dispensing incentive for pharmacists to dispense the premium-free brand where there is a multiple brand product. That will be $1.50 per script. So that will be an incentive and we will see how that washes through the system.

Ms Halton—Certainly, Senator, in the design work we did on this it was precisely to create an active incentive for the pharmacist to dispense the premium-free product. Whilst we know the system pretty well, even for us, going in and making sure we are equipped with the right information to know what the premium-free version is et cetera—because there has to be one in each of these groups—is not always easy. So we have put in place an incentive for the pharmacist to actually dispense that product.

Senator McLUCAS—So the brand premium could rise under this proposal but you do not expect it to?

Ms Halton—There is no reason for it to.

Ms Huxtable—I would say, too, in that regard that brand premiums both in percentage and in value have been a relatively stable feature of the PBS for many years. Generally their value is on average around the $2.70 mark or thereabouts. If you go back over the last 10 years they have not changed hugely in value. Similarly, the numbers of brand premiums—the percentages of brand premiums—have not tended to go up a huge amount either. Clearly companies need to make business related decisions about the degree to which they apply a premium or whether they apply a premium and then the value of the premium. I am sure that

they do take into account a whole range of factors when (a) they decide and (b) they set the value. The presence of a dispensing incentive of $1.50 no doubt will be part of the factors they look at when they come to a view about whether, and to what level, they apply a premium. It is hard to say what the behaviour will be. Just looking back at history, though, I think it would be fair to say that we would be surprised if anything very different happened in the future.

Ms Halton—I think we will see some changed behaviour. I think the pharmacist will have a much more active incentive to explain to somebody that there might be an alternative to a brand perhaps that they are used to which is premium free. The pharmacist gets something for doing that now under these arrangements. As I say, that was an important part in the design of this.

Senator McLUCAS—And that is outside the $1 billion compensation to pharmacy? That is not included in—

Ms Huxtable—No, that is part of it.

Senator McLUCAS—That is part of it?

Ms Huxtable—The compensation package has a number of components and that is one of them.

Senator McLUCAS—Could you run through those components?

Ms Huxtable—Sure. There are three parts. There is the dispensing incentive, the $1.50. There is an incentive for using PBS online as the means of communicating with Medicare Australia of 40c per prescription. Then there are changes to the mark-ups in dispensing fees for pharmacists that they are able to apply to the X manufacturer price in building up the price that the government pays.

Senator McLUCAS—Sorry, explain that to me again, please.

Ms Huxtable—In the pharmacy agreement as part of pharmacy remuneration there is a relatively complex range of mark-ups that can apply to medicines depending on the cost of the medicine and the nature of the medicine. There is also a dispensing fee. There are some changes to the mark-ups and dispensing fees as part of this.

Senator McLUCAS—The incentive to use Medicare online and the incentive to prescribe generics, are they—

Ms Huxtable—Senator, this is getting the generics dispensed. It is an important distinction.

Senator McLUCAS—It is a very important distinction. Is that a capped amount or is that an open- ended amount?

Ms Halton—The amount is fixed in terms of the amount per script and the amount of the transaction. It is volume driven.

Senator McLUCAS—It is volume driven?

Ms Huxtable—Yes. There is actually a fourth component which I forgot which is an increase to the amount of moneys for the community service obligation arrangements which are also part of the pharmacy agreement.

Senator McLUCAS—Which we will talk about in the inquiry rather than now. Senator Moore, I am thinking that these questions will be canvassed in the inquiry.

Senator MOORE—I think most of them will.

Senator McLUCAS—Given that we probably will not finish this outcome until after dinner, but we will not go a long way after dinner, we might just go to some more generic questions. The National Prescribing Service basically runs the Quality Use of Medicines Evaluation Program, as I recall. The annual report of 2005-06 states:

In the last 12 months—

It refers to July 2004 to June 2005—

at a minimum, NPS activities generated savings of $68.7 million to the PBS. These savings could, however, be as high as $151.0 million.

Can you provide an explanation to the committee of how those savings are tracking?

Ms Campion—We have not yet had an update for this financial year from the NPS about what level of savings we are expecting to generate for the PBS. As you can imagine, extracting savings and attributing them to one particular measure is always a difficult process but we do have an agreed methodology that the National Prescribing Service uses to determine the level of savings. At this stage, as I said, we do not have an update for 2005-06.

Senator McLUCAS—I understand that there is a contractual arrangement between the NPS and the government.

Ms Campion—Yes, that is correct.

Senator McLUCAS—I may be reading this incorrectly, but I am reading this to say that they are tracking higher than what was expected in the contract—no, clearly not.

Ms Huxtable—I am not sure what you are reading.

Senator McLUCAS—The annual report.

Ms Campion—Certainly when we are looking at our four-year funding for the National Prescribing Service, we estimate the amount of savings that we expect that they will generate. That is the minimum amount of savings that we expect that they would generate for the PBS in return for the money that we are providing to them to undertake quality use of medicines initiatives. As I said, it is difficult to be accurate about that because there are always a number of activities happening at any one time within the PBS to achieve savings or to better target the use of medicines. We set a figure for the forward estimates that we think will be a minimum figure but it is not an exact science.

Senator McLUCAS—I understand it is a contractual arrangement that these savings will be delivered.

Ms Campion—At a minimum, yes.

Senator McLUCAS—How do you measure that, then?

Ms Campion—As I said, there is an agreed methodology that we have determined with the National Prescribing Service that they use. Some of the National Prescribing Service activities will focus on the use of particular groups of medicines. For example, they have done a lot of work recently on proton pump inhibitors. They target initiatives to GPs and prescribers on how those medicines should be prescribed, to whom, how frequently et cetera. That is how we determine, or model, the amount of savings that we expect they will deliver over the forward estimates period.

Senator McLUCAS—What were the savings identified in the previous contract?

Ms Huxtable—I have some figures in another summary table which say that, between 1998 and 2003, they demonstrated savings of $170 million.

Senator McLUCAS—How regularly are the contracts signed?

Ms Campion—Every four years. We signed a new contract last year for 2005-06.

Senator McLUCAS—Can we talk about the July 2001 to 30 June 2005 agreement which was to deliver savings of $111 million to the PBS. Did that occur?

Ms Campion—I am afraid I do not have that information in my briefing papers. We will have to take that on notice.

Ms Huxtable—We have information for another period but not for that period.

Senator McLUCAS—That is a completed contract. That is why I am asking the question.

Ms Campion—Yes.

Senator McLUCAS—But it is a question that you can answer?

Ms Campion—No, I cannot.

Ms Huxtable—We cannot answer it right now.

Senator McLUCAS—Not this very minute, but it is a question that is answerable?

Ms Huxtable—We can take it on notice.

Ms Campion—I have information on the current contract here, but not on the previous one.

Senator McLUCAS—What is proposed to be saved during the life of the current contract?

Ms Campion—We are expecting $160 million will be saved. That is a gross saving. That does not include money that we will pay to the NPS to achieve those savings.

Senator McLUCAS—What is the payment to the NPS?

Ms Campion—The payment to the NPS is around about $100 million. I do not have the exact breakdown. We give them $73 million to do their core activities. There is an extra $20 million that they have been given to do consumer education activities over that period.

Senator McLUCAS—That is quite different to the arrangements described in their annual report. For the previous contract, it talks about a cost of $45.76 million to achieve savings of $111 million. I am looking at it as a ratio. It cost $100 million, which is more than double, to receive savings of $160 million. Am I reading that correctly?

Ms Campion—Yes, that is correct.

Senator McLUCAS—Why is there such a shift?

Ms Campion—I would have to take that on notice. I am not aware of the basis upon which the current contract was negotiated.

Senator McLUCAS—The sentence in the annual report says, 'These savings could, however, be as high as $151 million.' I am seeking an explanation of that sentence.

Ms Huxtable—Is the annual report the NPS annual report?

Senator McLUCAS—That is right.

Ms Huxtable—I thought it was our annual report. That is why I was wondering about it.

Senator McLUCAS—You could take those two questions on notice—that is, an explanation of that sentence from the annual report and an explanation of the change in costs and savings that the NPS will deliver—contract to contract.

Ms Huxtable—I think it is fair to say that we would need to talk to the NPS about some of the things that were in its annual report, because obviously we did not write it.

Senator McLUCAS—I understand. I turn to cost recovery in the PBAC. How is that travelling?

Mr Dellar—The process of implementing cost recovery, which is due to commence on 1 January next year, is on track.

Senator McLUCAS—What does that mean?

Mr Dellar—There are essentially three things. There is the consultation process with industry to help fill in the detail around the details of the cost recovery process. There is the legislation which will need to be put into parliament. There will need to be a change to the act and there will need to be a regulation. There will need to be a machinery built to essentially manage the receipt of payments and the process of receiving and accounting for the money.

Senator McLUCAS—You mean a cash register?

Mr Dellar—I guess you could say that.

Senator McLUCAS—A computer system?

Mr Dellar—No, not a computer system because we will be building on our own existing SAP system, which sits at the heart of the department's finances. We will use that. We need to have a process for invoicing people, for making sure people are paid, for resolving disputes that might arise and those sorts of things.

Senator McLUCAS—Has the issue of the interface between the implementation of a cost recovery policy and the very important element of the PBAC—its independence—been canvassed by the department? What is the thinking around the interface of those two elements of pharmaceutical pricing in Australia?

Mr Dellar—The independence of the PBAC is fundamental and crucial for the functioning of the pharmaceutical system. We do not believe that these changes will in any way impinge on that independence. I would say, by way of supporting that argument, that the TGA has

been fully cost recovered for quite a few years now. Its independence is never challenged—or, if it is ,I do not know that it is. We do not see that this system would be any different.

Senator McLUCAS—But you do recognise there is potential for allegations—which could never have been made previously—of bias by the PBAC as a result of implementation of a cost recovery policy?

Mr Dellar—I have certainly heard people say that.

Senator McLUCAS—I am not suggesting you did. What I am saying is that the addition of cost recovery into the system that we call pharmaceutical pricing in Australia allows that allegation to be made whereas previously it could not have been made.

Ms Halton—I do not think it makes any material difference as to whether it is cost recovery or not. Some people will allege at various points, usually because they do not like a decision, that the decision was biased. It can be biased because the person who was germane to the decision did not like someone or did not agree or whatever. There are any number of grounds that can be used to allege things. The trick with this is exactly as Mr Dellar has said: the independence of the PBAC is paramount and absolutely always will be. They personally will not be responsible for actually undertaking this task. They will continue to do what they do now.

Senator McLUCAS—Yes, I understand that. It is a changed policy that adds a change element. That is something I would hope the department has contemplated.

Ms Halton—We are certainly aware that allegations of bias can and, indeed, sometimes are made for a variety of reasons. You are right that they could be made as a consequence of cost recovery. In our experience, and given how this will be implemented, I do not think any such fear will be realised.

Senator McLUCAS—Industry sources have said that the cost of a submission to the Pharmaceutical Benefits Advisory Committee could be as much as $100,000 under cost recovery. What work have you done to ascertain what the cost of making a submission to the PBAC will be?

Mr Dellar—We actually issued a discussion paper which has been widely canvassed with industry. In that paper, we put to industry a number of options for the way in which fees and charges and, potentially, levies might be collected. The option that correlates with the $100,000 is what we called option 1. If that were the way we went about it, then there would be a fee and it would be in the order of $100,000. It is in the range of $90,000 to $110,000—that is what we said in our paper—which would be for a major submission. I would add that of course those fees actually relate to the cost that is incurred in managing a submission through the evaluation process and through the PBAC process to the point of decision.

Senator McLUCAS—Has the department done any analysis on whether or not the imposition of cost recovery may actually stop some pharmaceutical companies from making a submission?

Mr Dellar—We think it is very important to ensure that that does not happen, because it is true that there are some products where there are very small populations and not that many sales. So one of the issues we have been canvassing is the idea of exemptions for certain fees

and applications in certain circumstances. I cannot say that that is a decision; I can only say that that is a matter that is being canvassed at the moment. Where we are at in this particular process is that we are putting together a report for the minister with the results of the consultations and with a suggestion going forward about how the fees ought to be structured.

Senator McLUCAS—For example, I met with the Multiple Sclerosis Society of Queensland. I think there are 14,000 people with MS in Australia at any one time. The idea of a company taking a pharmaceutical through the PBAC process for that very small number of potential patients would never warrant $100,000.

Ms Huxtable—I think you will find that there are many instances where there are very highly targeted therapies that now come to the PBAC that do serve quite small populations but which are very high cost and provide a significant return to companies. For example, there are around 2,000 women a year who are likely to qualify for Herceptin. The cost of that drug is very significant and the total cost to government is very significant. So I do not think it is true to say that, as a matter of course, it is not necessarily in the interests of companies to provide medications for relatively small populations. In fact, I would say that, increasingly, we are seeing much more targeted therapies.

Senator McLUCAS—And that will happen naturally with time.

Ms Huxtable—That is happening and it will happen. The types of exemptions that have been canvassed in our discussion paper and which were discussed with industry are along the lines of the orphan drug type category for which the TGA already has as an exemption. There may be other cases where there is a public interest benefit in having a particular drug listed that may not be particularly appealing to the company. So there might be a range of cases but, as Mr Dellar said, the final design of this package is yet to be decided. The minister has not yet considered the outcome of the consultation, but certainly the factors that you are talking about were very much part of the consultation and have been an important part of our contemplation of those issues.

Senator McLUCAS—We all know that drug companies are producing more and more drugs that are for specific elements of ailments.

Ms Huxtable—That is right.

Senator McLUCAS—Especially with the biogenetic work that is happening, we get quite tailored pharmaceuticals.

Ms Huxtable—Very much so.

Senator McLUCAS—The other part of that is that some of those smaller and newer pharmaceutical companies are not the big pharmacy. For them to find $100,000 to go through Australia's listing process compared to what happens in other countries, has that been contemplated?

Ms Huxtable—The sort of case that you are raising is part of that contemplation of those cases where it may not be appropriate to charge a fee. But I would say, too, that in the biologic environment, as I said before, these are very expensive highly targeted drugs where the total cost to government is often extremely high. I think we are seeing some change in the nature of pharmaceuticals—moving away from the very high-volume, low-cost drugs of the

past and more into these very targeted therapies. But there are still significant profits to be made in these areas. The sort of fee that we are talking about pales somewhat when you think about the total cost of some of these things.

Senator McLUCAS—For the high-cost drugs. What is the benefit for patients with the implementation of full cost recovery?

Mr Dellar—I do not think it should make any difference to the experience of patients who fill prescriptions through the PBS.

Senator McLUCAS—But there may be potentially the absorption of that cost in a cost to taxpayers further down the line when the price discussions happen between the government and pharmaceutical companies. That $100,000 has to be paid somewhere down the line, so it will turn up in a higher cost for a prescription medicine.

Ms Huxtable—I do not have a great insight into how companies manage their pricing, but I would have thought that there is a whole variety of factors that they include in those calculations. In a program that is $6½ billion and growing, I guess that $11 million with regard to cost recovery is a fairly minor amount.

Senator McLUCAS—But we are not saying that pharmaceutical companies will absorb those costs, are we?

Ms Huxtable—I have no idea how pharmaceutical companies will manage this.

Senator McLUCAS—I am pretty sure they will not. That is all I have on full cost recovery. I want to ask some questions about two particular drugs for high cholesterol—Ezetrol and Vytorin. I understand there was a budget measure to widen access to those drugs becoming available on 1 August of this year. How many people were prescribed with Ezetrol and Vytorin in 2004-05? Let me ask the question differently. What is the basis of this measure?

Ms Huxtable—This is the coincidence of a PBAC recommendation, a government decision, a pricing negotiation and an announcement. As with any other announcement around a drug being listed or extended onto the PBS, this measure is a—

Senator McLUCAS—They do not usually turn up in the budget, though, do they?

Ms Huxtable—You will see from the budget papers that all of the high-cost drugs that were listed in the intervening period were budget measures, and this is another of those. So there is nothing different about this.

Senator McLUCAS—Nothing unusual?

Ms Huxtable—No, it is part of the process.

Senator McLUCAS—It is because it is a high-cost drug that it has appeared in the papers.

Ms Huxtable—Yes, that is right. There is also a measure that goes to the minor new listings. There are budget measures with regard to all of the things that we do on the PBS and they appear at the next appropriate time, whether it is at additional estimates or budget estimates.

Senator McLUCAS—How do you come to the figure of 42,000 additional people being able to access these drugs?

Ms Huxtable—As part of the work that is done both in the evaluation of an application and in the negotiations with companies, there are utilisation estimates that are generated. The Drug Utilisation Sub-Committee of the PBAC has a central role with regard to those and they do the modelling that they do around the uptake of these drugs. In the case of Ezetrol and Vytorin, their modelling was that 42,000 additional people would benefit.

Senator McLUCAS—Part of that modelling is to describe the increased eligibility?

Ms Huxtable—That is the increased eligibility. That is only the increased eligibility.

Senator McLUCAS—So how will eligibility be increased?

Ms Huxtable—The patients who are eligible to receive Ezetrol and Vytorin will now be broadened to include those who have high cholesterol with hypertension or a family history of coronary heart disease and where cholesterol levels have not been adequately controlled with a statin line.

Senator McLUCAS—Are they going to be—I forget the title of them—the drugs that doctors have to ring up to get approval to prescribe?

Ms Huxtable—'Authority required'?

Senator McLUCAS—Yes.

Ms Huxtable—I am not sure about that.

Mr Dellar—Yes, they are.

Senator McLUCAS—So they are authority required drugs?

Mr Dellar—They will require authority, those ones.

Ms Huxtable—They are authority required.

Senator McLUCAS—For those indications only, or the total?

Ms Huxtable—No, actually I think with these ones they were authority required to start with, but we might have to take that on notice because I would not want to mislead you.

Senator McLUCAS—If that is not correct, you can come back to us.

Ms Huxtable—We can confirm that it is authority required for all indications.

Senator McLUCAS—Thank you. I understand there has been an application for Tamiflu to have it made available over the counter. This was actually some time ago.

Ms Huxtable—I think that is not a matter for us. That is a scheduling—

Prof. Horvath—It is not a PBS certificate.

Senator McLUCAS—So that is the National Drugs and Poisons Schedule Committee?

Prof. Horvath—Correct.

Ms Halton—We believe it is the TGA.

Senator McLUCAS—They have gone home. The Aboriginal medical services and PBS section 100 drugs—how much is spent under that measure every year?

Ms Huxtable—The figure I have here is what we expect to spend in the 2006-07 year and that figure is $23.24 million.

Senator McLUCAS—Do you have the 2005-06 budget?

Ms Huxtable—I appear not to.

Mr O'Connor-Cox—You were asking for the 2005-06 expenditure?

Senator McLUCAS—Budget and expenditure, please.

Mr O'Connor-Cox—We have only expenditure, and that is at $25 million.

Senator McLUCAS—So $25 million is the actual expenditure for 2005-06?

Mr O'Connor-Cox—That is correct.

Senator McLUCAS—And then for 2006-07 the budget was $23.24 million.

Ms Huxtable—That is our estimate at this stage.

Senator McLUCAS—And how is that tracking?

Ms Huxtable—I could not tell you that.

Mr O'Connor-Cox—I have a figure as at April of $22.4 million.

Senator McLUCAS—That is as at the end of April?

Mr O'Connor-Cox—That is correct.

Senator McLUCAS—So two months to run.

Ms Huxtable—It sounds like it might be tracking a bit ahead.

Senator McLUCAS—Tracking a little bit ahead but less expenditure than 2005-06.

Ms Huxtable—It looks like it will probably be quite similar.

Senator McLUCAS—What is the budget for 2007-08?

Ms Huxtable—The anticipated budget for 2007-08 is $28 million.

Senator McLUCAS—And out years from there?

Ms Huxtable—I do not think we normally disaggregate down to that level in regard to PBS issues.

Senator McLUCAS—So for 2007-08 for the full four years, what is the total in the budget—or is that not described in that way?

Ms Huxtable—I do not have those figures here, but we can take it on notice and provide it for you.

Senator McLUCAS—We will put it as written if we require it. So do not take it on notice unless you get a written question.

Ms Huxtable—Okay.

Senator McLUCAS—When did the scheme start?

Ms Huxtable—In 1999, I believe.

Senator McLUCAS—In a general sense, how has expenditure tracked on the program since then?

Ms Huxtable—It has grown, I would say, fairly steadily.

Senator McLUCAS—Fairly steadily. So what was the 1999 figure?

Ms Huxtable—In 1999 it was $3 million—or $3.4 million.

Senator McLUCAS—In 1999 it was $3.4 million.

Ms Huxtable—Yes, that is actual expenditure. It grew from zero.

Senator McLUCAS—Yes.

Ms Huxtable—The year before to where it is today.

Senator McLUCAS—Is it possible to provide the committee with that actual expenditure since inception?

Ms Huxtable—Yes.

Senator McLUCAS—To the current year for the program?

Ms Huxtable—We can table that, if you wish. We have that here.

Senator McLUCAS—Thank you, if you have got that. How many Aboriginal medical services are in the scheme?

Mr O'Connor-Cox—166.

Senator McLUCAS—Has that changed much over time?

Mr O'Connor-Cox—I do not have the figures with me as to the growth, but I can see from the expenditure record that it has grown from virtually zero in the first year steadily up.

Senator McLUCAS—Yes, I understand that.

Mr O'Connor-Cox—But, if you require those figures, we can provide those.

Senator McLUCAS—With the total number of AMSs in Australia, you would have got to a good level fairly early, I would hope.

Mr O'Connor-Cox—I do not have those figures.

Ms Huxtable—I am not sure whether it is the number of AMSs or whether it is the number of services being provided.

Senator McLUCAS—So 166 services. I do not know the total number of AMSs in Australia. You do not happen to have that data. How many community pharmacies are involved in the program?

Mr O'Connor-Cox—It would be difficult to get those figures. I am just thinking whether we can access those. There is a process where the states actually tender for the bulk supply of medicines. We can see if we can provide an indication of those types—

Senator McLUCAS—No, that is not relevant, then. Sorry, the state governments—is that what you are saying?

Mr O'Connor-Cox—That is right.

Senator McLUCAS—Tender the pharmaceutical services into the AMSs?

Mr O'Connor-Cox—That is correct, yes.

Senator McLUCAS—Okay. The current unit cost for a drug dispensed under section 100 in the Aboriginal medical service—how does it operate? How are the costs applied?

Mr O'Connor-Cox—There is no copayment that is payable for these drugs. There is a dispensing fee that is a component of the cost, but the range of pharmaceuticals available generally reflects the PBS, apart from some drugs that are dependents and other pharmaceuticals that are included in what we call the doctor's bag. But the unit cost, apart from those considerations, would be—

Senator McLUCAS—To the consumer are nil.

Mr O'Connor-Cox—To the consumer there is no copayment.

Senator McLUCAS—There is no copayment to the consumer; I understand that. I thought the arrangement was between pharmacies and the AMSs, but you are telling me that the requirement is between state governments and the AMSs?

Mr O'Connor-Cox—Sorry, could you repeat that question?

Senator McLUCAS—Who provides the drugs to the Aboriginal medical services?

Mr O'Connor-Cox—They source those from pharmacies.

Senator McLUCAS—Community pharmacies?

Mr O'Connor-Cox—That is right.

Senator McLUCAS—Okay. But what involvement do the states have? I am sorry, you have confused me.

Mr O'Connor-Cox—Sorry. For Aboriginal health services that are the responsibility of the states, they have a tendering process where they purchase from community pharmacies through a tendering process. That is the issue that makes it quite difficult to describe the number of community pharmacies that are involved in these schemes, but the source of the pharmaceuticals is pharmacies.

Senator McLUCAS—Okay. I do not need to know the number of pharmacies. So what is the unit price that the pharmacy is paid—depending on the pharmaceutical, I guess?

Mr O'Connor-Cox—It would depend on the pharmaceutical, yes.

Senator McLUCAS—Is that price indexed? Sorry, I am getting this wrong. It is the dispensing price—the cost.

Ms Huxtable—The dispensing fee?

Senator McLUCAS—The fee. Is that a different system than what operates regularly in a community pharmacy?

Mr O'Connor-Cox—The handling fee for section 100 PBS medicines in remote area Aboriginal health services is $1.14, and that is different from what operates in community pharmacies.

Senator McLUCAS—What is that difference then?

Mr O'Connor-Cox—The figure in 1999, which was the basis of the calculation, was $4.34. I do not have the current fee.

Senator McLUCAS—So in 1999 pharmacists were paid $4.34 to dispense medication, but if they dispensed medication to an Aboriginal health service it was $1.14. Is that right?

Ms Huxtable—We are talking about quite a different arrangement.

Ms Halton—It is not the same sort of dispensing. Essentially what you are doing—

Senator McLUCAS—Let us not argue about whether or not it is appropriate to dispense in bulk to an AMS—and I know that is often done—compared to patient by patient. When I say 'in bulk', it will be often a large container of drugs that is sent out to a remote place.

Ms Halton—That is right. It is like a bulk order, so they do not write any labels, they do not read any scripts. What they do is package up what is effectively the bulk order—

Senator McLUCAS—The doctors' bags.

Ms Halton—It is a very large bag, I can tell you. If you walk into the store, which is a secure area, at Pukatja, for example—although the AMS at Pukatja regrettably burnt down recently, but before it burnt down—it is a largish cupboard or a small room, depending on your definition, with shelves that stock X number of antihypertensives et cetera. So they are basically filling in a bulk order. It is not really dispensing in that sense.

Senator McLUCAS—Has that figure of $1.14 in 1999 to dispense a medication in bulk, in a large box—whatever—changed since 1999?

Ms Huxtable—I am not sure that we know that. We might need to come back to you on how these various fees work.

Senator McLUCAS—Let us work on the basis that it has not. Have there been any evaluations of the scheme to date?

Mr O'Connor-Cox—There has been an evaluation of the scheme, yes.

Senator McLUCAS—One or two?

Mr O'Connor-Cox—One that I am aware of.

Senator McLUCAS—Did that evaluation recommend that there be an indexation to the dispensing fee?

CHAIR—Senator McLucas, it is after 6.30 pm. Would this be a natural point to take a break?

Senator McLUCAS—Nearly. I am really close.

CHAIR—You are really close? I am really pleased. Keep going.

Ms Halton—That was the butch response, Senator! Given the earlier comment, you are the man who is meant to be driving the timetable, remember?

CHAIR—Indeed, but I know when to bend and when to stand firm, Ms Halton!

Senator McLUCAS—Can I suggest that this might be an appropriate time to cease because it might give the officers time to get some information in order to finish off this issue when we come back after dinner.

Ms Halton—Exactly.

Senator McLUCAS—Is that the right answer?

Ms Halton—That is the right answer, thank you.

CHAIR—That sounds great. I am advised that it is still our intention to get through all of the remaining outcomes on the program tonight. Obviously the time allocated will have to be looked at, so we will concertina the remaining outcomes to fit within the time we have left and we will deal with them in the order they appear, so no-one unfortunately is excused to go home.

Ms Halton—Can I just provide some additional information to Senator McLucas. We were asked a question earlier about whether we had used Crosby Textor and we said we thought the answer was no. I can confirm that the answer is no.

Senator McLUCAS—Thank you.

CHAIR—The committee will break for dinner, and then we will continue with outcome 2.

Proceedings suspended from 6.34 pm to 7.35 pm

CHAIR—Before dinner we were still on outcome 2, Access to pharmaceutical services. Are there any answers to questions that were taken on notice before the last session?

Ms Huxtable—On notice, we are providing PBS expenditure in the section 100 program from the inception of the program through to the current year.

CHAIR—Thank you very much. Do you have outcome 2 questions, Senator McLucas?

Senator McLUCAS—Are Aboriginal medical services now called Aboriginal health services? What is the proper language? It depends which outcome you are in, doesn't it?

Ms Huxtable—Yes. I think it might be better to ask OATSIH that.

Senator McLUCAS—In relation to the dispensing cost per item, I asked just before we broke for dinner whether there had been any evaluations of the scheme conducted in the period since 1999 to the present. Have there been?

Ms Huxtable—Yes.

Senator McLUCAS—How many?

Mr O'Connor-Cox—I think I noted that I was aware of one evaluation of the scheme that was conducted in around 2003.

Senator McLUCAS—Who conducted that review?

Mr O'Connor-Cox—The University of Melbourne led a consortium that conducted that evaluation.

Senator McLUCAS—How many recommendations were there from that review?

Mr O'Connor-Cox—Forty-four recommendations were made.

Senator McLUCAS—Has the government responded to that review to this point in time?

Mr O'Connor-Cox—No.

Senator McLUCAS—When was it completed?

Mr O'Connor-Cox—2004. There has been no formal response to the recommendations but there are a number of recommendations that we have implemented.

Senator McLUCAS—Was there a recommendation about indexation of the dispensing fee?

Mr O'Connor-Cox—Yes, there was a recommendation for an increase in the dispensing fee.

Senator McLUCAS—A straight increase rather than indexation? What was the recommendation?

Mr O'Connor-Cox—That an additional freight component should be added to the section 100 handling fee where applicable.

Senator McLUCAS—Has that recommendation been adopted or considered by the department?

Ms Major—As part of the Fourth Community Pharmacy Agreement, there was an agreement between the government and the Pharmacy Guild of Australia to review the section 100 arrangements and the remuneration associated with that. That part of the recommendations will come under that review.

Senator McLUCAS—When is that intended to occur?

Ms Major—The review commenced in February 2007, once we had agreed the scope and extent of the review with the Pharmacy Guild, and it is expected to be completed later this year.

Senator McLUCAS—Does the agreed scope of the review include the Aboriginal medical services section 100 prescribing process?

Ms Major—It includes a number of section 100 programs, including the Aboriginal section 100 arrangements and including the handling fee. It will be the subject of consultancy.

Senator MOORE—So it has already started?

Ms Major—No. When I say it has started, we have started information gathering and are in the very early stages of the review, and a consultant will be appointed to take that forward.

Senator MOORE—Has that gone to a decision yet as to which consultant?

Ms Major—No, not yet. It has not been advertised as yet.

Senator MOORE—When is that planned?

Ms Major—I would expect that the consultancy would be advertised in the next couple of months.

Senator MOORE—Before the end of the financial year?

Ms Major—Probably not. That might be a little bit quick.

Senator McLUCAS—The recommendation was for an increased freight component where appropriate. Has the department had a look at an alternative way of increasing payment for dispensing—that is, through indexation? Has that been contemplated by the government?

Ms Huxtable—Not that I am aware of. I think these are matters that the review can look at.

Senator McLUCAS—So you would not have done any work on applying an indexation rate to the dispensing fee and therefore arriving at what that would cost.

Ms Major—Not at this stage. The review would need to take into account a number of other programs that also remunerate pharmacists in this area. For example, there is a quality use of medicines allowance that is paid to community pharmacies to provide services to Aboriginal medical services. We have done some preliminary work to look at some discrepancies regarding what is paid under existing arrangements. In the next stage we will look at the bigger picture and at what remuneration is offered across a range of programs in interventions that we run and then we will take it from there.

Senator McLUCAS—I wonder if you could go back and see if there was another review undertaken and if the review that you are referring to now could be provided to the committee. That would be useful, I think. If there is a previous review, could we also have a copy of that.

Ms Huxtable—Yes. I think that pre-dates all of us at the table, but we will go back and have a look.

Senator McLUCAS—Thank you. Has any work been done on considering extending the section 100 drugs and Aboriginal medical services arrangements to AMSs in urban communities?

Ms Huxtable—Certainly, these matters are considered from time to time, but the focus of the work that has been occurring in regard to urban and rural settings has been more in the context of moneys available under the Fourth Community Pharmacy Agreement for these types of matters. There has been an active engagement with the guild and with NACCHO around a project to look at quality use of medicines in urban and rural Aboriginal medical services, focused very much on quality use of medicines, particularly for people with chronic conditions requiring continuity and the stable use of medication. Those discussions are well advanced, and it has been agreed that this project will be going ahead. I am not sure of the date of commencement per se, but we are in active discussion with the guild and with NACCHO. The guild will be managing the operations of the project, in collaboration with NACCHO.

Senator McLUCAS—When are we expecting a roll-out of those arrangements?

Ms Major—Under this program, each Aboriginal medical service will be developing a quality use of medicines plan, in conjunction with the community pharmacy in the area, which is specifically tailored to their particular service and the issues that they face. We are starting preliminary work on that program in the new financial year. In fact, we are starting with funding arrangements now. Our expectation is that money will be flowing to the services themselves from about January 2008.

Senator McLUCAS—Directly to the AMSs?

Ms Major—We will fund the guild, who will work with NACCHO and have arrangements in place with each of the services. We are expecting to capture 80 services as part of the program.

Senator McLUCAS—These are 80 services outside of the current AMSs that are in the communities?

Ms Huxtable—That is right.

Ms Major—That is correct.

Senator McLUCAS—Does that capture all of the rest of the AMSs?

Ms Major—Our understanding is that it should capture all of the rest. On the most recent data we have, we think that captures all of them.

Senator McLUCAS—You talk about flexibility. I suppose that is recognising that local conditions vary enormously.

Ms Major—Yes. My understanding is that, of the sorts of things that have been contemplated, in some cases it might be as simple as a transport arrangement between the community pharmacy and the health service so that people do not have to take the extra step of getting to the community pharmacy. In many cases it will involve cultural awareness training for staff in community pharmacies who are dealing with people.

In other cases it may involve the community pharmacy spending time in the service and working with them on quality use of medicines issues, such as crushing and returning out-of-date stock. In other cases it will be to do reviews of medications in the service where you cannot, for example, get into someone's home. There is a very broad range of initiatives that they could undertake as part of this program and the intention is very much that each service tailors a package according to their particular local needs.

Senator McLUCAS—Most likely, but not absolutely, the relationship will be between the AMS and one pharmacy?

Ms Major—My understanding is that the guild is proposing that there will be a coordinator in each state. It is up to the local medical service how they want to engage with the community pharmacy. My understanding is that in many cases they do have a relationship with predominantly one pharmacist, but if a service for some reason has arrangements with several, it does not preclude that in any way. It is at their discretion.

Senator McLUCAS—Thank you very much for that. Can I go back to the proposed changes to the PBS that we got bogged down on. I understand that one of the objectives of the package is to create what is called 'headroom' in the PBS for new medicines into the future. Can you explain to the committee how that will happen and what measures are in place so that that objective will be achieved?

Ms Huxtable—This is a long-term objective about how the structure of the PBS can be well established for the future. Something we know about what the future looks like is that there will be many medicines coming off-patent in coming years. We anticipate that around 100 medicines will be coming off-patent in that time. There is an opportunity at the time a

medicine comes off-patent and competition enters the market to pay competitive market prices for those medicines. The intention of these reforms is to position the PBS so that where medicines have already been listed we pay the best price for those medicines in the long term. That means the PBS is as efficient as it can be in how it operates, which enables headroom to continue to list new medicines based on recommendations from the PBAC about the effectiveness and cost effectiveness of those medicines.

Senator McLUCAS—The language around headroom is essentially that costs for currently listed drugs will diminish over time, thus allowing newer drugs to come on and which, if these measures did not come into place, we would not be able to afford?

Ms Huxtable—Yes. The logic of this is that if the PBS were to continue as it is now with the pricing mechanisms that we have now, there will come a time in the future when it is very difficult to sustain the level of investment in new medicines that we have seen in the past. This is about positioning the PBS for the future by ensuring that medicines that are listed are good value for government.

Senator McLUCAS—I thought there might have been some internal policies that quarantined money for new drugs, but you are not telling me that.

Ms Huxtable—No. The processes of evaluation through PBAC processes are as they have always been. They will not change under these arrangements, but once a medicine is listed on the PBS then we can have some confidence that over time we will pay good prices for that medicine.

Senator McLUCAS—Are there any plans to change direct-to-consumer advertising, either as a part of this package or outside it completely? Has there been any contemplation of changing that?

Ms Halton—No.

Senator McLUCAS—'No' absolutely?

Ms Halton—DTC is not handled here; it is handled under the therapeutic goods arrangements, and the answer is no.

Senator McLUCAS—Does the prohibition on direct-to-consumer advertising extend to vaccines?

Ms Halton—You can advertise in the broad. You can make comments about particular illnesses or what have you but in terms of a particular product, you are not allowed to advertise.

Senator McLUCAS—I understand that some generics manufacturers are opposed to the reforms. That is certainly the point that has been expressed to me. The generics will appear in the F2 formulary. Is that right?

Ms Huxtable—Not necessarily. The drug will be on F1 if it is a single brand and on F2 if it is a multiple brand. There are certainly cases of medicines that are generic medicines on F1 if there is only a single brand.

Ms Halton—It is about the number of brands.

Ms Huxtable—Generally that will be medicines that are quite old where there is not a lot of activity in that medicine. About 10 per cent of F1 medicines are off-patent medicines.

Senator McLUCAS—Ten per cent of medicines on F1 are off-patent. What percentage on F2 are off-patent?

Ms Halton—The large majority.

Ms Huxtable—There are five on-patent medicines on F2 and the rest are off-patent. Just to be clear, that is not the reason a medicine is on one or the other. It is about whether there is competition in respect of that medicine.

Senator McLUCAS—Okay. I am trying to ascertain why the generics are less embracing of the proposal than other pharmaceuticals might be. Are the reductions in payments for these medications in the F2 category the reason why they are concerned about the proposal?

Ms Huxtable—These are medicines that are being discounted into pharmacies, so in terms of an impact on generic manufacturers' income, I do not expect they will have much impact at the moment. I would not want to put words in their mouths in terms of what their concerns may or may not be. Recently they were quite supportive of the things that were announced in the budget around the generic medicines awareness campaign.

Senator McLUCAS—That is a different component.

Ms Huxtable—They have been part of our stakeholder reference group and very much part of working with us to develop them first.

Senator McLUCAS—The broader policy question is: will this set of proposals encourage or discourage growth in the generic production?

Ms Halton—Encourage.

Senator McLUCAS—How will that happen?

Ms Halton—There will be a level playing field. If a formerly on-patent branded product which is now no longer the subject of an active patent has competition in the market from the so-called generics, we would anticipate that there will be active competition between those two, three or four—however many—brands. That will result in a reduced price to the Australian taxpayer. Whether we end up with a bigger or smaller market share of the formerly on-patent branded versus the so-called generic is a matter of debate and it will depend on the individual commercial decisions of the manufacturer.

As Ms Huxtable has mentioned, we have taken a number of steps, had a number of initiatives, which the domestic generic manufacturers have welcomed, particularly in relation to the moves to ensure consumers understand that the generic product—providing it is consistent with good manufacturing practice, and in this country it has to be—is the same thing. There has been a longstanding reluctance amongst Australian consumers to take anything other than the branded product, simply because of a lack of understanding that it is the same thing. Our view is that that will help them.

Senator McLUCAS—I suppose I am looking at it from an industry development point of view. Surely a strategy like this would be to encourage domestic production and manufacture

of pharmaceuticals. I am not sure that I am working out from what you are saying that the measure will encourage domestic production.

Ms Halton—We need to be clear about this. The PBS is not an industry support scheme.

Senator McLUCAS—I understand that.

Ms Halton—Yes. Our objective is to get the best possible price on the products that people have prescriptions for and they need to go and fill the prescriptions. We have already talked earlier on this evening about the incentive to dispense the product without a brand premium. We would imagine there would be some impact from that as well on the penetration of generics. Essentially what we want is the benefit of the generic pricing and we are neutral on whether it is the branded product or whether it is the generic product, provided we are getting the generic price. Essentially, the other measures we have talked about we think would be good for generics as we know them, but in terms of does it advantage one versus the other, it is a level playing field.

Senator McLUCAS—That is a reasonable answer.

Ms Halton—That said, there will be people from various parts of the industry who will paint you a doomsday scenario: 'We'll be rooned, Hanrahan.' What we have tried to do is put a balance of incentives in this package to deal with the issues as they have been put to us, but the PBS is not an industry support scheme.

Senator McLUCAS—No. But if there is industry development with a flow-on effect, that would be a desirable outcome.

Ms Halton—That is as may be.

Senator McLUCAS—My final question on this is the brand premium products. Currently in the therapeutic group—I think that is the right language—

Ms Halton—Yes.

Senator McLUCAS—a pharmaceutical company can make a decision to list their drug at a brand premium price. Even though you have the incentives in place to prescribe non-brand premium pharmaceuticals, is there anything to stop a pharmaceutical company from saying: 'Right, I'm basically thumbing my nose at all that. I don't think it is going to work. I will increase my price of my brand premium product'?

Ms Huxtable—As I said before dinner, they will make decisions about how they bring their product to market.

Senator McLUCAS—Sure, but nothing can stop them making that decision.

Ms Huxtable—There has never been anything to stop them except that, in the process of looking at the value of brand premiums et cetera, there is a toing and froing in regard to those things. If they were trying to set these premiums at very high levels, there would be some discussion about that. I would have thought also that it would be a high-risk strategy. With the therapeutic group premiums, which are a little bit different in that there is an alternative molecule at the benchmark price but not that same molecule, so there is not a molecule brand. If a clinician is of the view that the patient must take this particular molecule, then they can

have the premium; the government will basically have to reimburse the premium in that environment.

Ms Halton—Yes.

Senator McLUCAS—But there is nothing in this set of measures that could preclude a pharmaceutical company from making a decision to increase their brand premium product price, as it is currently?

Ms Huxtable—Nothing changes in terms of the brand premium policy, but one of the differences obviously is that the $1.50 dispensing incentive is an overlaying factor. If there is an alternative at the benchmark price and the brand premium is set very highly, I imagine consumers would vote with their feet in that environment.

Senator McLUCAS—If they are informed. That is really important.

Ms Huxtable—And the generics medicines awareness campaign is part of the strategy of informing them.

Ms Halton—And the incentive, yes.

Senator McLUCAS—Yes. I can see that there are elements that are trying to amend the current situation where people are not taking up generics when they are quite appropriate to take.

Ms Huxtable—There is more in this package that goes to those issues than there has been in the past.

Senator McLUCAS—Yes.

Ms Huxtable—Before you ask the next question, I did err before when you asked me how many patented drugs were on F2. There are more than five because there are so-called licensed generics on F2 where a manufacturer enters a licensing arrangement with another company prior to patent expiry. That creates a multiple brand situation and those medicines are on F2, and there are quite a few of those licensed generics on F2, so apologies for that.

Senator McLUCAS—What is the average brand premium at the moment?

Ms Huxtable—It is $2.76.

Senator McLUCAS—What is the range, Ms Huxtable?

Ms Huxtable—The range is from 6c to $79.48.

Senator McLUCAS—Is it inappropriate to ask what drug it is that has a brand premium of $79.48?

Ms Huxtable—I was just asking that question myself but an answer was not forthcoming.

Senator McLUCAS—I would like to know so I am not buying it!

Mr Dellar—I can have an educated guess but I might confirm. I think it is Bleomycin. I will check that.

Ms Halton—Never guess on these matters or there will be a very agitated drug company if it is the wrong guess.

Ms Huxtable—We will have to get back to you on that one.

Mr Dellar—I will get you an answer shortly.

Senator McLUCAS—Is there a published list of brand premium drugs?

Ms Huxtable—It is in the schedule.

Senator McLUCAS—In the schedule?

Ms Huxtable—The PBS.

Senator McLUCAS—That doctors get; can we get a copy of that?

Ms Huxtable—Yes.

Mr Dellar—Yes, Senator. We gave you a copy, in November, of the latest version but we would be happy to get you a new version.

Senator McLUCAS—Thank you.

Ms Huxtable—It is on the web, a link onto www.pbs.gov.au. Have a look at it.

Ms Halton—You were not here earlier for the URLs.

Senator McLUCAS—We have been down that road.

Ms Halton—We have already had the URL discussion this evening and the need for a 13-year-old boy!

Senator McLUCAS—When cabinet approval of medicines for the PBS is required—that is, over the $10 million threshold—

Ms Halton—It is actually cabinet consideration.

Senator McLUCAS—Thank you.

Ms Huxtable—It is $10 million in any one year.

Senator McLUCAS—Is there a protocol that requires the minister to take a PBA recommendation for cabinet's consideration within a certain time period?

Ms Huxtable—No.

Senator McLUCAS—So the process is that PBAC comes to a view with the price volume arrangements; that goes then to the minister; if it is over $10 million annually—that is not correct?

Ms Huxtable—In part.

Senator McLUCAS—Maybe you could tell me the process.

Ms Huxtable—The PBAC makes a recommendation based on the evidence that is before it. There is then generally a process of negotiation and discussion with the company around the risk-sharing arrangement that may be suitable. As part of that, there will be a close look at the utilisation estimates in respect of the drug. There also needs to be work around the wording of any restriction that may be required. There is a process that needs to be gone through. That process is not entirely in our control because there is another party to that which is the company. There will also be a process between the department of finance and us around agreeing costings in respect of the particular drug and the arrangement. When all those things

come together, it is in a position to be able to be considered by cabinet and then it is a matter of getting a spot in the cabinet timetable et cetera, and on you go.

Senator McLUCAS—What is the average time taken for cabinet to consider the addition of a medication to the PBS—given what you have said, that there is more than one party in this event?

Ms Huxtable—I can assure you that we work as expeditiously as we can.

Senator McLUCAS—I dare say it is in the company's interest to be expeditious as well.

Ms Huxtable—One would think so, but there are times when these negotiations can be quite difficult, particularly if the PBAC has made a recommendation and, at the same time, suggested some restrictions or some rules around continuing therapy or the like that the company may disagree with. So it can be a prolonged period. I am not aware of us going through a process of measuring how long it takes. I certainly do know that we all work as quickly as possible, and Stephen has a team of people who do this work with the companies, and we have very close relationships with the companies. I would say that it is generally in everyone's interest to see these things listed as soon as possible, and that is what everyone works towards.

Senator McLUCAS—Correct me if I am wrong. All your work, advice and agreement between the company, Finance and within Health ends up with a recommendation to your minister. Am I right?

Ms Huxtable—Yes. I did miss out the pricing authority. There is a pricing authority thing in there, too.

Senator McLUCAS—So there is a recommendation to the minister, and the minister then has to take that to cabinet. What is the average time from the receipt of the recommendation from the department to actually completing the cabinet process?

Ms Huxtable—Having been in this position through a number of these drugs going to cabinet, I would say that the process—the point at which we get advice to the minister and then we need to go through the established time lines about when something needs to be circulated as an exposure draft and the various other cabinet protocols—is very sequential and quick.

Mr Dellar—The basic process we use is that, when we think there is a drug that will need to go to cabinet, we seek an appointment right away. When we get to the point where we have to have a cabinet submission ready for all of those processes, we see if we are ready. If we are, we proceed; if we are not, we reschedule. Putting something on the cabinet agenda is not a simple thing. It competes with a lot of other things that the cabinet considers. We certainly try to ensure that, at the very moment that we are ready to take something to cabinet, that process begins. But as Ms Huxtable said, we are not the only party in this process and the company often wishes to negotiate things and those negotiations take as long as they take.

Senator McLUCAS—Has any consideration been given to increasing the $10 million per annum threshold?

Mr Dellar—That is a matter for government.

Senator McLUCAS—Okay, we will leave it at that. That is all I have on outcome 2.

[8.10 pm]

CHAIR—We will move to outcome 5, Primary care.

Senator MOORE—The first lot of questions is to do with the diabetes package.

Mr Eccles—A lot of the questions may be relevant to outcome 1, if it is the diabetes package that was announced in the budget.

Senator MOORE—It was—the COAG initiative. If I start them, you will be able to tell me whether they fit. Is that okay?

Mr Eccles—That would be good.

Senator MOORE—I am asking a series of questions about the diabetes package that was announced as a result of the COAG package: $103.4 million.

Mr Eccles—No, that is outcome 1.

Senator MOORE—My suggestion would be that we put them on notice, Senator McLucas, if we have missed out. What about GP vocational training?

Mr Eccles—That comes under workforce.

Senator MOORE—We are going to get through this really quickly, if we keep doing that!

Mr Eccles—Excellent, and long may it stay that way, Senator! That comes under outcome 12.

Senator MOORE—We are going to put the questions on the diabetes package under outcome 1 on notice, and we will return to our questions on GP vocational training under outcome 12.

Mr Eccles—That is right.

Senator MOORE—Senator McLucas, I would report to myself that we have finished outcome 5. Do you agree?

Senator McLUCAS—With our apologies. We thought we were getting pretty good at this.

Senator MOORE—I will just check. Senator Adams also has some questions which have moved to outcome 12 during the discussion, so we will just have to remind ourselves to go back to those at outcome 12. Senator McLucas, will we move on to outcome 6? Outcome 6 is rural health. We can only apologise, Ms Halton. It is really inconvenient that all those people were waiting, so we do apologise.

Ms Halton—This was just an extension of the office. They all bonded and did work over dinner!

[8.15 pm]

Senator MOORE—With respect to outcome 6, Rural health, you have given us this very useful document which shows the process for different things. Basically, under each of those, we want to ask a series of questions on the 12 major areas. We want to work out how the budget is going for each of them.

Ms Appleyard—This is the Rural Health Strategy?

Senator MOORE—Yes. I found this document that you provided very useful. They are purely budgetary questions—about budget expenditure and so on. The first one that I have listed is the Rural Primary Health initiative. Is that right?

Ms Appleyard—Yes, the Rural Primary Health Program. Were you after information on how it is going in terms of spending?

Senator MOORE—We want to find out how much has been spent each year on each of these 12 programs.

Ms Appleyard—We might have to take that one on notice. We did provide the information for 2004-05.

Senator MOORE—You did. That is right.

Ms Appleyard—And we can update that for subsequent years for you.

Senator MOORE—That answer that you gave us previously led to a little bit of explanation, because I think we had an extensive discussion trying to work that out on a previous occasion.

Ms Appleyard—Most definitely.

Senator MOORE—If you could take the same format, we would like to know about the expenditure and how it is going. The last available figures would be for 2005-06.

Ms Appleyard—Yes.

Senator MOORE—Is there any way of getting a snapshot? You have done it with a couple of others up to April of this year. Is that possible with any of these programs?

Mr Eccles—It might be difficult. The issue we have got is that there is a little bit of a lag. A lot of these programs are also administered through our state offices and they make decisions—

Senator MOORE—Most of them would be, would they not?

Mr Eccles—A lot of them are, yes. They make decisions on when to make progress payments, depending on how services go. I think we would have to wait until the end of the financial year to get an accurate snapshot.

Senator MOORE—None of these programs are due to wind up in this financial year.

Ms Appleyard—Not this financial year.

Senator MOORE—So they are all ongoing programs. If we can have the snapshot of budget expenditure until the end of 2005-06—

Ms Appleyard—Yes, no problem.

Senator MOORE—To the best of your knowledge, are there any issues with the budget expenditure? Are they on track?

Ms Appleyard—We are watching them very closely. They are tracking quite well.

Senator MOORE—All of them?

Ms Appleyard—I can only speak for the ones in outcome 6, because you will notice that a lot of those are in other outcomes.

Senator MOORE—Yes.

Ms Appleyard—But I can certainly speak for outcome 6 programs.

Senator MOORE—Okay. Senator McLucas, are you happy with that for the budget? Are there any further budget questions that you wanted to ask about?

Senator McLUCAS—Yes. When you say that you can vouch for outcome 6 programs, can you point me to the question where you originally got this information from?

Mr Eccles—It was the estimates before last.

Ms Appleyard—It was the estimates before last. I think it was about—

Senator MOORE—I think it was about this time last year.

Mr Eccles—Yes, it might have been this time last year, so it was a question on notice. In response we submitted a table.

Ms Appleyard—That is right.

Mr Eccles—We will just add another cell to the end and update everything.

Senator MOORE—The program title is listed in this format down here, and you have said you are able to give us the answers on all the ones that are under outcome 6, and you have been watching those?

Mr Eccles—We were saying that we can tell you now—give you a verbal assurance—that things are on track for the programs under outcome 6, but we can certainly provide you with the information across the department regarding all the rural programs, like we did last time.

Senator MOORE—So for outcome 4, aged care, Senator McLucas will be following that up tomorrow; for outcome 12, we will be asking questions. That is the kind of thing you are talking about?

Ms Appleyard—Absolutely. We can provide that written answer for all outcomes.

Senator MOORE—Okay.

Senator McLUCAS—Mr Eccles, is there a third column with year to date 2006-07?

Mr Eccles—I do not think we can because it is not going to be accurate universally across the programs. For those that are administered centrally, we might have some information, but we are so close to the end of the financial year that it might be better to wait a couple of months and we would have a pretty clear idea exactly how it has been spent.

Ms Halton—When will you answer?

Mr Eccles—There are a lot of contracts being finalised and a lot of payments being made.

Senator McLUCAS—Thanks.

Senator MOORE—I am just re-reading this list you have given us, which I did not have a look at earlier today. We let all those outcome 5 people go and there is a whole bunch of those programs there, but that is fine. Is the Visiting Optometrist Scheme in your area?

Ms Appleyard—It is appropriated to outcome 3, but it is my program now.

Senator MOORE—There is a revised Visiting Optometrist Scheme.

Ms Appleyard—Yes.

Senator MOORE—We have had questions before about the previous program.

Ms Appleyard—Yes.

Senator MOORE—Can you tell us where the coverage will be extended to.

Ms Appleyard—What we want to do is to extend the coverage as far as possible to remote and very remote areas as defined under the ARIA classification.

Senator MOORE—Using the ARIA process?

Ms Appleyard—Yes, using the ARIA classification.

Senator MOORE—How many optometrists are currently receiving support?

Ms Appleyard—About 70.

Senator MOORE—So 70 are getting it now?

Ms Appleyard—That is right.

Senator MOORE—Do you know how many you were hoping to extend to?

Ms Appleyard—We are hoping to extend to about 100 over the four-year period, but that is—

Senator MOORE—100 more or 30 more?

Ms Appleyard—No, that is a total of 100—30 more.

Senator MOORE—Are the 70 that are now receiving support under the scheme in the ARIA remote areas?

Ms Appleyard—Not all of them, no. Some of them are providing in more accessible areas.

Senator MOORE—You believe that there will be a total of 100 optometrists through this scheme that will be a bit better serviced?

Ms Appleyard—There will be a total of 100 optometrists supported, and it would be our hope that those services will be redistributed to two areas of greater need; mainly remote and very remote.

Senator MOORE—When are you hoping to have that in place?

Ms Appleyard—Very soon. Basically we have a little bit of work to do to completely change the guidelines because the scheme really does have to be revamped. I have chatted to the optometrists association, and we are aiming for implementation maybe on 1 October if we can.

Senator MOORE—Has there been an evaluation of a previous program?

Ms Appleyard—There was a review, and that was undertaken by my branch.

Senator MOORE—An internal review, Ms Appleyard?

Ms Appleyard—It was an internal review, yes, but the optometrists association was on the steering committee.

Senator MOORE—Have you established a new steering committee for the extended program?

Ms Appleyard—We have not yet, but we are certainly in discussions with them and we have some ideas in mind for a national steering committee.

Senator MOORE—Do you have consumers on that committee?

Ms Appleyard—We have not decided that at this stage, but there could well be.

Senator MOORE—Are the Rural Health Alliance and people of that nature involved in these programs?

Ms Appleyard—Generally, we would always seek comments from the Rural Health Alliance. We would imagine though that those things they would be interested in would be able to be covered by the optometrists association or someone like ICEE; the International Centre for Eyecare Education.

Senator MOORE—What was the costing of the current scheme?

Ms Appleyard—What I can tell you is that we expect to spend about $760,000 in this financial year.

Senator MOORE—$760,000?

Ms Appleyard—That is right, approximately.

Senator MOORE—Do they come under your little list that you are going to tell us about?

Ms Appleyard—No, they do not. It is a different one.

Senator MOORE—It would seem to me that it is one of the programs that comes under that. Would you mind adding that one as well.

Ms Appleyard—That would be a pleasure.

Senator MOORE—The more that we can standardise the process of questions and reporting, the easier it will be for all of us.

Ms Appleyard—Absolutely.

Senator MOORE—If you can whack that on the bottom of the list, that would be good.

Ms Appleyard—Okay.

Senator MOORE—Regarding the Royal Flying Doctor Service, I have basically two budget questions. I am just working out where the $118 million is in the PBS. The budget included a commitment of $156.7 million over five years, including $0.1 million in 2006-07.

Ms Appleyard—That is right.

Senator MOORE—How is the expenditure of that $0.1 million going?

Ms Appleyard—I think we would definitely have achieved that expenditure. That is to do with departmental funding for staffing in my branch for progressing the review, and I think I

have employed about two extra FTEs throughout the year to work on that. So we have more than expended that $100,000.

Senator MOORE—So that $0.1 million is administrative funding?

Ms Appleyard—It is departmental funding.

Senator MOORE—When you say 'departmental funding', that includes all the on-costs?

Ms Appleyard—That is correct.

Senator MOORE—How many did you say you had employed?

Ms Appleyard—Two extra.

Mr Eccles—I think it would be fair to say that in two other aspects—because the review was quite a large—

Senator MOORE—It was a significant one, wasn't it?

Mr Eccles—It was a significant review, with a lot of time and a lot of effort.

Senator MOORE—Senator McLucas, would you mind having a look at the question referring to $118 million.

Senator McLUCAS—Yes, I am just having a look at that now, actually.

Senator MOORE—Does the figure of $118 million mean anything to you, Ms Appleyard?

Ms Appleyard—No, I must say it does not in respect of the RFDS.

Mr Eccles—We have got pages of numbers but none of them are $118 million.

Senator McLUCAS—In the 2006-07 budget, what were the forward estimates for RFDS?

Ms Appleyard—The forward estimates are about $92½ million, and that is from 2007-08 to 2010-11. There would have been an amount of approximately $21 million in 2006-07.

Mr Eccles—Yes, that is right. So $92.854 million, I think, were the forward estimates. Is that right? Then there is $154 million which was announced in the budget on top of that.

Senator McLUCAS—Yes, for 2007-08. So that is new money?

Ms Appleyard—That is right. That is new money.

Mr Eccles—The new money that was announced in the budget was $154 million which is on top of the $92 million, so it is a total of $247 million.

Senator MOORE—$250 million?

Mr Eccles—About that, yes.

Senator MOORE—That is ongoing support funding for the RFDS.

Ms Appleyard—Yes, indeed.

Senator MOORE—The Commonwealth component of the support for the whole service.

Mr Eccles—Exactly.

Senator MOORE—Has that quantum been determined by the review that was done?

Ms Appleyard—After the review we hired some consultants to build an activity based costing model. On the basis of that we established a case for finance.

Mr Eccles—But the review certainly guided what was put into the model.

Senator MOORE—And it is now a standard funding model for the RFDS?

Ms Appleyard—Yes, it is.

Senator MOORE—Is that a public model?

Ms Appleyard—No.

Senator MOORE—And that should provide the funding base from now until 2010-11?

Ms Appleyard—Yes, indeed.

Senator MOORE—The only way the funding would be increased would be by way of a new budget initiative?

Ms Appleyard—That is right, Senator, in our NPP.

Senator MOORE—A new policy that would go on top of that. Okay. The Rural Women's GP Service: have we got a map of where the existing locations are?

Ms Appleyard—I sure have. I have a list of them. There are over 200 of them.

Senator MOORE—Just put that on notice.

Ms Appleyard—Okay.

Senator MOORE—Where will the new ones be located?

Ms Appleyard—The new ones will be basically as determined by the Royal Flying Doctor Service based on submissions from communities.

Senator MOORE—When are you expecting to have a decision on that?

Ms Appleyard—We should get some submissions from the RFDS fairly soon; certainly in the 2007-08 year. In establishing new services what they generally do is wait until they have enough and then write to us—say, maybe a dozen or so—and they are submitted to the minister for approval.

Senator MOORE—So the $4.3 million is to further improve—

Ms Appleyard—That is right.

Senator MOORE—access by expanding the service to additional locations?

Ms Appleyard—Exactly.

Senator MOORE—This is over a four-year period beginning in 2007-08?

Ms Appleyard—That is correct.

Senator MOORE—Who will make the final decision?

Ms Appleyard—The minister decides based on recommendations from the department and the RFDS.

Senator MOORE—Do you have a program team deciding that?

Ms Appleyard—We actually base it on what the RFDS give us.

Senator MOORE—The RFDS, on the basis of their visitation schedule.

Mr Eccles—Exactly.

Ms Appleyard—Yes.

Senator MOORE—And they recommend to the department. The department then has a look at that and then puts it through to the minister.

Ms Appleyard—Yes, pretty much. That is right.

Senator MOORE—Is it across all states?

Ms Appleyard—Yes. Not the ACT, but there is one in Braidwood.

Senator MOORE—After a previous experience, I am not going to say anything about the ACT! The ACT does not at the moment have a rural women's GP service?

Ms Appleyard—No.

Senator McLUCAS—If they do, can you alert us?

Senator MOORE—And we can go to it! You said you would be expecting it soon.

Ms Appleyard—The RFDS are at liberty at any time now—from 1 July—to put more suggested sites to us for consideration. As I said, they generally save them up until they have enough, but I would hope that before the end of the year we would have some proposed new sites from the RFDS.

Senator MOORE—Does the money stay secure even if they do not expend it in that time?

Ms Appleyard—Yes. What we normally do is ask them to come up with a revised service plan that can make use of the funding we have given them, so we are not inflexible there at all.

Senator MOORE—What does the money provided through the scheme go to? I know that sounds dumb, but does it cover the travel costs and the salaries of the female GPs?

Ms Appleyard—Yes, it covers all of those things. It covers support they might need at the other end if they have to hire a receptionist or if they have to hire a venue.

Senator MOORE—Is anything precluded? Is there anything that they cannot use the money for?

Ms Appleyard—I imagine there would be lots of things they cannot use the money for.

Mr Eccles—Anything within the realms of common sense and things that are going to facilitate female GPs getting out to these hard-to-reach areas.

Senator MOORE—Have you ever had to say no?

Mr Eccles—Not in my memory.

Ms Appleyard—No. The only time we have ever said no to a service is if there was a suggestion put up and it really was not eligible.

Senator MOORE—It wasn't remote?

Ms Appleyard—No, that is right.

Senator MOORE—Are clinic costs and those kinds of things all covered?

Ms Appleyard—Yes. Generally, they are hosted by a male GP, but the male GP is allowed to pass on costs associated with the infrastructure, the use of clinic support et cetera.

Senator MOORE—Has this service been reviewed?

Ms Appleyard—It was reviewed, yes, this year. It was as a consequence of that review that we did an NPP.

Senator MOORE—It was reviewed in 2006-07?

Ms Appleyard—That is correct.

Senator MOORE—Internally?

Ms Appleyard—No. We had an economic evaluation done by an external consultant, but there was also a component done internally within the department.

Senator MOORE—So the format of the internal information was then given to the external consultant?

Ms Appleyard—That is right.

Senator MOORE—Who was the external consultant?

Ms Appleyard—I will see if I have that information for you. It used to be in another division, and we inherited it relatively recently.

Senator MOORE—You are going to give us the 200 sites in answer to the previous question, so you can throw in that review.

Ms Appleyard—We will certainly do that.

Senator McLUCAS—Going back to the RFDS, I think I have worked out where the $118 million comes from. The forward estimates prior to this budget showed how much?

Ms Appleyard—This may not be a satisfactory answer, but I know that there was $21 million appropriated in 2006-07 and the forward estimates would have shown from 2007-08 around $92½ million, but I am giving you a five-year figure there.

Mr Eccles—The forward estimates for 2006-07 would have looked like $21 million plus—

Ms Appleyard—Plus three years.

Mr Eccles—appropriate indexation out for whatever period of time.

Senator McLUCAS—The budget fact sheet says that the package would provide up to $156 million, bringing it to a total of $274 million.

Ms Appleyard—That is right.

Senator McLUCAS—If you take those away from each other, you can get $118 million, believe it or not. What I am interested in is the 'up to'. What is that conditional on?

Mr Eccles—We expect to go very close. We would not want to call it 'fat', but there is a little bit of leeway in there. A lot of the costs of the RFDS are not fixed. They are dependent on currency variations between the Australian dollar and the US dollar—and the US dollar is

very important when they do an aircraft replacement—and they are dependent on fuel prices, which is a key driver for how much money the RFDS spends.

Senator McLUCAS—So this has some capital in it?

Mr Eccles—Absolutely. One of the significant changes under the new arrangement is that there is now a discrete component identified for capital. There is a little bit of money there. We expect it will be 'up to', but it will not be far short.

Senator McLUCAS—The existing forward estimates of $118 million are essentially operational costs?

Ms Appleyard—It is all operational costs; that is right.

Senator McLUCAS—What proportion of the 'up to $156 million' is operational and what is capital?

Ms Appleyard—About 40 per cent of it is capital and about 60 per cent of it is operating expenses. I can probably give you the figures, if you are interested.

Senator McLUCAS—Thank you.

Ms Appleyard—Over the four-year period, for capital it is about $56.9 million, which is new money, and new recurrent funding is about $97.4 million.

Mr Eccles—We are working with the RFDS now to make those figures a little bit more accurate and make sure that everything is going to sit nicely.

Senator McLUCAS—In terms of the capital and the recurrent funding?

Ms Appleyard—Yes.

Mr Eccles—The whole bucket is not going to change, but we are looking at exactly how much capital they are going to need.

Senator McLUCAS—How many planes do you get for $56 million?

Ms Appleyard—Twenty-seven overall, and we have 40 per cent of that liability.

Mr Eccles—I think planes are between $5 million and $6 million each.

Ms Appleyard—There are two types of aircraft: there is the B200 and the PC9. The PC9 is less expensive and operates in a couple of sections. The rest have B200s, which are twin-engine aircraft and are a bit more expensive.

Senator McLUCAS—I bet that is information you thought you would never have to know, working in the department of health!

Ms Appleyard—I will never forget it now.

Mr Eccles—This review has been a learning experience.

Senator McLUCAS—It is a very wonderful service, and 27 planes would be great. Thank you.

Senator MOORE—Can you give us a consolidated list of the services that are funded under MSOAP, the kinds of specialist services that they offer and the locations.

Ms Appleyard—Yes. We will take that on notice. You would like that for 2006-07, would you?

Senator MOORE—Yes. Actually, how far back can you give me? Is that too hard? I do not remember asking for this one before.

Ms Appleyard—We did a similar question on notice.

Senator MOORE—It was a new budget initiative at the beginning of the 2000s, when it first started.

Ms Appleyard—Yes, it was—2000 and 2001—but it took long time to establish itself.

Senator MOORE—It took a long time to get going; that is right.

Ms Appleyard—The record keeping that we have now that would have enabled us to answer that has only more recently existed.

Senator MOORE—I definitely want it for 2006-07.

Mr Eccles—I have a feeling we took one on notice two years ago. We can give the following year and then where we are at now.

Senator MOORE—That would be good. In your answer, could you refer to the previous question on notice so we can match it up.

Ms Appleyard—Yes.

Mr Eccles—Sure.

Senator MOORE—That would make it easier. Who makes the determination of approval for an MSOAP application?

Ms Appleyard—The department approves and the MSOAP advisory forum recommends.

Senator MOORE—Who is on that?

Ms Appleyard—It is chaired by this department and it consists of a stakeholder group. There could be representatives of specialists, peak bodies and state Health. There is one in each state.

Senator MOORE—There are state Health people?

Ms Appleyard—Yes.

Senator MOORE—With the exception of the ACT, do we have MSOAP services across the country?

Ms Appleyard—Yes, we do.

Senator MOORE—There was $48.4 million over four years in 2001, so 2001-02, 2002-03, 2003-04 and 2004-05. Was it re-funded at the end of the four years?

Ms Appleyard—It was.

Senator MOORE—What was the re-funding?

Ms Appleyard—It was $59.2 million over four years.

Senator MOORE—Which began in 2005-06?

Ms Appleyard—In 2004-05.

Senator MOORE—Is there any funding this year?

Ms Appleyard—Yes. There is $15.1 million in 2006-07.

Senator MOORE—Is that part of the $59.2 million?

Ms Appleyard—Yes.

Senator MOORE—So there was no new money on top of what was already allocated. It was the third-year allocation of the pre-existing four-year allocation.

Ms Appleyard—It was expanded. We got about $6 million extra, and I think that was per year, for MSOAP. That was to enable us to extend MSOAP services to existing specialist services.

Senator MOORE—That was an injection of $6 million.

Ms Appleyard—It was an injection of $6 million.

Senator MOORE—When did that happen?

Ms Appleyard—That would have been in 2004-05.

Senator MOORE—Each year or just for one half?

Ms Appleyard—Each year. It would have been ongoing.

Senator MOORE—I am just looking at a historical perspective of the funding: $48.4 million for the first four years, then a further $59.2 million for another four-year program. Where does the extra $6 million a year fit in that sequence?

Ms Appleyard—I am thinking about that as you say it. I think what happened in the first four years of MSOAP was that there were some significant underspends and they were rolled over, so I would have to find out for you for sure what that $6 million was on top of—whether it was last year's expenditure, which I am suspecting it may have been.

Ms Halton—Yes.

Ms Appleyard—Yes.

Senator MOORE—In 2004-05 when the $6 million came in, it was actually—

Ms Halton—A rollover.

Senator MOORE—a rollover from previous nonexpenditure.

Ms Appleyard—Yes.

Senator MOORE—It was not exactly new money; it was just making sure that the money was spent for the same purpose.

Ms Appleyard—And also for an additional purpose, which was established specialist services, which were not eligible under the first MSOAP.

Senator MOORE—The eligibility changed in the second?

Ms Appleyard—That is correct.

Senator MOORE—So that was to enhance the eligibility?

Ms Appleyard—That is correct, yes.

Senator MOORE—It operates, as you said, through the advisory committee. Are funds divided up between fundholders from the annual budget allocation, or are they allocated on a program-by-program basis?

Ms Appleyard—What has happened historically is that there is an allocation per state, but there is often more than one fundholder per state—by which I mean only two—so quite often you will have an NGO, like the local SBO, the division peak in the state, and you might also have state Health auspicing MSOAP. The reason it was done that way is that we would generally get state salaried specialists auspiced by the state health department, and the NGOs generally have the private specialists on their books.

Senator MOORE—We are in the last year of funding now, of the current four-year period?

Ms Appleyard—We are in the second-last year.

Mr Eccles—The last year of the current period is 2007-08.

Senator MOORE—2007-08. So we are turning over. How is it tracking?

Ms Appleyard—Excellently—coming in very close, Senator.

Senator MOORE—We have heard reports that there have been applications for this program which have not been funded, and the rationale has been that there has been insufficient funding.

Ms Appleyard—Occasionally that happens.

Senator MOORE—How does that work?

Ms Appleyard—What will happen is that the MSOAP advisory forum will draw up a prioritised list of services. It adds up the value of the services, draws a line where the funding allocation is arrived at, and then says that we can fund what is above the line, and what is below the line we can reconsider if funding becomes available throughout the year.

Senator MOORE—Do you seek applications for funding? Is it a funding submission round?

Ms Appleyard—It is not so much a round. Specialists are invited to put in submissions to MSOAP at any time. They can do that, but there is generally an annual service plan done by each state and that annual service plan is then put up to the department for approval.

Senator MOORE—From what you have told me, at the early stages there was a historical underspend.

Ms Appleyard—Sure.

Senator MOORE—So the money flowed over.

Ms Appleyard—Yes.

Senator MOORE—Is there any way of bringing money forward in a four-year program?

Ms Appleyard—You can. It is called a reprofiling. But we generally would not do it because it is robbing Peter to pay Paul.

Mr Eccles—It has not happened here. It is a technical possibility, but it is not something that we would entertain here. You do not want to have a situation where you have got more funding and then less funding.

Senator MOORE—It is just that the stated aim of the program is to provide specialist services to regional areas, and I do not want to name one because that automatically creates a problem, but if you have a specialist service required in Dirranbandi—for the sake of a place, because I know it—and they say, 'No, we've run out of money,' that does seem to defeat the purpose of the program.

Mr Eccles—It is prioritised by the local stakeholders. Each state has its own MSOAP advisory committee, and they do prioritise. We would expect and hope and believe that they do take into account the relative needs in putting forward the list.

Senator MOORE—Do you know how many are waiting for approval at the moment?

Mr Eccles—I do not.

Ms Appleyard—No. In the last answer to the question on notice I think we said around 26 services were not able to be supported in that year.

Senator MOORE—In that year, which was two years ago?

Ms Appleyard—It was 2005-06 or 2004-05. I will check that for you.

Senator MOORE—At that stage there were 26 services that had got to the stage of saying, 'We want to do it; we're prepared to do it'?

Mr Eccles—Who made a submission.

Senator MOORE—Had gone through a submission process.

Ms Appleyard—That is right.

Senator MOORE—The first round to their state?

Ms Appleyard—Yes.

Senator MOORE—That would be through the state government?

Ms Appleyard—No, not the state government—the state based advisory forum, which is actually our department's forum.

Senator MOORE—Which includes state government people?

Ms Appleyard—It includes a state government representative, yes. The fundholder is often the state government.

Senator MOORE—I hasten to add that I know of no service that has requested to be in Dirranbandi, but, using it as an example, if there were a specialist need for something in Dirranbandi, they would provide a submission as to what services they could provide, how often they could do it, what cost that would be, and put it, as they would be aware, through the state based advisory group.

Ms Appleyard—The specialist would, that is right. They would submit it to the fundholder and then the fundholder would pull that all together and provide that list to the advisory forum—the fundholder would be a member of that advisory forum—and then it is submitted

to the department for a final decision. In answer to your question about what we might do about services that are unable to be funded initially, we always have flexibility in the program towards the end of the financial year to identify where there may be some underachievement.

Senator MOORE—Like now.

Ms Appleyard—Like now, exactly. If we were finding that, for instance, New South Wales had totally committed their funds but there might be a little bit of money left in Western Australia that was not able to be used—and this is not a good example, because this is not the case—

Mr Eccles—It is very hypothetical!

Ms Appleyard—but if it were—or vice versa, I hasten to add—we might be able to suggest a reallocation, because it is more important to us to fund a specialist service.

Senator MOORE—Are they funded for a year? Is it an annual funding basis?

Ms Appleyard—Yes, there is an annual plan approved. That is correct, yes.

Senator MOORE—If a service came on line now in May-June, when would it be funded to? The end of this financial year or the end of the next financial year?

Ms Appleyard—It probably would not be a realistic example. At about this time of year we are receiving funding plans for the next financial year, and the idea would be that the service would start on 1 July and end on 30 June.

Senator MOORE—So most of the services that you are going to list and give to me would be funded from July to June?

Ms Appleyard—That is correct.

Senator MOORE—Just remind me. On the funding side, as we move into the fourth year of the four-year funding plan, is it normal for people to start looking at whether there would be a submission made to government to extend, and how would you do that?

Ms Appleyard—To extend their service?

Mr Eccles—Or is this to extend the whole program?

Senator MOORE—The whole program, because what we have is a four-year program that is wound down and then being re-funded for another four years. I just want to be reminded. In the budget cycle, in a program that has been described in a number of places as being extremely efficient and providing great service—

Ms Appleyard—Yes, that is right. However, it is lapsing.

Senator MOORE—what is the timing to start saying, 'Although maybe not able to service everything we want, we are funded now, we are serviced now, until financial year 2007-08'? When do you start collecting the data to go through for the next four years?

Mr Eccles—Shortly. The budget process never really ends. Once the budget is handed down, we almost straightaway start doing the preparatory work for the next one. We will be starting to draw the information together and holding discussions with the department of finance with a view to preparing a case for whatever outcome is required.

Senator MOORE—And each of your advisory groups in each of the states would be putting their figures together to give to the national one now, for next year?

Ms Appleyard—Yes, next year's annual plans are being submitted around now.

Senator MOORE—You said the minister has the final say after it goes to the department.

Ms Appleyard—Not on this program, no. This one is recommended by the advisory forum and decided by the department.

Senator MOORE—Where is the delegation?

Ms Appleyard—The delegation in the department is at the state and territory office level, if I remember rightly.

Mr Eccles—The state managers.

Senator MOORE—It is not determined nationally; it is determined state by state?

Ms Appleyard—Yes, that is my understanding, but I will certainly correct the record if I am wrong.

Senator MOORE—Can you double-check in case that is not true.

Ms Appleyard—Absolutely, yes. I am sure that is correct.

Senator MOORE—So for the Dirranbandi service, it would be the state manager in the Queensland office?

Ms Appleyard—Yes, I think so. I have been in the outcome for two years now and I cannot remember exercising a delegation in approving MSOAP, so it must be in the state.

Mr Eccles—But you may have?

Ms Appleyard—I may have.

Senator MOORE—Is there an appeal process if, for any reason, someone does not get picked up and it is not a funding issue? Have you ever had that?

Mr Eccles—There is always an appeal process and we see it quite often in a range of programs where people, who believe they should have got a guernsey, miss out for whatever reason and they often write to us. There is no formal appeals process for this particular program.

Senator MOORE—Can one particular specialist pick up more than one contract? If I am a heart specialist can I receive—

Mr Eccles—Can you go to two places?

Senator MOORE—Only two?

Mr Eccles—No.

Ms Appleyard—You can have more than one service.

Mr Eccles—You can go to multiple.

Senator MOORE—If I put my services through to the state manager in Queensland I can get funding under as much as I am prepared to do and they are prepared to give me.

Ms Appleyard—Yes, that is correct.

Mr Eccles—Depending on the priority that—

Senator MOORE—Can I cross the border?

Ms Appleyard—Yes. If you wanted to do a service in New South Wales as well—sometimes this happens in remote areas where you might get a cardiologist wanting to go to the Northern Territory and also to Queensland—that would not be a problem.

Senator MOORE—There is nothing to stop that and that would come under the state approval of the place where I am doing it?

Ms Appleyard—That is right, yes.

Senator MOORE—You are going to provide me with the current services funding and you are also going to tell me currently how many services are on—

Ms Appleyard—Yes.

Senator MOORE—the waiting list is the wrong term, but services that have gone through the process and only because of funding restrictions cannot be serviced this year.

Mr Eccles—Yes. We will show that alongside the number that are serviced, so that you can get a sense of relativity. In 2006-07 there are 1,287 services being supported so we will put that into that context.

Senator MOORE—Similarly to my previous questions of the service; this funding can cover anything?

Ms Appleyard—MSOAP funding basically covers travel and accommodation assistance, support at the other end for a receptionist and room hire. It covers the cost of up-skilling activity if the specialist is going to up-skill local health professionals. Occasionally a sessional payment will be made to a specialist in lieu of Medicare or other fee for service if a specialist is providing a service in a very remote area and they may be seeing patients who do not have Medicare cards or where there might be a chance of a large no-show; then we are able to negotiate a sessional payment for the specialist.

Senator MOORE—Does that happen often?

Ms Appleyard—No. It is in the minority, but it is a good provision to have because occasionally, especially in remote areas, it is likely.

Mr Eccles—We do not want to put any disincentives to not being part of this one.

Senator MOORE—Is there a modelling process for the quantum of the funding? Where do the figures of 48.4 and 59.2 come from?

Ms Appleyard—It is a historical type of a block funding arrangement. I believe there was a formula, probably some time ago at the start of the program.

Senator MOORE—2000-01.

Ms Appleyard—Exactly. There may have been a formula but what we have tended to do is to continue, based on those proportions.

Senator MOORE—Whatever discussions will happen this year for potential, there is no model that you do?

Ms Appleyard—It is something we would definitely look at to see whether—

Senator MOORE—Okay. I shudder to say that looks like the end of 6, unless Senator Adams—

Senator ADAMS—We might need to drill down a little bit below the actual specialist, but the person that goes to see the specialist, may I ask some questions on that?

Mr Eccles—Yes.

Senator ADAMS—I do not know where it is going to fit in otherwise.

Ms Appleyard—Whether we can answer them is another matter. We do not really keep patient data. That is not something that—

Senator ADAMS—It is not particularly that. It is just the general overview of it. It has been a huge problem. You have got one specialist coming out, the patient goes to see that specialist, they apply for PATS to go and see that specialist. Next month, guess what? That specialist does not come back. The next specialist comes and so the continuity for the patient is that they have to go to the nearest specialist. These programs are great and I would never knock the fact that we have specialists going out there, but there are some huge problems with it. How much do these specialists know about the Patient Assistance Travel Schemes? Do they promote them or not? All these questions are coming up in our inquiry. We have had a lot of submissions and I thought I had the opportunity so I will ask.

Mr Eccles—That is a good point. We do not know the extent to which the specialists that we support through this program understand the Patient Assistance Travel Scheme in the particular jurisdiction that they are going to. It is something that we should have a look at.

Senator ADAMS—Especially as most of the guidelines in each state say that you must go to the nearest specialist. As I said, often you may get somebody with that speciality but it is not the same person.

Mr Eccles—I would hope that the specialists who go out to these rural areas are, more often than not, people have got an interest in the health of rural people. They are doing it because they want to help people in rural areas. I would expect that a significant number of them did know a bit about the PAT Scheme to the extent that they can recommend to patients how they go about maybe going into the city for more complicated treatment, but it is a sound point you raise.

Senator ADAMS—The problem is that they have been to see you.

Mr Eccles—I understand.

Senator ADAMS—You are back in the city, so therefore you really want to continue with your patient but they cannot because someone else who is doing the same speciality has arrived back in your place or you have got a tandem thing going that you go one month and they go the next.

Mr Eccles—Yes.

Senator ADAMS—There are a lot of complications like that, so I thought I would flag it now while we are talking about specialists.

Mr Eccles—It is a good point, Senator.

Ms Appleyard—It is good that you raise it, Senator, because we will be doing a review of the MSOAP program as part of our deliberations on the future of the Rural Health Strategy. This is something we would definitely put in as a question; it is something to be looked at.

Senator ADAMS—Thank you.

Senator MOORE—In terms of the deliberations on the future of the rural health program, how does that operate?

Ms Appleyard—Basically what is happening at the moment, as I understand it, is a decision has to be made about the ongoing status of the program. It is currently a lapsing program, as you know, and so a decision is yet to be made about whether the program will be reviewed. We expect that decision to be made quite shortly. What I can tell you is that there is money in the forward estimates for the Rural Health Strategy.

Senator MOORE—Yes, there is.

Ms Appleyard—I am certainly aware that the minister has committed publicly to the National Rural Health Alliance around the government's support for rural health programs, so I would expect to have a decision fairly soon about whether the program is going to have to be reviewed or will be made ongoing.

Senator MOORE—When you say 'fairly soon', is it a financial year thing?

Mr Eccles—We have got all of next financial year as well. Yes, it is fairly soon.

Senator MOORE—Yes, it is fairly soon. In terms of that process is it likely to have an external component of review or is it internal?

Ms Appleyard—We do not know yet because that will be part of this decision about whether the strategy has to be reviewed.

Senator MOORE—Right. Can you give me some up-to-date information on the aligning services in rural and remote areas process? I know it is a COAG program.

Ms Appleyard—It is.

Senator MOORE—Can you give me an update on where that is, funding, stakeholders and exactly how that project is operating at the moment?

Ms Appleyard—I cannot give you a lot of detail because the measure is being progressed through an AHMAC subcommittee called the Rural Health Standing Committee. The standing committee has put together a paper and some options for consideration through the committee structure. I can tell you that it is making its way through the committee structure at the moment.

Mr Eccles—It is being considered by governments.

Senator MOORE—Who are the members on that committee?

Ms Appleyard—The Rural Health Standing Committee? Each state except the ACT and the Australian government.

Mr Eccles—The Australian government is on it.

Senator MOORE—At what level are the members of that committee?

Ms Appleyard—I am a member of the Australian government.

Senator MOORE—You are the Commonwealth government rep?

Ms Appleyard—Yes, I am the Commonwealth representative.

Senator MOORE—And you are a section head?

Ms Appleyard—I am an SES band 1.

Senator MOORE—So at that level—I am trying to think of the right—a branch manager?

Ms Appleyard—Branch head, yes.

Mr Eccles—You are the assistant secretary, also known as the branch head?

Senator MOORE—No, it is at an SES level.

Ms Appleyard—That is correct, yes.

Senator MOORE—What about the state government components? Are they from their state health departments?

Ms Appleyard—They are all from their state health departments and they often come from strategic policy areas with a rural health responsibility underneath them.

Senator MOORE—When was this particular project started; at what COAG?

Ms Appleyard—The February 2006 COAG.

Senator MOORE—That was a meeting of COAG but it was through the health ministers?

Ms Appleyard—It was a decision out of the COAG meeting of February 2006.

Senator MOORE—The aim was—because it was discussed widely—but aligning the rural and remote, yes.

Ms Appleyard—It was to try and break down some of the funding silos between rural programs that are basically either funded by states or the Commonwealth, so that we can more flexibly apply that funding and therefore more flexibly deliver the services that a particular community needs, with the size of the community being around 7,000 or less.

Senator MOORE—Is that particular measure of 7,000 across the board?

Ms Appleyard—It will be applied nationally—that is right—in each jurisdiction, yes.

Senator MOORE—Then each individual state would have their own version? I know there has been some discussion in the industry, but a 7,000 figure in Queensland is significantly different to a 7,000 figure in Tasmania.

Ms Appleyard—Having been made as part of a COAG announcement, it is a figure that was agreed amongst jurisdictions at that time as being appropriate.

Senator MOORE—The original concept came out in February 2006 and there were media releases put out at that stage about it.

Ms Appleyard—Yes, there were.

Senator MOORE—How many times has that particular committee met?

Ms Appleyard—The rural health standing committee since then has met maybe three or four times, I could tell you for sure—probably closer to four. We have had frequent teleconferences too.

Senator MOORE—That does make sense, considering the process. So you have met three or four times since then. Is this project the only issue that you are talking about in that committee?

Ms Appleyard—No.

Mr Eccles—We have used that also to consult on the RFDS, for example.

Senator MOORE—How about the MSOAP?

Mr Eccles—It has been discussed, but I do not think it is a standing agenda item. We have other advisory channels for that.

Senator MOORE—Does the rural committee look at data exchange or collection of data?

Ms Appleyard—No, it does not.

Senator MOORE—Does it have any input with another standing committee that there is through the process that looks at information technologies? One of those standing committees looks specifically at how you keep data.

Mr Eccles—Is that the National Health Information Management Principle Committee?

Senator MOORE—I think it is, yes.

Mr Eccles—The linking point is me. I am on that and I frequently turn up to this one.

Senator MOORE—Good, because my question is: exactly how, with all health but in particular with rural health service delivery, are the appropriate mechanisms for information technology and data management handled and costed, and how is best practice ensured?

Mr Eccles—It is something that we do discuss, between the Commonwealth and the states, because e-Health and Telehealth are going to have some of their strongest applications in joining up rural areas.

Senator MOORE—Outcome 10 for this portfolio crosses over with those kinds of issues, doesn't it?

Mr Eccles—E-Health is covered under outcome 10.

Senator MOORE—Within the Aligning Services in Rural and Remote Areas initiative, the e-Health issue is the concept of service delivery through telephone services and through the internet. Is that an issue for that committee?

Ms Appleyard—I do not think it is on our forward work plan at the moment specifically, generally because it would form a subset of an item that is probably on the work plan of the committee that Richard is talking about. What we would generally do is make contact with

other committees where we know they are working on similar issues. Health Workforce Principal Committee is a very good example of this.

Mr Eccles—And of course the CEOs all meet at a common point, the AHMAC committee.

Senator MOORE—I know you are reporting back to COAG about the Aligning Services in Rural and Remote Areas initiative, but is that a time-focused work plan?

Ms Appleyard—We do provide regular updates and reporting. We were given four years; it was a four-year measure.

Mr Eccles—We will get the report up as soon as possible. We are close.

Senator MOORE—Right, but the time frame was a four-year period?

Ms Appleyard—Yes. What we are thinking is the most sensible thing from the Australian government's point of view is for the renewal of the Rural Health Strategy to contain some of the principles that would come out of the better alignment measure. We would hope to be able to implement those, should the Rural Health Strategy continue, from around 1 July 2008.

Senator MOORE—In terms of the structure around the discussions in that area—you gave it to me in an earlier answer, the Medicare division of regions. I keep thinking ARIA, but it is not that.

Ms Appleyard—Is it ARIA that you mean?

Ms Halton—There are two: ARIA and RRMA.

Senator MOORE—RRMA, thank you. I want to know whether there is any discussion about a standardisation of those definitions, because it comes up consistently. We talk about RRMA and we have great discussions about what RRMA a location fits into—and then we have the other one as well. I am hoping, from seeing the brief thumbnail sketch of what this particular program is about, that under Aligning Services in Rural and Remote Areas there is some consideration of that definition.

Ms Halton—The short answer, Senator, is that it is a whole-of-portfolio issue. It is regrettably the case that to have one system would cost us a lot of money, if we were not to have losers.

Senator MOORE—In terms of individual locations being losers?

Ms Halton—Absolutely. We have done a lot of work on this issue. It is very hard to say to somebody who under one classification at the moment is advantaged in some way that, if you actually brought in a new classification and disadvantaged nobody, it would cost you a very large amount of money.

Senator MOORE—So, whilst that consideration would be a discussion point in this particular group, there has been a lot of work done on it?

Ms Halton—It is a much higher order issue.

Senator MOORE—I am just double-checking I have all the rural and regional questions out of the way.

Mr Eccles—Can I just correct something while it is fresh? We will update the MSOAP profile we gave you on 1 November 2006. That was the last time we gave you that table.

Senator MOORE—Thank you. That was the one you remembered doing?

Mr Eccles—That is right. I thought my memory was too good.

Senator ADAMS—I have a question. Is the Multipurpose Centre Program going on and where is it?

Mr Eccles—Is that under aged care?

Ms Appleyard—No, it is not.

Mr Eccles—I am thinking MPS as opposed to MPC.

Ms Appleyard—It is a small and continuing program, Senator. It is part of the Rural Health Strategy. We spend the fairly small budget we have for that, which is, I think, just over $1 million a year. It is meant to be a no-growth program but it does have some handy applications in rural and remote areas, as you know.

Mr Eccles—The MPS took over from that. That is right.

Ms Appleyard—What we will probably do in reviewing the Rural Health Strategy is have a good look at MPC while we are at it.

Senator ADAMS—It does work for some of the smaller communities. The MPS just does not, as far as the aged care component goes. You get a coastal community that can have a medical centre and come in under that program.

Ms Appleyard—That is right.

Senator ADAMS—As it develops and grows, of course it is going to change, but it is very valuable, so I would not like to see that go. Thank you.

Senator MOORE—What is the current status of the Multipurpose Centre Program?

Mr Eccles—It is an ongoing program, Senator.

Senator MOORE—Funded until when?

Ms Appleyard—I believe it might be a component of the Rural Health Strategy, which means that it lapses in—

Senator MOORE—That is my understanding. I think it is part of that.

Ms Appleyard—Yes.

Senator MOORE—In the data you are going to give me, you are going to give me that funding up till now?

Ms Appleyard—Yes.

Senator MOORE—That is good. Now I have finished.

CHAIR—That is outcome 6 done—very good. I understand the proposal at this point is that we will go to outcome 12 in order to delay slightly the discussion of outcome 7, hearing health, to allow Senator Crossin to join us. So can we have officers in outcome 12 to the table, please. Senator McLucas.

[9.06 pm]

Senator McLUCAS—What is the department's current benchmark for GP to population ratios?

Prof. Calder—I did not hear the first part of your question, Senator. Did you ask me what is the current benchmark?

Senator McLUCAS—Yes, for GP to population ratios.

Prof. Calder—We use a national average in determining areas of workforce shortage, if that is where you are heading. It is a national average, so it is within the range of ratios. I will get some advice, because it varies.

Mr Dennis—The national average doctor to population ratio is in the order of one to 1,350. That is, of course, for the current dataset, which became effective for the last quarter. The doctor to population ratio is the number of people per doctor, so one doctor per 1,350 people, as measured by the latest ABS statistics for population. It is a full-time equivalent measure, so it takes into account whether doctors are working full time or part time.

Senator McLUCAS—That one to 1,350 is the average nationally at the moment?

Ms Halton—Yes.

Senator McLUCAS—What is the ratio we use to ascertain under which figure we are in an area of workforce shortage?

Mr Dennis—All figures below that, meaning all areas that are less well supplied than that which have higher ratios than one to 1,350, are considered to be areas of workforce shortage, and of course the obverse is true—anywhere which is oversupplied is not considered to be an area of workforce shortage.

Senator McLUCAS—It used to be one in 1,400. What is that shift?

Mr Dennis—It changes quarter by quarter. Each quarter the Medicare billing statistics which determine the number of doctors per population are calculated for each of the statistical local areas, and the ratio changes. Each ratio of each SLA—statistical local area—is recalculated, as is the national average, so it changes within a range.

Mr Kalisch—This is one of the vagaries of the system we use.

Senator McLUCAS—It is variable?

Mr Kalisch—Predicated on where that average falls. If there are a few more doctors that enter the country, we will have a change in that situation.

Ms Halton—Or graduates from university.

Mr Kalisch—Yes, as we see more graduating in coming years.

Senator McLUCAS—Can the department provide us with GP to population ratios by state and territory?

Mr Dennis—Yes, I think that would be possible.

Senator McLUCAS—Can you do it by RRMA categories or area, depending on which is the more appropriate? I would prefer RRMA because I know that better.

Mr Dennis—The units that we normally use to calculate these are statistical local areas, and they are not subordinate units of RRMAs. So any attempt to massage one unit into another will be imprecise and will lead to misleading statistics.

Senator McLUCAS—All right, I accept that, so do not take that as a request. Going to SLAs, is it possible for you to provide us, on a quarterly basis, with the doctor to patient ratio by SLA in Australia currently?

Mr Dennis—That information is not generally released at that level. I understand that a similar question was asked at the last estimates hearing, and we attempted to do the best we could. The number of SLAs that constitute the land mass of Australia is approximately 1,400, so it becomes extremely unwieldy due to the magnitude of the exercise and conveying the data in that form.

Senator McLUCAS—But you have the data, don't you?

Mr Dennis—You asked previously for a state average. We could certainly provide that without any issue, I believe.

Senator McLUCAS—But you do have doctor to patient ratios by SLA. You have indicated that already.

Mr Dennis—The department holds that data, that is correct.

Senator McLUCAS—In order to produce that information, it would simply be pushing a button on a computer and printing it, wouldn't it?

Ms Halton—I think we have had this conversation before, Senator, about what constitutes the push of a button. I think, in fact, there was a whole separate inquiry about what constituted the push of a button. The bottom line is you can create a program to produce information but it is not one push of a button.

Senator McLUCAS—But there is a list somewhere in the department, on a quarterly basis, of the 1,400 SLAs in Australia and the GP to patient ratio in those SLAs.

Prof. Calder—We do not really work like that. What we do is, on request, check an area as to whether it is an area of workforce shortage for the purposes for which we use the data. When an application is received, we will check the area. Some areas do not change—we know that—but we still check against the current quarter's figures. There is no standing list.

Senator MOORE—Isn't the SLA the bottom line of the statistical input? I could be getting this wrong, Mr Dennis—and I can remember having this discussion, or similar, in the past—but the previous information you have given us is that it is all worked out on an SLA basis, determined by the number of doctors or people with qualifications who come in.

Mr Dennis—Yes.

Senator MOORE—But the bottom line is the SLA.

Mr Dennis—When you say 'the bottom line', there is denominator and a numerator. One is the population within the SLA and the other is the number of medical services or the Medicare billing data that is provided loosely within the SLA.

Senator MOORE—And the SLA is a Bureau of Statistics unit.

Mr Dennis—That is correct.

Senator McLUCAS—When a doctor gets a practice, he is given a provider number. That is identified into an SLA, isn't it?

Mr Dennis—My understanding is that it is location specific.

Ms Halton—It is a particular address. You can have a series of different numbers if you are practising in a number of different places.

Senator McLUCAS—Yes, I understand that. So you would practise in SLA No. 322 for three-fifths of the week—

Ms Halton—No. You practise at a particular address. We know the address, and then—and this comes from Medicare Australia—the issue is the statistical overlay that you put on top of that, which for some purposes might be an SLA but actually we would use the ARIA classification. So the issue here is: how do you map the address into some other construct? So it is the algorithm you use to take addresses into whatever is the construct you are using.

Senator McLUCAS—Into a geographical system?

Ms Halton—Yes.

Senator McLUCAS—Whether that be SLA, a map of Australia or ARIAs?

Ms Halton—That is right.

Mr Kalisch—State or territory.

Ms Halton—Precisely.

Senator MOORE—So Dirranbandi would be defined in three or four different ways.

Ms Halton—It could be, yes.

Senator MOORE—For the purpose of the discussion, Dirranbandi would be—

Ms Halton—We gather it is in Queensland!

Senator MOORE—It is in Queensland.

Ms Halton—Would it be in western, remote, rural Queensland?

Senator MOORE—Exactly, and I think it is an area of workforce shortage. For this purpose, if someone requested, as you said, a stimulant to determine whether it meets the criteria or not, Dirranbandi would be defined by its SLA. It would be defined for health purposes by its ARIA definition.

Mr Dennis—No. I believe the town that you mentioned is treated as a locality.

Senator MOORE—Locality? I am trying to get the terminology right.

Mr Dennis—The SLA is in fact a boundary that defines a region.

Senator MOORE—For statistical purposes.

Mr Dennis—For the purposes of calculation of district workforce shortage. That town would sit within that SLA and would constitute part of the population of that SLA, which would be the denominator, and the number of services billed at the town that you mention would be the numerator but probably not the only one. There may be several or many

localities within an SLA, bearing in mind that one is a town and the SLA in fact defines a region.

Ms Halton—And remembering that this is based on billing data.

Senator MOORE—That is right.

Ms Halton—Again, we have had this conversation before. It is basically services that were billed in this location. I think the conversation that we have had before—not about Dirranbandi in particular—has been about a rural town where you may have a small hospital where a GP might be the VMO part time and in a practice part time: they might spend three days one week and one day the next as a VMO, with the balance in the practice. That will significantly influence the billing hours and it is the billing hours that we use as the basis for working out how much doctoring went on—that is, how much effective full-time equivalent went on; therefore is it an area of workforce shortage.

Senator McLUCAS—That is interesting. If you are in a small locality with one general practitioner working in the hospital and in a private practice, which is not uncommon, you are only counting the billing hours in private practice.

Ms Halton—That is right. That is exactly right.

Mr Kalisch—It is just on a Medicare billing.

Senator McLUCAS—So that location may be deemed an area of workforce shortage, and probably is.

Ms Halton—Yes.

Senator McLUCAS—But service level to the community is not represented by that data.

Ms Halton—It is a picture of what is going on in general practice as funded by the Medical Benefits Schedule. It is not a picture of the aggregate of medical service in that location, by definition, because that does not include outpatients or whatever else. Effectively, you assume outpatients as a bit of a constant, which in big areas is perfectly fine—and it has to work as a methodology here. We all know that the smaller the location the more variability there will be in that component of the equation, which means that the numbers are more volatile; the smaller the number of doctors that you are talking about, the smaller the area—what is this town called, Dirranbandi?

Senator MOORE—Dirranbandi.

Ms Halton—By definition, those figures are going to be more volatile. Frankly, if the GP goes on holidays—

Senator MOORE—That is right. He has gone.

Ms Halton—and they might get a locum who comes in for two or three days—

Senator McLUCAS—And just does the hospital.

Ms Halton—Yes.

Senator MOORE—So for that quarter, as you were talking about, the variations will throw the whole thing out.

Ms Halton—Yes, that is right. That is my point.

Senator MOORE—What about the Royal Flying Doctor Service—if you want a general question? In terms of the process, they are servicing an area because—

Ms Halton—If it is billed it is in and—

Senator MOORE—But all the other outreach services, none of that counts in terms of this particular statistic?

Ms Halton—No. That is right.

Prof. Horvath—If I may: it goes back to your very first question about benchmarks. In my former life, for my sins I tried to do three general practice workforce reports. There is no such thing. Nobody can tell you what is the benchmark or right ratio. They are all comparators. There is not a measure of saying, 'This is how much general practice a community needs.'

Ms Halton—There is no objective standard.

Prof. Horvath—There is not an objective measure, unfortunately. You can have ends of ratios and say, 'There's no doubt there's a lot of general practice being done at that end and clearly not enough down that end.' Every time, as Chair of AMWAC, I tried—thank you, Secretary, for laughing—we got into the most horrible fights.

Ms Halton—He wrapped himself in knots, I think, is the short description.

Prof. Horvath—Yes, that would be the short. And people kept changing sides on me even.

Ms Halton—Yes, exactly.

Prof. Horvath—The AMA even changed sides three times in the one debate. There is not a way that we can answer your question with any sense. What the secretary has described is a constant measure, and it is something that we can work with so that there is a level of constant comparability and fairness. But it is not the gold standard of how many we should have.

Ms Halton—It is very interesting. If you go to international comparisons, you can look at countries which have quite different levels of general practice available to populations, some of whom have got excellent health outcomes, some of whom have got very poor outcomes, and it is not that you have got more necessarily. Sometimes they are completely reversed. This is Professor Horvath's point: if you go around and look internationally at the data on this and say, 'Well, there must be some objective truth on this. How many doctors do I need to deliver what have you?'—and this is where I laughed at Professor Horvath wrapping himself in knots, and it was unkind of me, but that is precisely the exercise. If you try and do this, you cannot come up, I think, with a completely defensible objective standard. The policy decision that was taken—and it preceded me—which would use this basically moving average as the way of identifying relative shortage, was really seen to be the fair compromise.

Mr Kalisch—The key to it is that we use a consistent methodology.

Senator McLUCAS—That is right.

Ms Halton—That is the point.

Mr Kalisch—We understand the flaws in it and we use other things around it as well to guide decision making, so it is not the only piece of information.

Senator McLUCAS—Let me ask the question differently. If I were looking at Australia to try and identify where, consistently, districts of workforce shortage were, what question would I ask you? It is called coming at it a different way.

Ms Halton—Are we going to give you the questions?

Senator McLUCAS—You know what I want; you know what I am looking for.

Ms Halton—Yes.

Mr Dennis—I might ask, Senator, which of the SLAs consistently, over whichever time frame you were to choose, had doctor to population ratios which were beneath the national average? That would go some way to answering your point.

Ms Halton—You see, I do not even think that that is the right question. Personally, I think the question is quite complex. The real question is: if there is a distribution of Medicare billable hours, who is consistently at the left-hand end of the distribution in terms of low availability and which of those areas have a similarly low availability of outpatients—you know, all the other things, AMSs?

Senator McLUCAS—Which you do not count in that data.

Ms Halton—No.

Senator McLUCAS—But I can find out by looking up a phone book.

Ms Halton—Yes. But if you were really to go to the total amount of doctoring—if I can put it that way—that goes in geographically, you would have to build up a much more complex picture to ascertain that, and remembering that even things like outpatients are complex because they are located in a particular geographic physical location but we know that they draw from a much broader catchment. Then you get into all the issues about, even though it looks like it is close, there is a river in between and you cannot get there. That is why, when you try and do that, you discover you are wrapping yourself in knots three times over, again, so you end up still with this relative measure.

Senator McLUCAS—Going back to pressing the computer button and spitting out something without going to a huge amount of time and effort, Mr Dennis, you seem to say that you do have the SLAs that are consistently under the national average of GP to patient ratio.

Mr Dennis—In line with what my colleagues have said, though, that is one simple factor. When it is decided as to whether overseas trained doctors or exemptions will be granted in a particular area, other factors might be considered. Even though you might hit a button and get some figures, they would not give you a very comprehensive picture of the question that you have asked.

Senator McLUCAS—I understand that. I do understand the qualifications that we have made about there being available an outpatients or an AMS or a fly-in doctor, or a fly-in, fly-out community that does not require a doctor. All of those realities are there, but, given that that data is available, can I request that data?

Ms Halton—Yes. Probably the right question is: what regions are there at the left-hand end of the distribution—that is, they are well off the national average, but they are geographically

proximate to areas in a similar classification? By definition, it is much harder to drive from one area to another area. So if you have one tiny area which is nominally 'workforce shortage' but it is surrounded by a series of areas that are not, you can probably assume that you can get to a doctor by going into one of these other areas.

Senator McLUCAS—Not necessarily. You cannot make that assumption.

Ms Halton—In urban areas you can.

Senator McLUCAS—Of course. Townsville, for example.

Ms Halton—Yes. I am really talking about areas left-hand in the distribution, probably regional, remote, that are surrounded by relatively similar geographic regions.

Prof. Calder—Senator, just to follow up on what I think your question is, we do not keep that list.

Ms Halton—Now, yes.

Prof. Calder—But if you were to say, 'Can you tell me which areas have consistently been down that end of the spectrum over a period of time?', we could press the buttons and produce something. It would then, because of all we have said, hold for that quarter and give you a trend before that quarter, but, with obvious exceptions, it may not be much about the projections into the future.

Senator McLUCAS—Professor, would it be realistic then to ask for the areas that have been areas of workforce shortage for a year and areas that have been areas of workforce shortage for five years?

Prof. Calder—We can certainly do a year.

Ms Halton—We will look and see what period we can do.

Senator McLUCAS—If you cannot do both, can you do three?

Ms Halton—We will have a look at the data.

Senator MOORE—But what we will get is an SLA. The area you will provide to us is an SLA. That goes back to what the basic unit is, by this system. The question Senator McLucas is asking is one that would dip below that average over a year, which would be four snapshots if you do it by quarter. Taking that as your standard base, it would still come back to an SLA, so that would have to be then the reinforcement of what constitutes that region.

Ms Halton—We do not do it by SLA. We do it by bigger areas than that, because SLAs are too fine a level.

Senator MOORE—What is the smallest you keep, then? I thought we opened up this discussion by saying we did it by SLA.

Prof. Calder—I will try and come in with an analogy. It is a building block to a piece of data that you want. The SLA is a building block, and we might have three of them or five of them or two of them or 20 of them, depending on the area. We only pull in the data around areas of workforce shortage, not SLAs of workforce shortage.

Senator MOORE—I am having a huge mental block with this, because it seems to me your building block is your first point.

Ms Halton—No, it is addresses. That is exactly what I said. Building block is address, and then the issue is what statistical overlay you put across it. We use these areas.

Senator MOORE—What is your basis, when Senator McLucas is asking for an area that is consistently subject to workforce shortage?

Ms Halton—The areas that we use as classification.

Senator MOORE—Which are?

Ms Halton—Those areas might be constituted on the map of three, four, 10, whatever, SLAs, if you drew them into the map, but we take the address and then we map them into these areas.

Senator McLUCAS—So will you provide me a map or will you provide me a list—an area called Johnson, for want of a better word, that has SLAs 343, 345, 346? Is that how the material will come to me?

Prof. Calder—We will do it by place, by area.

Senator McLUCAS—How will I know where the boundary of that area is?

Mr Kalisch—We can show you the maps.

Senator McLUCAS—All right. I think we have something. Is it possible to provide us the areas that have become areas of workforce shortage in the last quarter for which data is available?

Prof. Calder—Do you mean areas that have not been before?

Senator McLUCAS—Yes, the new areas of workforce shortage.

Mr Dennis—It would take considerable effort. It might be possible.

Prof. Calder—We do not hold comparative data. We get the data at the point of time it is needed.

Ms Halton—We would have to go through the archival data.

Prof. Calder—We will have to do some comparisons.

Ms Halton—Let us have a look at it and see.

Senator McLUCAS—You basically work in response to an application from a doctor or somebody to have an assessment of an area of workforce shortage?

Mr Kalisch—That is correct.

Prof. Horvath—It may have been an area of workforce shortage two years ago and then was not because somebody else came to town; then somebody got sick and it was again. I know what you are getting at, Senator, and I have tied myself in knots on this particular issue, too. It is too dynamic. Something that crops up today—Gulargambone—suddenly becomes an area because a doctor has left town and suddenly we drop below the ratio, and, while we are processing it, it can change because somebody else will come to town or fly in and get a provider number.

Mr Kalisch—We have seen that very instant, where someone has put in an application and, at the time when they put it in or first inquired, it was a district of workforce shortage

and then, by the time the application is finalised and dealt with, it is no longer an area of workforce shortage because of changes in the statistics.

Prof. Calder—Whilst we obviously can do it, because data is there, to actually do it we would have to pull up two quarters of 1,400 lots of information and compare manually. We do not have a program to do that because we do not do it. We use the data at the time.

Mr Kalisch—For that location.

Ms Halton—It is quite an interesting research project, but we do not because of the way—

Senator Mason—Got the time for that?

Mr Kalisch—It is about a three-year job!

Senator McLUCAS—I do know of a community that does not apply to have district or workforce shortage status—and they do this through their division—because they do not want to have overseas-trained doctors in their area. You can argue the merits, or not, of that and that is a different question. Does that mean that there is a three-week wait to see a doctor if you have a cold because the community as a group have made a decision not to apply for area of workforce shortage status?

Ms Halton—Someone else can apply.

Prof. Calder—Senator, it is not an application process. There is no flag that you get that says, 'This area is an area of workforce shortage.' We use it as a guide. It is not even a real measure and, for all the reasons we have talked about, it is a point of comparison to say, 'Because of where it sits on this long list of ratios, an overseas-trained doctor application can be addressed.'

Ms Halton—The issue is not that they have to apply, whoever 'they' are. It is—

Senator McLUCAS—The division in that region.

Ms Halton—Yes, in this particular case. If there were some other sponsor or, indeed, a doctor on own motion or because they have a friend in that community, whatever it might be, they can make application themselves to go and practise in that particular place. Indeed, we see cases of that.

Prof. Calder—It is an application to practise, not an application for status.

Senator McLUCAS—Where the overseas-trained doctor decides that he or she wants to go to that particular location?

Prof. Calder—Yes.

Senator McLUCAS—Are they usually very remote, when the doctor who is overseas trained thinks that they might like to go to a very remote place with an unpronounceable name?

Ms Halton—It varies.

Prof. Calder—It does happen.

Senator McLUCAS—Unusual, I would imagine.

Prof. Calder—No, it does happen.

Ms Halton—I do not know about that. I have met overseas-trained doctors out in the middle of nowhere.

Senator McLUCAS—I have met a lot of overseas-trained doctors out in the middle of the country, but can I say I do not know any of them who have written to the Department of Health and Ageing and said, 'Please can I go to this extremely remote place.' They do not know where it is, and why would they dream that that might be a good place to go? It is always done by application from an Aboriginal health service, a council, a doctor who is practising in the area and he is wanting to retire; all of those scenarios.

Ms Halton—Not necessarily the divisions. That is the point.

Senator McLUCAS—Not necessarily, but in a situation where the division as a collective decides not to do this, the net result of that is that the community waits longer to see the doctor.

Ms Halton—Senator, there are issues. It is not the sort of time to canvass this. We are aware of issues and it is not just overseas-trained doctors. I can think of a couple of people out of Sydney who wanted to go and practise up on the north coast of New South Wales. Basically the people who were already there would not have a bar of it.

Prof. Horvath—What the secretary says, and I am going to come in on this—and I can talk for New South Wales, which I knew quite well—there are a number of closed towns.

Senator McLUCAS—Yes, there is an area of oversupply, shall we call it.

Ms Halton—No.

Senator McLUCAS—'Closed towns'. It is a different story completely, which is what I am getting to.

Prof. Horvath—The practitioners. But we as a department of health are not aware of it.

Senator McLUCAS—Which gets me to the point of why we do not locate doctors in SLAs, count the numbers of billings that they have so that the department has an idea of where the real areas of workforce shortage are, given all the nuances and realities that we have talked about, rather than wait for an application from somebody to practise in a certain area or to ascertain whether it is a DWS or not.

Ms Halton—Yes. It depends on what you mean by 'locate doctors'. If you mean we physically put them there—is that what you mean?

Senator McLUCAS—No. If it is an area of workforce shortage, then there are certain encouragements that are allowed to put in NVR doctors, OTDs or whatever.

Ms Halton—But essentially we do have our workforce agencies, and that is precisely their job. So we actually have a structure around whose job it is to say, 'This, this and this are real areas of need and it is our job to get doctors into those locations.' We can have a debate about whether they are as effective as they might be, but we actually have instrumentalities whose precise job it is to do that.

Senator McLUCAS—Do they have the SLAs that have the lower—

Ms Halton—They work with us pretty closely.

Senator McLUCAS—Who are 'they'?

Ms Halton—They have a fair idea.

Prof. Calder—They are rural workforce agencies. That is their group name but they have various local names.

Mr Kalisch—There is a national association.

Mr Dennis—There is one in each state—

Ms Halton—Yes, and we fund them.

Mr Dennis—and the Northern Territory. Each are independent agencies but all have that same purpose, amongst others.

Ms Halton—Exactly. But they can actually go on overseas recruitment drives.

Senator McLUCAS—And they would have the doctor-patient ratio by SLA?

Ms Halton—Yes, we would give them information. They have a much more detailed understanding of those dynamics we have just talked about—which is a closed town and which is not. Working with, for example, the shire in some cases they would identify (1) the need and (2) the opportunity. Then they actively go out recruiting.

Mr Kalisch—The other dynamic here is that, apart from these workforce-specific measures, there are other measures in terms of encouraging practices in remote areas. With the programs that we have just finished, in terms of rural health and primary care, each have major initiatives that provide a greater incentive for people to practise in rural and remote areas. That sort of adds onto this.

Senator McLUCAS—It is not just rural and remote.

Mr Kalisch—We have regional as well, yes. The whole RRMA classification comes into play.

Senator McLUCAS—Regional towns cannot attract GPs for sometimes unknown reasons. Going back to the SLAs again, how many changed eligibility status for DWS in the last quarter? Is that something you could provide us with?

Ms Halton—We can do it by region; the regions we have talked about.

Senator McLUCAS—Okay.

Ms Halton—Of which we are going to give you a list, and then we can tell you how many of them changed.

Senator McLUCAS—Then I will forget SLAs. Go to regions. About how many regions are there in Australia?

Mr Dennis—If it is an SSD perhaps, in the order of a couple of hundred.

Senator McLUCAS—What is an SSD?

Mr Dennis—It is a grouping of a set of contiguous SLAs.

Senator McLUCAS—That is good.

Mr Kalisch—It is the next building block that the ABS uses.

Senator McLUCAS—Good. So about 200?

Mr Dennis—In the order of that.

Senator McLUCAS—Could we have a list of those 200 regions? I am sure you have a document that says, 'This is the SSD and it contains these six SLAs' or eight or whatever it is. The ABS could give me that, couldn't they?

Mr Dennis—They may be able to do so.

Ms Halton—We will give you a document.

Senator MOORE—Which is the SSD list that you use?

Senator McLUCAS—Could you give me those 200 regions with their current status in terms of whether or not they are a DWS or not at that level.

Prof. Calder—We will give you a list.

Senator McLUCAS—So the current status as of today?

Prof. Calder—Yes.

Senator McLUCAS—Areas that have been DWS for a year, and maybe five years, if you can do that; then areas that have changed eligibility status in the last quarter, is that possible?

Ms Halton—Remembering there is a lag in our data, when you say 'last quarter', it would be the last quarter of analysis?

Senator McLUCAS—The last quarter available.

Ms Halton—Yes, because the data gets updated. We have been caught by this in the past. It is the point that was being made earlier. When you ask the first question, 'Is this an area of workforce shortage?' you get told yes, and then by the time the application comes in we may have actually updated the data but there is a lag in the data.

Senator McLUCAS—At a certain point in time, recognising that things change.

Ms Halton—Yes.

Senator McLUCAS—Professor, I said 'changed eligibility'; if that changed eligibility and became a DWS or changed and stopped being a DWS.

Ms Halton—Yes.

Mr Kalisch—They have moved across the barrier.

Senator McLUCAS—That is right; jumped across the fence. That is good. That will help. Thank you. In terms of specialist to patient—I am not going to say 'ratio'—how do you make decisions about the appropriate number of specialists?

Mr Dennis—Again, it is not a matter of what is an appropriate number or a benchmark. These are matters of distribution rather than adequacy, so again it is very much the same. The same method is applied, bearing in mind that specialists frequently need to be closer to metropolitan units which have the specialist equipment they use. Whilst the methodology is the same, greater scope is applied being considerate of that factor; factors of practice of course.

Prof. Horvath—Perhaps I can add to that: there is a very good publication which I hold credit for that AMWAC put out some years ago that the secretary actually endorsed, as did all the state CEOs. It is very good because it not only looks at this mythical number of specialists but all the things that are required by a specialist to practise. So if you are an orthopaedic surgeon, yes, you need a table, an operating theatre, physiotherapists, pathology et cetera. So it put a bigger picture around what you needed and you cannot have a town with one specialist because they cannot be on call 24/7. That is a document that gives a much bigger picture, and we use it in the department to come up with some of those more complex answers as to whether we need another specialist in the area.

Senator MOORE—Is that document used for the MSOAP program?

Prof. Horvath—I do not know. MSOAP?

Mr Dennis—No, I do not know.

Ms Halton—They have gone home.

Senator MOORE—For the unknown MSOAP person, can you give me that answer in the other list of answers you are going to provide?

Prof. Horvath—I suppose, Senator, whether the actual document is—the philosophy is there.

Senator MOORE—The philosophy behind that.

Prof. Horvath—There is no point in an MSOAP—a surgeon going somewhere where they cannot actually do it.

Senator MOORE—If they have not got all the stuff they need. That makes sense, Professor.

Senator McLUCAS—So in terms of the point you made about distribution being more important than numbers, is it reasonable to ask state by state for the numbers and types of specialists to population?

Mr Dennis—I do not believe that I said that distribution was more important than numbers. I think that, in an environment where the demand for medical services is infinite, there needs to be some recognition that perhaps no location will have the adequate supply or reach whatever benchmark is ultimately decided upon. We have a situation in distribution where we need to properly and equitably divide and distribute a finite resource, and that is what we attempt to do through these mechanisms.

Senator McLUCAS—But the raw data by state for specialists and by specialty?

Mr Dennis—Yes, we can do that, bearing in mind that there is not good data generally about subspecialty. With that in mind, that can be provided.

Senator McLUCAS—Is there a nomenclature of specialities that you could go through?

Mr Dennis—Yes.

Senator McLUCAS—At that higher level as a start?

Mr Dennis—Broadly grouped by state, we could provide that.

Senator McLUCAS—Thank you.

Ms Halton—Recognising that with the smaller jurisdictions you are getting into a finer grade of detail.

Senator McLUCAS—Sure. The ACT will not have as many as Queensland.

Mr Kalisch—The jurisdictional issue is an important one, because they also play a key role in terms of the training of specialists—in particular, in terms of the places that they provide within the public hospital system.

Senator McLUCAS—Yes, we are going to get to that.

Mr Kalisch—That has a big bearing on the number of specialists that you end up seeing in each jurisdiction.

Senator McLUCAS—Going to the discussion we were having about how an area becomes an area of workforce shortage, someone asks, essentially. Is that right?

Mr Kalisch—They ask.

Ms Halton—They are one by definition of the figures.

Prof. Calder—And they may or may not know that.

Senator McLUCAS—They are one by definition?

Ms Halton—It is sort of into areas of philosophy: does a tree make a sound if it falls over in a forest and no-one is around to hear it? It is an area of workforce shortage if the numbers fall below the benchmark.

Senator McLUCAS—So no-one can say, 'I got this area designated as an area of workforce shortage'?

Ms Halton—No, not unless they physically killed one of the doctors in the location or caused them to go and practise somewhere else.

Senator McLUCAS—I do not know that we could accuse Mr Laming of that. That would be terrible! So Mr Laming could not say, 'I got this area workforce shortage status.'

Prof. Calder—No. It is not a declaration, it is not a badge, it is a current measure.

Senator MOORE—It is not like a drought declaration.

Senator McLUCAS—That is all I needed on that, thank you. How does the Commonwealth contribute to clinical training placement payments?

Prof. Calder—We have established a new program which has expanded specialist training, and we will be funding those positions on a variety of methods. Other than that, clinical training occurs in the public hospital system.

Ms Halton—The answer is that we do not. DEST makes a contribution through the funding that they provide to higher educational institutions, which is meant to include some components. Obviously, state governments are meant to make a contribution to that clinical training as well.

Senator McLUCAS—So it is through DEST rather than—

Mr Kalisch—It is through DEST in terms of the Commonwealth contributions, as the secretary explained, but also in the COAG agreements in July last year, around the extra medical training placements and the extra nursing training placements the state and territory government premiers and chief ministers each made a commitment as part of that COAG communiqué that they would provide sufficient clinical training placements and intern placements for those new graduate training positions.

Senator McLUCAS—They are totally funded by the states?

Mr Kalisch—Taking into account the Commonwealth contribution. The states are committed to picking up the remaining cost.

Senator McLUCAS—For the new numbers?

Mr Kalisch—Yes.

Senator McLUCAS—Including nurses?

Mr Kalisch—There is really an implicit understanding within the health care agreements that states and territories take on that role.

Ms Halton—Let us be quite clear about this. This has turned into contested space in the not-too-distant past. The historical approach to this was always that the Commonwealth, via its funding of higher education institutions, provided some moneys as a kind of notional, nominal contribution to the higher education institutions as some sort of assistance; and states and territories, via their public hospital systems, provided the significant proportion of the costs for this activity and got a workforce as a consequence.

There was both a short-term benefit to them and a long-term benefit. The short-term benefit was a bunch of training bodies who get to spend their time in accident and emergency at three in the morning. The medium and longer term benefit was that they ended up with a highly skilled cadre of specialists to work in both the private and the public systems. It was a benefit.

Senator McLUCAS—And we get GPs too.

Ms Halton—That is exactly right. There was a kind of mutually reinforcing benefit of these arrangements. In the last little while, some of the states have decided that other people should be paying for clinical training, and it is probably a fair enough debate to be had in relation to full-fee-paying students, particularly overseas students. But in terms of the public good, on which the system is founded, this is a debate which we are quite clear on. They have an obligation. As Mr Kalisch was saying, in that recent COAG discussion we found it necessary to make it absolutely clear and explicit that this was the expectation on them. It has never been necessary to make that clear and explicit in the past, because the understanding upon which the system was founded was robust.

Mr Kalisch—To give you an example of another change, in Victoria the state government is drawing the payment that DEST makes to the universities from those universities to contribute to the cost of clinical training that they need to meet.

Senator McLUCAS—Are they thinking that the universities are not applying that money to training?

Mr Kalisch—They are presuming that the universities do not need the money or do not make any contribution, which they clearly do. They clearly have a role in terms of that process.

Senator McLUCAS—What about undergraduate nurse training?

Ms Halton—There is the same issue. The other overlay on this, of course, is the insurance angle. This is complex.

Senator McLUCAS—Is the undergraduate nurse aged care scholarship in this outcome or in outcome 4?

Ms Halton—It is in outcome 4.

Senator McLUCAS—This is picking up from where we were in February this year. I do not have a copy of the question here, but you indicated that the department does not collect any data on the dental workforce. Is that still the case?

Prof. Calder—That was correct at the time. Since then we have started to collect some publicly available data that places like the Australian Dental Association have been willing to provide to us so that we can start building up our own knowledge of the current workforce situation. We did not have any information prior to acquiring this data just in the last couple of weeks. As we said to you in the last estimates discussion, we rely on the Australian Institute of Health and Welfare and their data. They do have the comprehensive data. What we have acquired is a small batch of data, and we do not quite know what it is going to tell us yet.

Senator McLUCAS—That is basically the number of dentists practising and where they practice, I dare say.

Ms Halton—We have some idea about that—rural versus metropolitan.

Senator McLUCAS—What is the new data?

Prof. Calder—We are hoping to get a picture of the age profile of the workforce and those sorts of things so that we can be much better informed in our own thinking.

Mr Kalisch—The key for us is trying to anticipate the training needs for the future and what other pieces of information we need.

Senator McLUCAS—Which leads me to my next question. On what basis do you make a decision about a new dental school being placed anywhere? How is that decision made?

Prof. Calder—We have used information that is available, including jurisdiction, reports on shortages in local areas and academic institution and professional association advice about areas of shortage requirements.

Ms Halton—There is also a question about what interest there is on foot. Let us be quite clear about this. You have to have both a buyer and a seller. To the extent that we have an interest in increasing the dental workforce and, more particularly, recognising that there is a distributional issue in respect of the dental workforce, we know that there is a much more acute shortage of dentistry in the bush.

From our experience with medical practitioners, we know with doctors that kids who come from the bush are much more likely to go back and practise in the bush and are much happier

to stay there. Kids who do part of their training in the bush, even if they come from the city, are more likely to stay there et cetera. These things are now properly understood features of training and we build in those incentives so that when it comes to the dental workforce training issues, which are relatively new areas of endeavour, we are informed by all of that history and experience, which we have no reason to believe will be any different for dentists or doctors. Then there is the question of who is out there with an interest in and a capability of delivering some of this.

Senator McLUCAS—How do you assess that interest and capability?

Ms Halton—Based on, in the recent past, a number of people who came to me with quite detailed propositions.

Senator McLUCAS—Including James Cook University?

Ms Halton—Yes.

Senator McLUCAS—It was essentially a competition between Charles Sturt and James Cook. Is that right? Not a competition; that is not the right way to put it.

Ms Halton—Yes.

Senator McLUCAS—You have to analyse and make a judgement that one is more capable than the other.

Ms Halton—That is right, in the context of what funding is available and in the context of the package.

Senator McLUCAS—That assessment happens in the department?

Ms Halton—It happens across a number of departments, in truth.

Senator McLUCAS—But the decision is made at a departmental level?

Mr Kalisch—The decision is made essentially by government.

Senator McLUCAS—It is made by government.

Ms Halton—Yes, absolutely.

Senator McLUCAS—So you provide advice.

Ms Halton—Absolutely.

Senator McLUCAS—I do not want to know what that advice is. You provide advice to government and the government makes a decision.

Ms Halton—Yes. A number of departments are involved in that process for obvious reasons. Higher education is not our core business. It is particularly relevant to us, obviously, in a number of areas. It is not our core business so Education has a role, we have a role, our fiscal friends by the lake have a role et cetera.

Senator McLUCAS—Current dental training places: I would like to confirm this data. It has been said that the number of dental training places has increased from 221 in 1995 to 312 in 2005, to a planned 516 in 2010. Does that sound right to you?

Prof. Calder—We do not have that data that I am aware of. It sounds like DEST data to me.

Senator McLUCAS—Yes, it does, doesn't it? If you can confirm that or otherwise, that would be helpful.

Ms Halton—I have seen some data recently on this issue. I have to say that first per year quota does not sound right.

Senator McLUCAS—It is 221 in 1995.

Ms Halton—Yes. I do not think that is right, but we will see what we can find.

Senator McLUCAS—Thank you. What is the optimum number of dental practitioners that we should look for?

Ms Halton—The same problem.

Senator McLUCAS—I am not suggesting one for every 1,350—and taking, Professor, your comments about distribution—but we recognise nationally that we have an undersupply of dentists. We know nationally that there is some work to remedy that. What is the number we should be aiming for?

Prof. Calder—All of the same discussion applies. We are starting to gather information and data that will help us to understand where the workforce is and the characteristics of the workforce—the age profile et cetera—as I mentioned. We will obviously be looking at need and that will include all of the measures we have talked about in terms of access to medical services. It will be much the same.

Ms Halton—Again, it is the same issue. We are not going to ever have a gold standard, but I do think we can come up with broad orders of magnitude that, for example, say, 'You need to increase by 30 or 40 per cent,' recognising that again this is exactly like the doctor issue, because if you do not have dental hygienists, for example, you need more dentists. With respect to having a combined workforce that comprises dental hygienists and improved oral health, use of fluoride et cetera, I note that you were brought up in Queensland. Senator Mason is perhaps not similarly afflicted; I do not know. We do not need to know!

Senator McLUCAS—Yes, he is.

Senator Mason—I have got no fillings.

Senator McLUCAS—You did not grow up in Queensland.

Senator Mason—Yes.

Ms Halton—A mother who administered fluoride tablets, dare I ask?

Senator Mason—I spent my youth in Canberra.

Ms Halton—He is not a real Queenslander, Senator!

Senator McLUCAS—We are getting off track. It is getting late.

Ms Halton—Again, it is back to the point of the answer to the question, 'How many dentists do you need?' There is a bunch of subsidiary questions that go to the answer you get to. If you work on a basis that says, 'Look, particularly for communities where access is an issue, ability to pay is an issue, then in fact a mixed workforce, which is probably a fair input of dental hygiene, together with that speciality dental service, is probably the right model,' and again that is going to give you a different answer.

Mr Kalisch—And taking the secretary's response a little bit further, where you have good access to affordable dentistry or dental oral care then that is the objective you want to get. It is not so much a workforce number.

Senator McLUCAS—But that is part of it.

Ms Halton—Workforce number is part of it.

Senator McLUCAS—It has to be part of it. Senator Crossin is ready to go, I can tell, but I just want to go a bit further. There has been some concern expressed in some quarters that we will have an oversupply of dentists in five years time as all these dentists graduate. I can make no judgement about whether or not that is valid, but I am concerned that the department cannot make a judgement about whether that is valid or not either.

Ms Halton—My view on that, I have to say, is that, based on what we know about the supply of dentists at the moment, and access to dental services, I would be completely gobsmacked if we had an oversupply in that many years.

Senator McLUCAS—I will share that view. It is an uninformed view from my point of view but that is my gut feeling. I do not want to be making policy on gut feeling.

Ms Halton—No, exactly.

Senator McLUCAS—There has got to be a number that we should be aiming for and I am concerned that we do not know that number.

Ms Halton—What I am saying to you is based on what I have seen in relation to the distribution, issues around waiting lists and a whole series of other things and, based on what I have seen in terms of the numbers coming through, I do not believe that is going to lead us to an oversupply. There are a range of other relevant factors. For example, how do we get some of these people to make sure they do not practise in Mosman and—

Senator McLUCAS—But they can practise in Mossman, north of Cairns!

Ms Halton—That is precisely the point. They can have one Mossman, not the other. But we cannot compel them, and you understand full well the issues we have in relation to medical practitioners, using the stick part not the carrot part. Of course, with respect to dentistry, we have no say and hence the need to pick up the rural training issue that we talked about.

Senator McLUCAS—Overseas-trained dentists practising in Australia: how many do we have? Is it a number we know? Do we count them?

Mr Kalisch—Yes, I know I have seen a number.

Ms Halton—I have seen a number too, but can I remember where I saw it?

Mr Kalisch—I thought it was in the region of 100 or so.

Senator McLUCAS—If you could take that on notice, that would be good. Are overseas-trained dentists obliged to work in certain areas like we can do with overseas-trained doctors?

Ms Halton—At the moment the answer is 'no'; however, the answer to, 'Could they be made to?' I think is, 'Most likely.'

Senator McLUCAS—How would that happen?

Ms Halton—Condition of visa. If they come in as a spouse or something you would not be able to, so you cannot say that it applies 100 per cent.

Senator McLUCAS—No. I understand the government committed to a review of Australia's dental workforce on 20 March this year. What is the status of that review?

Ms Halton—From what would he have drawn that?

Senator McLUCAS—Minister Abbott committed to a review of Australia's dental workforce at the launch of the National Oral Health Alliance.

Ms Halton—He might have said, 'We'll look at the workforce issues.' I do not think he said a formal review.

Senator McLUCAS—And we have got information from the ADA. So it is not a formal review.

Ms Halton—No.

Mr Kalisch—They are certainly doing much further work in this area and being better informed.

Senator ADAMS—I would like to ask about the workforce issue around Medicare item number 16400. That commenced on 1 November last year, on antenatal care in rural and remote areas. It is to do with nurses, midwives and Aboriginal health workers. As far as the training goes, under this Medicare item it stipulates that a nurse must have appropriate training and skills to provide an antenatal service. Is there anyone here from Workforce Division who could give me a description of what that training involves or what they have to do to be able to practise under that?

Mr Dennis—The department has commissioned the Royal College of Nursing Australia to determine answers to the questions that you have posed and in so doing create a training package to ensure that all nurses who would provide such services are adequately trained. The training package and the needs analysis are due for completion on 31 October this year.

Senator ADAMS—The item number commenced last November and the package is not ready. How many occasions of service have been billed under this item number so far?

Prof. Calder—We would not have that data.

Senator ADAMS—Is there any way of supplying it?

Prof. Calder—That is another division of the department. We can probably do that.

Senator ADAMS—I did not ask it under Medicare because it was a Workforce issue. I was directed to this particular one. The other thing is that I have been lobbied. I am a midwife, and a number of rural nurses and the midwives association, the ANF—practically everyone that has anything to do with rural obstetrics—has been to see me about this. The midwives feel very strongly that there should be another number for them paid at a higher rate because at the moment they are working alongside an Aboriginal health worker or an enrolled nurse and they are all getting paid that same rate. They are highly qualified people, so I wondered where this is at with the department, because I am sure you have had the same correspondence that I have.

Prof. Calder—Senator, our role is around the training. We do not deal with the MBS item numbers, so that is not a matter we can respond on.

Senator ADAMS—Where can I get an answer to it? Who do I write to?

Ms Halton—It was under program 3, the MBS.

Senator ADAMS—I tried to ask it then and I was given guidance that I had to ask it here. I was ready and waiting.

Prof. Calder—Should we take it as a question on notice perhaps?

Ms Halton—We are happy to take it on notice. That is the best I can do for you.

Senator ADAMS—That is fine, but it really is a huge problem and I think we should be looking a lot closer at this. We do everything to get midwives out into rural and remote areas.

Ms Halton—Tell me exactly what the problem is.

Senator ADAMS—The problem is that this Medicare item number comes under a GP and it is paid to either a nurse, a midwife or an Aboriginal health worker. The midwives feel that they probably would be the better people to be training the Aboriginal health workers working alongside them, but if they are actually doing the antenatal visit or taking over the antenatal consultation, the midwife who is trained to be a midwife gets the same amount of money as an Aboriginal health worker or an enrolled nurse who is doing the same job. This is where they are feeling that it is a slight upon their profession.

Ms Halton—The only thing I would say about this is that this is how the schedule works. We pay for the task that is undertaken.

Senator ADAMS—I realise that.

Ms Halton—Some tasks require a high level of training and some do not. This particular task does not require that high level of training.

Senator ADAMS—Oh, look out!

Ms Halton—No, it is the particular task that is being paid for here, which can be undertaken by a registered nurse or an Aboriginal health worker. You could make exactly the same point about the bits of the schedule that can be accessed by both general practitioner and specialists, and the general practitioner and the specialist are paid the same amount for those tasks.

Prof. Horvath—To take that further, we would not have an item number for an Aboriginal health worker to do it if it were not appropriate in a clinical sense.

Ms Halton—That is right.

Senator ADAMS—Professor Horvath, I do not know about your background going back to when you were a med student or a registrar, but I am sure you did obstetrics at some stage.

Prof. Horvath—I did.

Senator ADAMS—I am an ex-midwife and I have done a lot of midwifery. To me, in this day and age, antenatal care is so important, especially because a lot of our mums are a lot older. We used to look at anyone over 35 as a quite elderly mum and quite a category of high

risk. Now, we are into that average age. I feel I should be supporting these midwives in this, and I am not happy that this is going the way it is. That is the reason I have asked the question tonight, so that they can see I am supporting them and I really would like someone to think a bit more about it.

Ms Halton—That I absolutely understand, but again this is a for and on behalf of item. It is an activity that is normally undertaken by a general practitioner. It is being undertaken for and on behalf of that general practitioner.

Senator ADAMS—I realise that.

Ms Halton—This is not a way to separately recognise the extra skill and ability of a midwife—which is undenied. We absolutely understand that, but the point here is: the particular task, which is a delegated task by a general practitioner, and what is required to do that. As Professor Horvath says, this item on the MBS can be undertaken by an Aboriginal health worker with appropriate training or a registered nurse or by someone with a higher skill level, but that higher skill level is not what is being reimbursed here. As I said, there are bits of the schedule pertaining to doctors, so this is not a discrimination against nurses or midwives. There are bits of the schedule that some specialists would access, but they are reimbursed at the same rate as general practitioners for that activity, because you do not have to be a specialist to do that piece of work.

Prof. Horvath—Correct, and it is a protocol driven, for-and-on-behalf-of item.

Senator ADAMS—I realise that, but I am thinking about the actual duty of care with it and it does worry me. I will rest my case.

[10.17 pm]

CHAIR—We come finally to outcome 7, Hearing services. We have officers at the table for questions in outcome 7.

Ms Morris—For the record, Senator McLucas asked me earlier about Medicare data—how we disaggregate it, when we release it and so on. I apologise for the fact that I could not give you a good answer at the time, but I have some information now. The department publishes bulk-billing and safety net statistics, by electorate, on an annual calendar-year basis. I think we had a bit of confusion when we were talking about it earlier. When we started publishing electorate based data it was on a financial-year basis, but, as we have discussed in previous estimates discussions, safety net statistics only make sense on a calendar-year basis. So I think there was a crossover period between the end of 2004-05 and the 2005 calendar year.

Ms Halton—Before the safety net?

Ms Morris—Yes. The bulk-billings stats for non-referred GP attendances show the total number bulk-billed and the percentage that were bulk-billed, by Commonwealth electoral division, based on claims processed by Medicare Australia, in the calendar years 2004, 2005 and 2006. These were the stats released in April 2007. The Medicate safety net statistics for the 2005 and 2006 calendar years of processing show the number of singles who had a claim processed for benefits under the safety nets, the number of people who are in a family unit where at least one member of the family had a claim processed under the safety nets, the number of singles who had a claim processed for benefits under the safety nets, the number of

families where at least one member had a claim processed under the safety nets, the number of singles and the number of members of families who had a claim processed under the safety nets and the total benefits under the safety nets based on claims processed. We gave you the URL reference for that earlier. We also publish, on an annual basis, annual financial-year statistics—they generally come out in late August. They show—by gender, age range and state or territory—Medicare services and benefits in total and per capita. Then we have our quarterly statistics, too.

Senator McLUCAS—When was the last year in which the annual financial total of Medicare services and benefits per capita was published?

Ms Morris—It would have come out in August last year for the 2005-06 financial year. I can get you a copy of that tomorrow, if that would help.

Senator McLUCAS—That would be fabulous.

Ms Morris—It is hard to think in the abstract about what it is and when it comes out. I can get you hard copies of what has been published in the last 12 months.

Senator McLUCAS—Were you intending to come here tomorrow?

Ms Morris—No, I was not.

Senator McLUCAS—If I need to follow up on that answer, I will ask.

Ms Morris—But I will get you the hard copies of what has been published.

Ms Halton—I will get you the hard copies. I do not know if it is necessary to have it tabled. But if there is something you want to know, if you talk to me tomorrow, then I am sure Ms Morris could be persuaded to visit again—at a pre-appointed time.

Ms Morris—Yes.

Senator McLUCAS—I know what the difference is. We do have Medicare services and benefits, by electorate, for 2004-05, but that is not now provided. Is that what you are telling me, Ms Morris?

Ms Morris—I think that is right.

Ms Halton—I think it was a one-off.

Ms Morris—Yes, I think it was. It predates my time in this area.

Senator McLUCAS—We are not looking at bulk-billing data; we are looking at total services. Admittedly, the bulk-billing data is on a calendar-year basis because of the safety net.

Ms Morris—That is right.

Senator McLUCAS—Is it possible to provide us with the total Medicare services and benefits, by electoral division, on a financial-year basis?

Ms Halton—This is where we go back to what the minister decided when he considered all of this stuff about what was released, in what order, when et cetera.

Senator McLUCAS—That is not my recollection. My recollection is that it was bulk-billing data, by electorate. Can you confirm with the minister that he will not release that data? Let us put it in that context.

Ms Halton—Yes. There was a very convoluted process around all of this.

Ms Morris—I will not read out the details because, as I said, we will get the hard copy to you. We publish quarterly Medicare statistics that have quite a lot of disaggregation in them. We also have the report on government services, which is published annually. It includes the percentage of GP attendances bulk-billed—by RRMA and by state or territory.

Senator McLUCAS—Okay.

Ms Morris—I previously spoke about the provision of something to the Parliamentary Library. What I said was incorrect and I want to correct it for the sake of the record.

Senator McLUCAS—So the document you have provided to me is what?

Ms Morris—I do not really know. It was not in my own papers, and I had a flurry of people providing things. I just wanted to make it clear what we do actually publish and what has been released. I will make sure that you get to see it.

Ms Halton—We will have a conversation with Minister Abbott. In fact, I will get them to dig out—so that I can have a look at it tomorrow morning—

Senator McLUCAS—There was a media release or a letter or a document that said, 'This is what we can provide'?

Ms Halton—That is precisely right. So we will just go back and get the history on all of that.

Senator McLUCAS—I will rephrase that. It did not say what you can provide—because we know that you can provide a lot—

Ms Halton—No. It is what is going to be provided on a regular basis.

Senator McLUCAS—but what the government is prepared to provide.

Ms Halton—Yes.

Senator McLUCAS—All right. Thank you, Ms Morris.

CHAIR—We have dealt with that. Do you have questions in outcome 7, Senator Crossin?

Senator CROSSIN—Thanks. Can I start by asking you to give me a total cost for your hearing services for this coming financial year? Is that the $306.2 million on page 115 of the PBS?

Ms Morris—Sorry, what was the figure, Senator?

Senator CROSSIN—I am looking at the $306.265 million on page 115. Is that your total allocation for hearing services?

Ms Morris—Yes, I think that is right.

Senator CROSSIN—How much of that is to go to Australian Hearing?

Ms Morris—In 2007-08 they will get $44.363 million.

Senator CROSSIN—Of that total allocation, what will go to departmental funds for administering the program?

Ms Morris—That is administered program funds. The departmental costings are separate.

Senator CROSSIN—How is that $306.2 million broken down?

Ms Morris—There is the money for Australian Hearing, which we just gave you. There is voucher expenditure, which will be $251.285 million. But there is new funding in there for the budget initiatives, which is $11.875 million, and there will be some additional CSO funding in that $11.875 million.

Senator CROSSIN—What is the total CSO funding?

Ms Morris—The total for the CSO will be $44.363 million plus, in 2007-08, $7.790 million. That $7.790 million consists of $1.1 million for the upgrade of FM systems in classrooms, $1.4 million for other devices and a rebasing of their funding of $5.290 million. We have had an increase of funding for the CSO from this budget.

Senator CROSSIN—Does Australian Hearing manage your vouchers and the CSO?

Ms Morris—It is the sole provider for the CSO but it is only one of around 200 providers for the vouchers. It competes for business for the vouchers but it is the sole provider of the community service obligation.

Senator CROSSIN—There is $70.7 million over four years in Budget Paper No. 2 on page 236. I can see the breakdown of that allocation. That is $0.2 million over four years to Medicare Australia.

Ms Morris—Yes, that is right.

Senator CROSSIN—There is only $0.1 million in the graph but it mentions $0.2 million underneath.

Ms Morris—It is $0.151 million, which rounds up to $0.2 million.

Senator CROSSIN—Can you provide me with a breakdown of the $70.7 million.

Ms Morris—Yes, I can. I will start off with rehabilitation. Over the four years, starting 2007-08, the first year will be $3.6 million.

Senator CROSSIN—If you just said rehabilitation is going to be—

Ms Morris—I would have to add it up then. It is about $27 million for rehabilitation over the four years. Someone will confirm these figures, and we will make sure they are right for the record. Prevention and research is about $9.6 million, community service obligation is about $30 million and the changing clinical pathway is about $2.5 million.

Senator CROSSIN—What is that program meant to achieve?

Ms Morris—The changing clinical pathway?

Senator CROSSIN—Yes.

Ms Morris—I would not call it a program. It is more a change in the way the existing program will work. We will be moving towards having more information presented to the GP on a client's hearing loss when the GP makes a call on whether the client should be given a

voucher for the program. Currently there is no requirement for someone to turn up with the audiologist's or audiometrist's report. With that, we will be working very closely with GP groups to provide them with a lot more information about hearing loss and what sorts of levels might warrant a hearing aid and what a hearing aid can do for someone, so there is better information all round and so that the patients themselves are not bouncing between a GP and a hearing testing service. It is to make it clearer and to give it a stronger and more informed clinical focus.

Senator CROSSIN—What was the amount of money Australian Hearing got this year?

Ms Morris—In 2005-06, $35.746 million.

Senator CROSSIN—That is still nearly a $9 million increase.

Ms Morris—Yes.

Senator CROSSIN—What has caused that increase?

Ms Morris—Discussions with Australian Hearing about their client base and their needs and a business case developed on the basis of that, plus the money for the additional FM upgrades and better devices. We talk to Australian Hearing regularly and we felt that a case needed to be made to basically re-base their funding, and it was acceptable.

Senator CROSSIN—I have been following this for a few years now. Today, as a matter of interest, I dragged out of 2004 the revision of the CSO—the funding—because back in those days their money only went up from $800,000 to $820,000. They only got an increase of $20,000 one year in the CSO, so this coming year they will get an increase of how much for their CSO?

Ms Morris—It looks like close to $7.7 million.

Senator CROSSIN—Increase this coming year?

Ms Morris—Yes.

Senator CROSSIN—Australian Hearing told me one year they had a $4 million profit which they then used to give back to the department.

Ms Morris—We are fairly confident they do not have a profit at present.

Senator CROSSIN—If they did have a profit though, would they still have to hand back some money to you, or have things changed now?

Ms Morris—I am not sure. If they make a profit it is on their voucher business, where they are competing with other private providers. They would not make a profit on the CSO; all that money would be expended.

Senator CROSSIN—Are they contracted to spend a certain percentage of the money they get from you in their AHSPIA program?

Ms Morris—My colleague, Ms Savage, can answer that.

Ms Savage—Are you referring to the AHSPIA, Senator Crossin?

Senator CROSSIN—Yes. What is it?

Ms Savage—It is the Australian Hearing Specialist Program for Indigenous Australians.

Senator CROSSIN—Yes, that is it: Australian Hearing Specialist Program for Indigenous Australians.

Ms Savage—Yes, AHSPIA.

Senator CROSSIN—Do you oblige them to spend a certain percentage of their CSO on that program?

Ms Savage—Certainly there is an allocation for AHSPIA each year within the overall community service obligation.

Senator CROSSIN—Can you tell me what that was for 2006 and what it will be for 2007?

Ms Savage—Certainly. In 2006-07 it is $2.034 million; and in 2007-08, $2.068 million.

Senator CROSSIN—Not much of an increase though.

Ms Savage—No, but in 2008-09 that would increase to $2.270 million, so it is more the substantial increase the following year.

Senator CROSSIN—If I wanted to know how much of that they spend on travel or training health workers, I would need to ask that of Australian Hearing?

Ms Morris—You would, Senator.

Senator CROSSIN—I knew you were going to say that.

Ms Morris—I am sorry!

Senator CROSSIN—The average cost in the CSO to Australian Hearing, has that increased?

Ms Savage—The average cost?

Senator CROSSIN—The CSO: is that calculated on an average cost per client?

Ms Morris—How much it cost to deliver the CSO?

Senator CROSSIN—Yes.

Ms Morris—I do not have a figure I can give you, but it would go up. Part of the reason they are getting additional funding is the cost of devices, increases over time.

Ms Savage—To further explain, Australian Hearing implemented a new activity based costing model in 2003-04 so consequently it is the total cost to deliver the service.

Senator CROSSIN—Is there an increased demand in either the vouchers or the CSO? Is the demand increasing or is it that, as the amount of money increases, you can access more clients?

Ms Savage—Costs have certainly increased.

Ms Morris—I am going to see if I can find some figures. I am checking for you, Senator. Demand has been increasing, mainly in the complex adult category. They have been given extra money basically to help them meet demand.

Senator CROSSIN—Do you know how many clients will benefit from this increase? Take the CSO first.

Ms Morris—We are estimating 45,000 clients under the CSO next year, as opposed to this year where the number of clients is—

Senator CROSSIN—Thirty thousand?

Ms Morris—Somewhere in the 30s, yes, to 31 March; and maybe 36,000 by the end of the year. Yes, we are hoping that the new money will—

Senator CROSSIN—About a 9,000 increase in clients will be picked up by the $30 million then.

Ms Morris—Yes.

Senator CROSSIN—What about how many clients are expected to benefit from the increase in the rehabilitation services?

Ms Morris—Three hundred thousand extra over four years will benefit from the rehab.

Senator CROSSIN—Clients?

Ms Morris—Yes. The rehab item will apply to new clients so they will come back for a consultation.

Senator CROSSIN—Who will provide the rehabilitation services?

Ms Morris—The provider from whom they got the device in the first place.

Senator CROSSIN—That might vary right across the country, whoever has got—

Ms Morris—Yes.

Senator CROSSIN—The upgrade of the technology FM systems: how many schools? Do you do it by school or by classroom? How is that allocated?

Ms Morris—By cost per individual child.

Senator CROSSIN—What does that mean? If you have one child in a classroom, then you move in and put the system in that particular classroom?

Ms Morris—I think so. We pay for the device. We do not pay for the system. We pay for the device for the child so we are upgrading the device the child would be wearing to take advantage of the system in the classroom.

Senator CROSSIN—This is individual devices as opposed to the system that goes in a classroom so everyone can benefit.

Ms Savage—That is right.

Ms Morris—Yes.

Senator CROSSIN—Is there any provision in the budget to roll out better sound systems in your classrooms?

Ms Morris—No, there is not.

Senator CROSSIN—How many children do you think will benefit from that, out of the money?

Ms Morris—Sorry, Senator, if I could perhaps take that one on notice.

Senator CROSSIN—Okay. You have already explained to me about improving the availability for the general practitioners, but I wonder if you would be able to explain about the hearing research and the prevention activities. What is planned for the use of that money?

Ms Morris—This is new funding, to be administered by the department. It will be funding specifically for research that will focus on informing prevention activities in the future, including intervention strategies for the young, the Aboriginal and Torres Strait Islander population and those in the workplace. Prevention is the focus.

Senator CROSSIN—I understand. It will be delivered by the department or just administered by it?

Ms Morris—It will be administered by the department.

Senator CROSSIN—In terms of prevention in the workplace, you would give that to, say, state and territory work health authorities?

Ms Morris—We have not yet established the process by which the money will be given out, but presumably there would be some sort of funding round for research, either open or selective.

Senator CROSSIN—Is the definition of a voucher eligible client still the same under the Hearing Services Administration Act? Has it changed?

Ms Morris—It has not changed.

Senator CROSSIN—So what I have in front of me in terms of who is eligible to get a voucher has been the same for years and years?

Ms Morris—Yes, eligibility remains the same.

Senator CROSSIN—Okay, that has not changed.

Ms Morris—For a voucher, no.

Senator CROSSIN—It will not come as a surprise to you that I ask this question: do you have a breakdown of the number of children and adults who receive hearing services under your program, and do you have that broken down by Indigenous and non-Indigenous population?

Ms Savage—We certainly have a breakdown of children and we certainly have Indigenous clients who have accessed services. Would you like the Indigenous?

Senator CROSSIN—Yes. Would this be under the CSO or is this the voucher system?

Ms Savage—CSO first, and, if I can work through my folder, I can find you voucher as well. For Indigenous CSO clients, would you like year to date, as in this financial year, 1 July to 31 March?

Senator CROSSIN—Yes, that would be good.

Ms Savage—Under CSO, a total of 4,357. That is made up of 2,649 children; adult CSO, 120; and those eligible under the 2005 budget measure—those that are 50 years and older and those on CDEP—1,588. In the 2006-07 year to date, 173 clients identifying as Indigenous Australians have accessed voucher services during the period 1 July to 31 March. A point to note is that individuals accessing voucher services are not required to identify themselves as

being Aboriginal or Torres Strait Islander, so the data numbers may well be an underestimation.

Senator CROSSIN—Okay. Of that 1,588, do you have a breakdown of those over 50 and those on CDEP?

Ms Savage—Of the 1,588 for year to date, this financial year, adults 50 years and over is 1,131 and CDEP is 457.

Senator CROSSIN—The latest figures I brought with me are from 2003, and there is certainly a marked difference in the CSO. You probably do not have the figures with you, but the figure I had back then was only 1,328, and you have just told me 4,357, so that is a huge difference in four years. The voucher numbers are 65 back in 2003 and only 173 now. I know part of that problem will be that we do not have to identify as Indigenous, but it is a number that I thought might have increased more than that over this period of time. Is there a problem with getting access to Indigenous people or getting knowledge out about the voucher system?

Ms Savage—The voucher system is a much harder route, perhaps, for Aboriginal and Torres Strait Islander people, but certainly people are accessing it. As you say, the utilisation or access to it may not be growing at a rate that one might expect, but it could possibly be that they are also being picked up through the community service obligations.

Ms Morris—My understanding, Senator, is that take-up has improved over about the last 12 months for Indigenous people under the program, and an effort is being made to promote the availability of services to those populations.

Senator CROSSIN—Okay. We had this area identified and we had a bit of a win, I thought, between us, where people on CDEP had the CSO extended to them, but CDEP does not exist on 1 July in urban areas. Will that mean that if people are moved onto Newstart or to the STEP program they would still be eligible to access services, or have we just moved from one barrier to another?

Ms Savage—We are in close negotiation and discussion with our colleagues in DEWR and are looking to working on a solution to the issue of CDEP participants who may be affected by the changes come 1 July.

Senator CROSSIN—Are you telling me that they will not be automatically eligible? They will not be eligible, will they?

Ms Savage—Technically, around the changes, no, but we are working on a solution to ensure that there is some coverage. We are working quickly and hard to put in place a workable solution.

Senator CROSSIN—Let us just go through this, then. If these people move onto Newstart, they will be eligible, because that is a Centrelink payment. Is that right?

Ms Savage—No. The current eligibility is that they are on CDEP, so, with the changes, if they are no longer on CDEP they would technically not be eligible, although that would not extend to those who have already accessed the CSO hearing services who have been on CDEP. What we are doing at the moment is trying to put in place a solution to extend services to those who may otherwise be affected by the changes come 1 July.

Senator CROSSIN—People who have a healthcare card are eligible? No?

Ms Morris—No.

Ms Savage—Not under the CSO.

Senator CROSSIN—If they are on the STEP program they are not eligible?

Ms Savage—No, Senator.

Senator CROSSIN—That is pretty distressing. What sorts of solutions are you looking at, then?

Ms Morris—We are still negotiating with the department.

Senator CROSSIN—Around what? To pick up another area of eligibility so that, if you were on CDEP prior to 1 July but you are not now, someone will keep a record of that somewhere? How is this going to work?

Ms Morris—We are currently looking at what would be the options, but we do not have the policy authority to implement them. I think until we do I cannot—

Senator CROSSIN—What is the barrier? No agreement from the minister?

Ms Morris—We need to explore what the numbers are, who is affected and what possible options there are and talk to ministers about it.

Senator CROSSIN—You do not know how many people would be affected?

Ms Morris—No, we do not know the exact number; I am sorry.

Senator CROSSIN—So there are these 457 CDEP people, and how many last year would there have been? The program is only two years old, I think, isn't it?

Ms Morris—It is fairly new.

Senator CROSSIN—Was it in December 2005 that it started?

Ms Savage—On 1 December 2005, yes; 552 people.

Senator CROSSIN—Last year?

Ms Savage—Since 1 December 2005.

Senator CROSSIN—That includes that 457, does it?

Ms Savage—The 552? Yes, it does.

Senator CROSSIN—Five hundred and fifty-two since December and that includes that 457?

Ms Savage—Yes, that is right.

Senator CROSSIN—And we do not know how many of those 552 live in urban areas?

Ms Savage—No, Senator.

Senator CROSSIN—Is there any way you can find that out?

Ms Savage—These are discussions we are in at the moment with—

Senator CROSSIN—You must have an address somewhere for these people.

Ms Morris—We recognise it is a problem, Senator, and we are trying to find a solution for it, but I cannot tell you today what the solution might be. So, yes, we are aware that it is an issue and we are trying to get to a better place on it.

Senator CROSSIN—It would be interesting to know how many of those 552 were in urban areas.

Ms Morris—We are trying to find that out too.

Senator CROSSIN—I suspect a number of them are.

Ms Savage—In relation to those on CDEP who have accessed CSO, we do know that the majority were in rural and remote communities.

Senator CROSSIN—Ms Halton, did you hear that?

Ms Halton—I am sorry; I was talking about midwives.

Senator CROSSIN—We won the battle over getting people on CDEP extended access to hearing services in December 2005. Now somebody's government, not necessarily mine, is taking CDEP away from people in urban areas on 1 July. So we have taken 10 steps forward and 30 back and in relation to Indigenous people. Why am I surprised? How fast can this be resolved?

Ms Halton—I am very aware of this issue. Representations have been made. I think that would be the right way to describe it.

Ms Morris—Yes. We are in negotiations.

Ms Halton—It has been raised. I cannot promise you I can fix this one quickly, but I am absolutely aware of it.

Senator CROSSIN—We always seem to discover these problems very late at night when it comes to Indigenous people. It is very unfortunate. The problem after 1 July, which you may or may not know—we have been talking to DEWR—is that they are going to be scattered like marbles in all different directions—in different organisations, on Newstart, on STEP—so they will be hard to track.

Ms Halton—I know.

Senator CROSSIN—Is it a flow-on from the policy that no-one in government thought about until suddenly someone said, 'Hang on! What about people on CDEP who can get access to hearing services?'

Ms Halton—No, do not worry. It was raised.

Senator CROSSIN—Not soon enough, I suspect. All right, I will put lots of questions on notice in the next three weeks about it, unless I hear a public announcement from the minister's office that he has solved it.

CHAIR—Thank you very much, Senator Crossin. Thank you, Minister. Thank you, Ms Halton. Thank you, officers, and thank you, senators. The committee is suspended until 9 am tomorrow morning, at which point we will commence on outcome 4, Aged care and population ageing.

Committee adjourned at 11.00 pm