
COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

# SENATE

## STANDING COMMITTEE ON COMMUNITY AFFAIRS

## ESTIMATES

**(Budget Estimates)**

THURSDAY, 31 MAY 2007

CANBERRA

BY AUTHORITY OF THE SENATE

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**SENATE STANDING COMMITTEE ON**

**COMMUNITY AFFAIRS**

**Thursday, 31 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, Boyce, Carol Brown, Crossin, Eggleston, Humphries, Joyce, McLucas, Moore, Patterson, Polley, Siewert and Webber

**Committee met at 9.03 am**

## HEALTH AND AGEING PORTFOLIO

Consideration resumed from 30 May 2007

**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 ands 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)**—I declare open this public hearing of the Senate Standing Committee on Community Affairs considering the budget estimates. As everyone will know,

we have completed approximately half of the outcomes in the Health and Ageing portfolio and we continue with the other half today. I welcome back Senator Brett Mason, the Parliamentary Secretary to the Minister for Health and Ageing, and Ms Halton and officers of the Department of Health and Ageing. Before we proceed with outcome 4, are there any questions or issues that were raised yesterday on which there is any reporting back or answers to be provided at this point?

**Ms Halton**—Not at this point.

[9.04 am]

**CHAIR**—In that case, we will plunge straight into outcome 4. The intention of course is to deal with the remaining outcomes in the order in which they appear and in approximately the times that they are allocated, but we will see how we go. We are looking at outcome 4, aged care and population ageing. Senator McLucas.

**Senator McLUCAS**—I want to go first of all to any unspent funds against the 2006-07 budget in outcome 4, please.

**Mr Stuart**—Are you asking about administered funds?

**Senator McLUCAS**—Yes.

**Mr Broadhead**—Overall, the difference between the figures you would last have seen, which would have been after portfolio additional estimates, and the figures in the estimated actual for 2006-07 is about $1.6 million lower in total. This results from a series of adjustments—in particular, an increase of about $8.4 million in the special appropriation for subsidies and a number of smaller adjustments for changes in particular subprograms, for example.

**Senator McLUCAS**—Could you go through those? First of all, the increase in $8.4 million on subsidies—that is from additional estimates to now. Am I right there?

**Mr Broadhead**—Correct. It is $8.422 million and it is residential care subsidies. As we have discussed in the past, I think, we review how the estimates are travelling three times during the year and adjust them for changes that are apparent through the year. This is an example of that. There have been some slight changes in occupancy in the numbers of people by RCS category as residents and also one or two accounting changes in terms of accrual effects, resulting in the $8.422 million adjustment to care subsidies. So it has increased from 4.776 to 4.774.

**Senator McLUCAS**—Could you say those figures again, please?

**Mr Broadhead**—It was 4,776,454, I believe, and it has been revised to 4,774,876.

**Senator McLUCAS**—So it is a reduction in subsidy payments?

**Mr Broadhead**—No, it is an increase from 4.776 to 4.774.

**Mr Stuart**—It is 4.766.

**Mr Broadhead**—Sorry, 4.766; forgive me.

**Mr Stuart**—Let's do that again.

**Senator McLUCAS**—That would be good, because I could not see the increase.

**Mr Stuart**—An increase at additional estimates from—

**Mr Broadhead**—The figure at additional estimates—I am sorry, I misread it—is 4.766. It has been revised to 4.774.

**Mr Stuart**—And they are billions of dollars.

**Senator McLUCAS**—So there is an increase in subsidies of $8.422 million?

**Mr Broadhead**—Yes.

**Senator McLUCAS**—And a reduction in?

**Mr Broadhead**—For example, under program 4.2, aged-care workforce, there has been a revision of $2.4 million. This reflects the fact that a number of people accessing scholarships as part of that program have deferred studies or are studying part-time, so the money will be spent over a longer period.

**Senator McLUCAS**—And $2.4 million is out of a total allocation in this current year of how much?

**Mr Broadhead**—At additional estimates the figure was $8.2 million.

**Senator McLUCAS**—So that is a reduction of $2.4 million. Please keep going.

**Mr Broadhead**—The National Eye Health Initiative—there has been a variation there which relates to rephasing optical health support funds. This reflects the fact that the early activity was largely around research and development to then inform the subsequent activities. Because the research and development has taken a little longer than originally anticipated, some of the activities that were to be built upon that have been shifted back slightly and will now occur at a later period, so there is some rephasing there.

**Senator McLUCAS**—So the total 2006-07 figure was what?

**Mr Broadhead**—I think originally the measure was $1.680 million after PAES and it is now $0.862 million.

**Senator McLUCAS**—So that is workforce and the national eye health program. What else?

**Mr Broadhead**—Multipurpose services. Again, new services and places did not come online as quickly as anticipated in the predicted growth of the program, so there has been a variation there from $72.6 million to $69.5 million.

**Senator McLUCAS**—Which ones did not come online? Do you have that detail?

**Mr Broadhead**—I do not have those details.

**Senator McLUCAS**—Someone else will be able to tell me that later?

**Mr Broadhead**—Yes. The Aged Care Innovative Pool—there has been a variation there. This reflects the fact that the innovative pool is not a steady program. It is used for a range of initiatives. There are a number of pilots which have come to a close in the period. There have been changes in levels of occupancy and lengths of stay and so on, so the revision of that is from $10 million to $8 million, essentially.

**Senator McLUCAS**—We will talk more about that later. So $10 million to $8 million—so there is a saving of $2 million there.

**Mr Broadhead**—Yes.

**Senator McLUCAS**—Can you break that down for me? There are subsidies and there are—what other funds are in that?

**Mr Broadhead**—It is largely subsidies for flexible places. So it is essentially subsidies.

**Senator McLUCAS**—I thought there was other money in there, as well as subsidies.

**Mr Broadhead**—I do not think so, but I will come back to you on that, if I may.

**Senator McLUCAS**—If you could just separate out the $10 million—my recollection was that there was a subsidy component but then there was, for want of a better word, an operational component.

**Mr Broadhead**—I do not think so. I think it is largely subsidies paid out as flexible care subsidies, under the innovative pool. I think that is what that figure refers to. But I will check to be sure.

**Mr Stuart**—There are a number of flexible care subsidies under the appropriation.

**Mr Broadhead**—Yes. I do not think there is any other component there in those figures. Transition care—there has actually been a faster than expected uptake there. In fact, we had at additional estimates expected to spend $25.3 million, but we now expect to spend $31.8 million. There is an estimate variation in relation to the EACH Dementia packages, which has gone from $35.8 million down to $27.6 million.

**Senator McLUCAS**—What is the reason for that?

**Mr Broadhead**—I think we were too optimistic in putting the original estimate about how fast they would be taken up, so the original estimate was a half-year figure. Because they are only announced in December, they do not actually all hit their straps on 1 January, so it has been revised to a four-month figure to be more realistic about the time it takes for them to actually come online.

**Senator McLUCAS**—I find that interesting. I remember some years ago talking about the time it took for beds to come online and asking the then assistant secretary when CACP came online; his answer was ‘the next day’. That seems to have changed.

**Mr Broadhead**—I think it varies according to the packages. I think, in the case of the EACH Dementia packages, they take a little longer because they are not so well established. There are fewer of them, and the kinds of people who can be looked after at home who have high-care needs are not necessarily right there, right then at the beginning. Certainly our experience with EACH generally has been that uptake can take some time.

**Senator McLUCAS**—I will talk about this later.

**Mr Broadhead**—The CACP can—

**Mr Stuart**—Perhaps I can take that slightly further. The funding becomes available to the provider immediately, as soon as they are able to start assisting clients. But our experience with CACP is that it takes about nine months for newly allocated CACP allocations to become

fully operational. Some will start very soon, but they will not all be filled for up to about a nine-month period.

**Senator McLUCAS**—When you say CACP, you mean all of the Community Aged Care Packages?

**Mr Stuart**—Yes, that is right.

**Senator McLUCAS**—CACP and EACHD?

**Mr Stuart**—That is right.

**Senator McLUCAS**—You have answered a question on notice about vacancy rates and CACP, which seems to suggest a trend upwards in vacancy rates. Is that because of the point you just made, Mr Broadhead, about EACHD being harder to fill because of the nature of the client?

**Mr Broadhead**—Slower to fill rather than harder, but yes. Yes, our experience is that, if you look only at recently allocated places, occupancy levels can be quite low. If you look at places that have been out there for some time, occupancy levels are very high. If you divide out those that have been recently allocated and look at those that have been there for a year or more, the occupancy rates in general are above 95 per cent. But it takes time to actually fill the new places.

**Senator McLUCAS**—For the newly allocated ones to be filled.

**Mr Broadhead**—Yes. So often what you see, when you look at occupancy levels by region, for example, is that low occupancy tends to reflect the fact that there have been new places allocated recently.

**Senator McLUCAS**—Let us continue.

**Mr Stuart**—That is the last of the ups and downs on that.

**Senator McLUCAS**—If you take away and add up, you end up with an underspend of $1.6 million in this current year. Is that right?

**Mr Broadhead**—It is a mixture of specials or standing appropriations and annual appropriations. I do not think you can call a variation in a special appropriation an underspend; it is driven by whatever drives the special appropriation. So I would hesitate to call it an underspend, but you do end up with a difference of about $1.6 million in the estimated outcome.

**Ms Halton**—We should be clear about this. In a standing appropriation it is actually not technically an underspend.

**Senator McLUCAS**—I understand that. This is an estimate of what would be spent given the take-up of the various programs that are offered.

**Ms Halton**—Exactly. It means that the original estimate was out to that extent, but it is not under the standing appropriation an underspend.

**Senator McLUCAS**—Are you in trouble for that, Mr Broadhead?

**Ms Halton**—Not especially.

**Mr Broadhead**—Not at all as far as I am aware!

**Senator McLUCAS**—What percentage is that of the total? Let us not go there!

**Mr Broadhead**—Very small is the answer.

**Ms Halton**—When it comes to our error rate, that is not a big problem.

**Mr Broadhead**—I understand that we try to get within half of a per cent, and this is well within that tolerance.

**Ms Halton**—That is right.

**Senator McLUCAS**—Going to the budget, I have to say that working out Securing the Future has been difficult for me, as it has for the aged-care sector; however, let us start pressing through it. In the February package Securing the Future, the two supplements used primarily by the industry for care purposes have been moved essentially from the care income stream to the capital stream. Is that agreed as a starting point?

**Mr Broadhead**—No. I do not believe that, if one goes back into the history of these payments, they were care payments as such.

**Senator McLUCAS**—Let us go through them then.

**Mr Broadhead**—However, I would also make the point that, in allocating subsidies, how they are used by the homes that receive them is a matter for the providers. We do not require that subsidies or supplements that are paid in respect of accommodation, for example, only be used in respect of accommodation. There are no red or blue dollars, essentially. We put them out under various headings, and we structure them in relation to what the government is trying to achieve in relation to those types of funding, if you like. But, in the end, how a home chooses to apply the money is up to the home. It is not tied to a particular use.

**Senator McLUCAS**—So you do not track how the pensioner supplement is used?

**Mr Broadhead**—No, we do not. We pay it under a particular heading, as it were. If you go back, you will find that it is and has been an accommodation payment, but it is not required that it only be spent on accommodation. We do not track through the dollars, as it were, to the end point.

**Senator McLUCAS**—The former minister talked a lot about the high level of consultation with the sector. Did you talk to the sector about where that money was being used in a real sense in aged-care facilities in Australia?

**Mr Broadhead**—I think our experience has been that it is used in a variety of ways in different homes.

**Senator McLUCAS**—That is a very good answer, Mr Broadhead—

**Mr Broadhead**—Certainly I would imagine and I believe some homes—

**Senator McLUCAS**—but it is not the right answer.

**Mr Broadhead**—I am sorry?

**Senator McLUCAS**—That is a very good answer, but it is not the right answer. ‘A variety of ways in a variety of homes’—come on.

**Mr Broadhead**—I believe that is true. Different homes account for their revenue in different ways, as I understand it.

**Senator McLUCAS**—And the majority of homes would use the pensioner supplement—let us start with that one—for what types of services? How does it sit on their books?

**Mr Broadhead**—I cannot speak on that. We do not track the dollars to the uses to which the home puts those dollars.

**Senator McLUCAS**—I thought the department would know what these two supplements had been used for before they removed them.

**Mr Broadhead**—They have not been removed as such, in the sense that they have disappeared. There has been a restructuring of subsidies and supplements. The outcome of that is that the pensioner supplement will not be paid as a pensioner supplement in the future, but there has been no withdrawal of the total funding. There has been an increase in the total funding that is provided.

**Senator McLUCAS**—That is a moot point for some facilities.

**Mr Broadhead**—I believe there will be an extra, over the next four years, in excess of $800 million spent by the government on accommodation supplements. That is real additional money, so the money has not been withdrawn; it has been differently allocated. Additional money is being allocated as well.

**Senator McLUCAS**—The higher basic daily care fee—where was that usually applied in aged-care facilities?

**Mr Broadhead**—Again that is not a question I can give a definitive answer to. It is a matter for the homes to determine how they apply their revenue to the business of providing care and accommodation for residents.

**Senator McLUCAS**—Does the department have an understanding of where that money is currently being used in aged-care facilities?

**Mr Stuart**—I do not think we have a kind of model in our minds of aged-care homes that get paid through a single payment arrangement—made up of a mix of different payments, certainly, but ultimately a single payment arrangement—into a single bank account. I do not think we have an understanding that aged-care homes then split that funding up into different pools and hypothecate it for different purposes.

**Senator McLUCAS**—Is that why you end up with unintended consequences?

**Mr Stuart**—No, I do not think so. That is certainly not an explanation. There is an amount of funding paid monthly to each aged-care home in respect of the residents that occupy beds, and that is calculated up in a certain way. But the money then arrives with the aged-care provider and they are at liberty to spend it on property, if they need to, or on care, if they need to, as they need to do.

**Senator McLUCAS**—Then why did we need the transitional accommodation subsidy?

**Mr Broadhead**—That relates to the government's view that, because the maximum accommodation supplement that has been introduced as part of the package is being phased up, there should be a payment in the interim while that new supplement phases up in low care.

There is also a top-up of accommodation charges in high care that was part of the original package. But these are transitional arrangements because the payments under the package are being phased in. So, while the changes are being phased in, there are some transitional payments also being paid during that initial four-year period—for residents who enter during that initial period, I should say, because they will be paid in respect of residents beyond the four-year period.

**Senator McLUCAS**—So those residents who are currently in aged care will be funded according to the current regime.

**Mr Broadhead**—Yes.

**Senator McLUCAS**—And, as those people depart aged-care facilities and new residents come in, they will take up the TAS.

**Mr Broadhead**—Take up which, sorry,?

**Senator McLUCAS**—The transitional accommodation subsidy.

**Mr Broadhead**—A new acronym. We have not used that one yet.

**Senator McLUCAS**—The sector is using it. When people started talking to me about the TAS, I had to go back and find out what it meant. But that is what they are saying now.

**Mr Broadhead**—I thought it was an island south of here! Yes, the new arrangements begin to come into effect from 20 March. In respect of accommodation payments, they are set at the time of the person's entry into care. So what a person receives under the new arrangements will depend on when they enter care, and that will be different during the phase-in period according to the arrangements that apply. But from 20 March next year inclusive going forward, new residents will be under the new arrangements, and those of them who would receive less than the pensioner supplement in low care will receive the transition supplement to ensure that they receive the equivalent of the pensioner supplement.

**Senator McLUCAS**—You would be aware that Aged and Community Services Australia called it 'a welcome short-term boost for aged-care services'. Is the government planning any other changes to ensure long-term sustainability of the sector?

**Mr Broadhead**—I can only comment on what the government has decided.

**Senator McLUCAS**—You would have done a considerable amount of modelling, I imagine, prior to announcing the securing the future package.

**Mr Broadhead**—Yes.

**Senator McLUCAS**—Did that modelling show that facilities, particularly smaller facilities, with a larger proportion of low-care residents would be worse off under Securing the Future?

**Mr Broadhead**—The modelling that we have done does not suggest that there is an issue in relation to size of facility.

**Senator McLUCAS**—But you would have taken, for example, a 40-bed—old language—hostel type facility and modelled that, I would hope.

**Mr Broadhead**—We have done modelling across the board. We do not have definitive information in the department about the asset levels of new residents. So we model from two sources. We model using external data from a sample survey around the income and assets of older people and use that to look at what might happen in terms of new entrants, and we also use what data we have in relation to accommodation bonds in low care to give us an estimate of the likely assets that people will have. But we do not have a long time series of the latter, and it is not a perfect measure of people's assets because different homes have different policies in relation to the size of the bonds that they charge.

**Senator McLUCAS**—That is right.

**Mr Broadhead**—But, yes, we did do modelling with the data that we had and, as I say, we did not find a correlation with the size of the facility. We did in discussions with the industry identify that it was at least theoretically possible that a home could have a mix of new residents in a particular asset range, which led to the introduction of the transition supplement, because they might not be gaining so much at one end and they might not be doing so well at the other end, and so there was an issue in the middle, if I can try and state it simply.

**Mr Stuart**—The issue that emerged after the announcement of the package was not one that we were well able to model. It was essentially a group of aged-care providers in particular circumstances coming back to the department and saying, 'Hang on a sec. You may well have assumed that most aged-care low-care homes have a distribution of different kinds of residents, but in some homes in some very particular places we just happen to have a very high clustering of residents who have assets sufficient to pay bonds but only low bonds.'

**Senator McLUCAS**—Where were those facilities?

**Mr Stuart**—That would really require that those homes are in areas where there are a very high proportion of homeowners and very few pensioners, but the homes that are owned are of comparatively low value. I have to say that in our modelling we do not have the data that would have allowed us to investigate that in any depth, but also we were not subsequently able to exclude that possibility, when we went back to look at our data. So we had a range of conversations with providers where they took us through their data at some level of depth, and the government then acknowledged that there was an issue and has chosen to provide an additional $92.2 million to cover off that possibility.

**Senator McLUCAS**—I have to say, Mr Stuart, that there are only 3,000 aged-care facilities in Australia. We are not talking about an enormous number. It is not the health system, for example. I am surprised that the modelling did not show what I think I knew—that is, facilities in poorer parts of the nation, exactly as you have just described, would have been worse off. I am surprised that that was not revealed in the modelling that was done prior to announcing Securing the Future.

**Mr Stuart**—The explanation for that is that in poorer areas, by and large, there are considerable numbers of pensioners, and in this package there is a benefit to aged-care homes that are able to achieve more than 40 per cent of assisted residents, which pays a higher subsidy level. So in the very particular circumstance, if you are in a place where there are substantial numbers of low-income people and they are pensioners, then under this package that home should actually go forward and not backward. It is the preponderance of non-

pensioner—well, not necessarily non-pensioner, but middle-asset individuals that was the issue that we were not able to predict.

**Senator McLUCAS**—I know exactly where you are talking about. I know that and I am surprised that the department could not have worked that out in spending $1.3 million, I think it was, developing up the government's long-term response to Hogan. I am surprised that that did not become evident. Are we ever going to see the document which is called the government's long-term response to Hogan?

**Mr Broadhead**—I expect that there will be a document which sets out or summarises the final response available shortly.

**Mr Stuart**—The package which was announced is the government's final response to the Hogan recommendations.

**Senator McLUCAS**—According to the Prime Minister.

**Mr Stuart**—In the announcement of the package, the various responses to the various Hogan recommendations were made reasonably clear and the package responds in some way to all or almost all of the Hogan recommendations. What the department has done is to produce a reconciliation of action over the last four years against all the various Hogan recommendations, and we are close to finalising that and that should be available soon.

**Senator McLUCAS**—So we are going to see a document.

**Mr Stuart**—There will be a sort of summary document accounting for the government's actions against each of the Hogan recommendations, yes.

**Senator McLUCAS**—But the document that was developed in 2005: I understand there was a committee—I forget who chaired it—and they did come up with a report. The document that are you talking about is not that report, is it?

**Mr Broadhead**—I am not aware of the report you are talking about. You will recall in 2004 there was a table, essentially, which showed for the recommendations the government's response. What we are proposing is a similar document which would then show, again in column format, the recommendations and the responses in the two parts of the response, if you like—the initial response in 2004 and the final response in 2007. So it will summarise, against the recommendations in the report, the government's response.

**Senator McLUCAS**—When will that be available?

**Mr Broadhead**—I would expect within days.

**Senator McLUCAS**—Within days?

**Mr Broadhead**—Yes. We are working on it. We want to be sure it is right in summarising the—

**Senator McLUCAS**—When I asked a former minister when we would see the long-term response to Hogan, the answer from him was often 'soon'.

**Mr Broadhead**—I think that was prior to the announcement of the package. Can I distinguish between a document which attempts to summarise the response and the actual response itself. As you said—

**Senator McLUCAS**—Yes, I am making that distinction as well.

**Mr Broadhead**—The measures announced in the Securing the Future package are the final response, in the government's view, to the recommendations that Professor Hogan made. So we have the final response; we are working on a document which sets that out in summary form.

**Senator McLUCAS**—In table form?

**Mr Broadhead**—Yes.

**Senator McLUCAS**—So we will not ever see the document that the former minister used to say we would see soon.

**Mr Broadhead**—I am not aware of another document coming out.

**Senator McLUCAS**—No is the answer. Is that right?

**Mr Broadhead**—I am not aware of another document coming out.

**Mr Stuart**—Actually, I am uncertain whether the minister at the time meant the response in terms of policy or the response in terms of a document. We suspect he may have meant policy. Certainly the government's final response has been its policy.

**Senator McLUCAS**—That is not what I thought he meant, but we will probably never know.

**Ms Halton**—No, I am not intending to ask him.

**Senator McLUCAS**—We cannot ask him the question anymore. The budget announced additional funding of $6.7 million over five years to strengthen the quality assurance framework for companies that receive government payment and for checks for key personnel who own or run them. Can you tell me why it was necessary to undertake that measure?

**Mr Stuart**—Yes. The Aged Care Act as it has been framed was framed about a decade ago when most aged-care providers were sort of sole-operator businesses in which the approved provider was the business and in which the approved provider held sometimes one and sometimes a number of aged-care homes. More recently it has become more common for very significant enterprises to invest in aged care. Quite often under those structures the approved provider entity is at the aged-care home level and there is an overarching business structure which owns a number of approved providers. It has become more common for the business entities to change hands, either in part or in whole, and therefore for the approved providers that sit under them to come under the influence of new investors. The act at the moment gives the department no sway over those ownership structures. So I think what we have been experiencing is very significant transfers of aged-care assets which escape the department's capacity to scrutinise the transfer of aged-care places or the senior personnel who direct the overall affairs of those approved providers. We think that it is time to amend the legislation to come more in line with contemporary business realities.

**Senator McLUCAS**—How will that $6.7 million be used?

**Mr Stuart**—A substantial part of the funding which has been provided is for the department to be able to better scrutinise and follow up on changes of key personnel in aged-care entities.

**Senator McLUCAS**—How will that happen?

**Mr Stuart**—We will have a group of staff in central and state offices who will take an interest in changes in key personnel and regularly follow up on changes in key personnel in aged-care homes. At the moment we wait to be advised by aged-care homes and we think we should be more proactive.

**Senator McLUCAS**—Without identifying particular events, can you give me a flavour of what type of event would have necessitated this change?

**Mr Stuart**—The former I think I have already outlined. There are quite significant changes in investment and business structures in a section of the residential aged-care industry, in particular with the entry of significant capital investors into aged care and much more complex business structures. On the issue in relation to key personnel, I think we have been learning over the past few years the importance of key personnel to the effective operation of aged-care homes and find very often that significant reductions in quality have been accompanied by changes in key personnel, sometimes of which we are aware and sometimes of which we are not aware.

**Senator McLUCAS**—Someone designated as the person who is the key personnel under the act but not actually doing the job.

**Mr Stuart**—When key management or clinical staff leave a home, where we have discovered significant reductions in quality it is often accompanying such a significant change in staff.

**Senator McLUCAS**—What are the forward estimates for that expenditure of $6.7 million over four years?

**Mr Stuart**—The estimates are $1.9 million in 2007-08, which includes a small capital component; $1.4 million in 2008-09; $1.5 million in 2009-10; and $1.5 million in 2010-11.

**Senator McLUCAS**—What is the capital component?

**Mr Stuart**—I believe that is system development.

**Senator McLUCAS**—Will the officers of the department who will undertake this work sit in the Office of Aged Care Quality and Compliance or in the department more generally?

**Mr Stuart**—The current expectation is that checks of key personnel will sit in the Office of Aged Care Quality and Compliance.

**Senator McLUCAS**—In a practical sense, how will the department do it? Will you just go to the facility and, for example, say, 'You are down on the list as being the key personnel for this operation; what do you do?' or something like that?

**Mr Stuart**—We are not quite at that stage yet. We are in the process of thinking about and framing draft regulation. We have not been to the minister with that draft regulation yet and we have not been out to consult with industry about this yet. I very much want to, because there is a balance to be struck between the effective flow of industry on the one hand and the capacity to effectively regulate on the other. So we think it is very important that we step through consultative processes before we finalise the implementation of this measure.

**Senator McLUCAS**—Does it also go to the question of transferring beds within an entity? You were talking about how we have more amalgamation of facilities potentially owned by a company not traditionally associated with aged care delivery. Does it go to the ability of a company to transfer beds within the company structure without necessarily referring to the department?

**Mr Stuart**—That depends entirely on the company structure. If a company has been set up such that it has 10 approved providers under it and it wants to move aged care places from home A to home B then that is a transfer of places between approved providers. If the approved provider is at the company structure level and it has 10 homes operating under it then that is not a transfer between approved providers. But, in any case, the department always needs to approve the physical movement of places from one site to another because of the impact on our planning arrangements.

**Senator McLUCAS**—So there is nothing wrong with the act in terms of managing that at the moment. Is that what you are saying?

**Mr Stuart**—There is no issue in the act in terms of managing the physical relocation of aged care places from one site to another.

**Senator McLUCAS**—The other element in the budget was ensuring quality in community care, with $26.8 million over four years. It states in the budget papers that there will be:

... increased monitoring of the care being provided by means of spot checks, as well as developing better models of care planning and delivery.

Could you explain how this money will be spent and what we can expect in a quality assurance model in community care?

**Ms Nicholls**—We are still in the process of scoping these activities, so I cannot go into huge amounts of detail at this point, and we obviously want to consult with the industry about the best strategies for implementation.

**Senator McLUCAS**—I am pleased to hear that. The industry is very keen to know how spot checks will happen in community care.

**Ms Nicholls**—In broad terms, the new funding has been allocated to achieve better assessment of the amount of care being delivered, enhance systems for monitoring quality, improve mechanisms for client feedback and allow more quality checks as well. So, under the current system, resources are only available and the requirement is only to visit every facility approximately once every three years. Resources are being provided to enable more visits to facilities to ensure that quality is being provided.

**Senator McLUCAS**—So, I am talking about quality in community care.

**Ms Nicholls**—That is the case as well for community care—that we visit every three years.

**Mr Stuart**—When Ms Nicholls said 'facilities', she meant community care services.

**Senator McLUCAS**—Who will do this?

**Ms Nicholls**—The current quality reporting system that is run for community care services that are funded by the Australian government is for departmental officers to go out and visit.

**Mr Stuart**—It remains to be decided. There is a significant piece of development work that needs to be undertaken before we finally decide who exactly is going to do what. The development of standards in community care has a little way to be evolved and then the operation of those standards needs some further thinking through as well. I do not think we have all the answers right now.

**Senator McLUCAS**—The budget paper says that there are going to be spot checks.

**Mr Stuart**—That is right.

**Senator McLUCAS**—How does that happen?

**Mr Stuart**—It will.

**Senator McLUCAS**—It will?

**Mr Stuart**—It certainly will happen.

**Senator McLUCAS**—The departmental officers will undertake that, or you are not sure yet?

**Mr Stuart**—We are not certain finally who will do that work.

**Senator McLUCAS**—Will the agency do that work?

**Mr Stuart**—The standards and the modus operandi first needs to be understood.

**Ms Halton**—The bottom line here is that spot checks are shorthand for saying that we need to be able to look at the quality of service as it is being delivered unvarnished without the opportunity for people to go around and tidy things up. You are quite right; that takes some thinking through. So the policy intention is clear that we need to go and look at what—unvarnished—is happening on a day-to-day basis in services, but how that occurs is something which I think, as Ms Nicholls has indicated, we will be talking through with providers and with industry and obviously with consumers as well to make sure that the system is practical.

**Senator McLUCAS**—Community care is delivered in people's homes.

**Ms Halton**—Yes, exactly.

**Senator McLUCAS**—Are we suggesting that there will be spot checks in somebody's home?

**Ms Nicholls**—No, I do not think we are. Currently the quality reporting requirements are that the departmental officers visit the community care organisation to satisfy themselves of how well the facility is delivering services.

**Ms Halton**—The services, not the facility.

**Ms Nicholls**—I am sorry; I apologise—to visit the service to see how well it is delivering the service.

**Senator McLUCAS**—How can you make an assessment if you go to Acme community care service, which is an office?

**Ms Murnane**—There are a number of things you could do if you go to the auspice—that is, employing the carers who go out to homes. You look at the people they are providing

services to, you look at what records they are keeping and you look at what care, visits, they have for that day. It is conceivable, although we have not decided that now, to say, 'Could we accompany somebody on one of those care visits?' There is a hub. All these carers that radiate out radiate out from a hub. That hub should keep records—a lot of records about what services they are delivering. There are many tracks we can then take from there.

**Senator McLUCAS**—The service is providing you, through their reporting system, hours of care, but that is not sufficient, obviously, to make an assessment about the quality of care being delivered?

**Ms Murnane**—No, it is not. But you have to balance here the issues of the privacy of the individual in their home and you touched on that. You have to balance it. There are a number of things that we are looking at that, with the approval of the people getting care. We might be able to talk to some of them and get reports back from them on what they are getting. It is very important. It is much harder to create a quality safeguard around home care, but it is equally if not more important. That is what we are now embarking on. We are going to embark on it carefully because it is really a new frontier, but it is a frontier that we need to be at.

**Senator McLUCAS**—I do not disagree with that, but I suppose what I am trying to understand is what is going to happen in the short term. Perhaps you could give me an understanding of what sort of contemplation the department is having at the moment about how the program might be developed.

**Mr Stuart**—We would like to provide a lot more advice to the minister about that and also to discuss further with the sector. The funding that we have for this particular measure assumes a development timetable first before roll-out, so we have some time to work through this with the sector.

**Senator McLUCAS**—$26 million over four years. How much is in 2007-08?

**Ms Nicholls**—$4.7 million.

**Senator McLUCAS**—That is departmental expenditure?

**Ms Nicholls**—That is departmental.

**Senator McLUCAS**—It is all departmental?

**Mr Stuart**—Yes, I think so.

**Senator McLUCAS**—In the out years is administrative expenditure identified?

**Ms Nicholls**—No, I believe it is all departmental. Could I just check that, please?

**Mr Stuart**—It is all departmental funding.

**Senator McLUCAS**—Let us go to the conditional adjustment payment. It finishes at the end of June.

**Mr Broadhead**—It was originally allocated over four years from 2004. The last year in the current arrangement is 2007-08 and the government has made a commitment to review the need for and level of the payment in the coming financial year.

**Senator McLUCAS**—How will that review occur?

**Mr Broadhead**—That is yet to be decided.

**Senator McLUCAS**—The current expenditure for conditional adjustment payment in 2007-08 is $368.9 million.

**Mr Broadhead**—That sounds about right, yes.

**Senator McLUCAS**—It is out of your budget papers.

**Mr Broadhead**—Then that undoubtedly is right.

**Senator McLUCAS**—If that money were lost to residential aged care, if you withdrew $368.9 million—how does that compare with the funds under Securing the Future?

**Mr Broadhead**—The funds from the government under Securing the Future are $1.6 billion over four years.

**Senator McLUCAS**—Let us do it annually.

**Mr Broadhead**—The difficulty I have with the question is that you have premised it by asking what would happen if that money were withdrawn. I am not aware of any intention to discontinue the CAP. It is going to increase to seven per cent of basic subsidy next year and there will be a review of the need for and the level of it. It is a hypothetical question, I think.

**Ms Murnane**—Yes, and I do not think it is a question that we can answer.

**Senator McLUCAS**—But if that measure was not continued, it really just means Securing the Future—

**Ms Murnane**—That is hypothetical.

**Mr Broadhead**—It has not yet been determined what the CAP—

**Mr Stuart**—Perhaps I should point out that there is ongoing funding for that measure in the forward estimates.

**Senator McLUCAS**—Can you point me to that?

**Mr Broadhead**—My colleague points out that it was not announced as a terminating program. That is probably the best way we can answer that question.

**Senator McLUCAS**—I am learning more language every day I come to estimates. So it is not a lapsing program, or is that different to a lapsing program?

**Mr Broadhead**—It is subject to review, clearly, and the government has made a commitment to review it in the coming financial year.

**Senator McLUCAS**—Mr Stuart, your comment about it showing in the forward estimates—I did not find that in here.

**Mr Broadhead**—There are no forward estimate figures—

**Senator McLUCAS**—In this book.

**Mr Broadhead**—In that book, yes, other than the budget year.

**Senator McLUCAS**—So where does it show?

**Mr Broadhead**—I do not believe there is a published document in which it shows it.

**Ms Halton**—'Show' is the wrong word. 'It is in' is the correct way to put it.

**Mr Stuart**—It is part of the general standing appropriation.

**Senator McLUCAS**—In the general standing appropriation what level does it appear at? It is a compounding payment.

**Mr Broadhead**—I suggest that the issue here is that the level at which it may continue will be subject to the outcome of the review that the government has undertaken.

**Senator McLUCAS**—I understand that, but Mr Stuart is saying that it is in—

**Mr Broadhead**—So what may or may not be in the estimates at this stage, the outcome will be determined as a result of the review.

**Senator McLUCAS**—But if there is a number in the forward estimates, I would like to know what that number is.

**Mr Broadhead**—I cannot tell you.

**Senator McLUCAS**—Why not?

**Mr Broadhead**—Because I do not have the number.

**Senator McLUCAS**—Could you get it for me, please?

**Mr Broadhead**—I would have to seek advice on that.

**Senator McLUCAS**—Why?

**Mr Broadhead**—As I understand it, the government in general has a principle that it does not reveal component level forward estimates beyond the budget year. If I am bound by that, that is the answer I would have to give, but I would like to check.

**Senator McLUCAS**—I would appreciate it if you would. Mr Stuart, I am pleased to know it is in the forward estimates. I have general questions on the outcome. A series of reviews are underway at the moment. Regarding the community care and subsidies review, the submissions closed at the end of January. How is that progressing?

**Mr Stuart**—That is handled by Alison Killen, the acting assistant secretary of the Community Care Branch, who is just coming to the table. We received over 50 submissions to that review and we are very pleased with the number and the quality of all of those submissions. They are all on the department's website. There was a considerable level of common view expressed through that review. Your question was: what are we currently doing?

**Senator McLUCAS**—The submissions have been received. What is happening now? What is the process from here?

**Ms Killen**—The process from here is that the review will make a report to government on progress to date and will seek further guidance from government. Following that process, we will be developing options for any changes that might be sensible to make to the community care system, in particular to the subsidy arrangements—the package care programs—and provide that to government in the first half of next year.

**Senator McLUCAS**—Where is the ACAT review up to?

**Ms Rosevear**—With regard to the ACAT review, the consultant who has undertaken most of the preliminary work has been to visit 50, I believe, ACATs and has conducted a survey of all ACATs. Preliminary findings were presented to ACAP officials on 14 May or 15 May at the meeting in Hobart, and they are in the process of going through a number of verification workshops with the ACAT teams.

**Senator McLUCAS**—Verification workshops to verify the information that the consultant—

**Ms Rosevear**—The consultant will go through their interpretation of what they think the findings are and discuss it with the ACAT teams, and thereafter we are expecting at least a preliminary report by the end of June for consideration by officials.

**Senator McLUCAS**—At the end of June it goes to officials.

**Ms Rosevear**—Then it will go to officials.

**Senator McLUCAS**—And from there a report to government?

**Ms Rosevear**—Yes.

**Senator McLUCAS**—When is that expected?

**Ms Rosevear**—It depends on the outcome of discussions of officials. The next meeting is not until November, but it depends if it is a document that they are happy to consider out of session, in which case a report to government will be within the next couple of months.

**Senator McLUCAS**—Who was the consultant in that report?

**Ms Rosevear**—The consultant is Communio.

**Senator McLUCAS**—Is consistency in assessment a theme that has emerged from the review?

**Ms Rosevear**—Yes, it is. We have also undertaken a variability study to look at that, and across both pieces of work there are some issues around consistency in assessment—whether that equates to different outcomes is something that needs to be analysed.

**Senator McLUCAS**—And at another time we had a discussion—with Mr Merciades a long time ago—about the regularity that an assessment often comes to a view that seems surprisingly to match the vacancies that currently exist. Has that issue come across as well?

**Ms Rosevear**—To some extent. ACATs may assess somebody as eligible for a number of different services, so they may say HACC, CACP, low-care residential and/or respite. That will, to a certain extent, reflect what services are available in the area overall. But the recommendation is not necessarily tied to what things are vacant; it is what type of services they believe they need. But we are doing a full analysis of that level of detail.

**Senator McLUCAS**—What other themes have appeared in the review?

**Ms Rosevear**—The review was essentially looking for best practice models that state and territory governments could use to do improvements. One of the main themes that appears to be emerging is that there is not a best model ACAT but there will be better outcomes where there is particular leadership styles et cetera. So it is not tied down to a model as such, but there is still a lot of analysis to be done in that regard to work out the level of detail.

**Senator McLUCAS**—I do not know whether you are going to be able to provide this to me, but I would like the latest data on the current numbers of people approved by ACATs for CACP, EACH, low care and high care; is that data you collect?

**Ms Rosevear**—The number of people that are approved?

**Senator McLUCAS**—Approved for.

**Ms Rosevear**—Yes, it is data that is collected.

**Senator McLUCAS**—How do you collect that data?

**Ms Rosevear**—The data is collected by ACATs and then they provide it to evaluation units within each state and territory. It then goes to a national data repository.

**Senator McLUCAS**—On a monthly basis?

**Ms Rosevear**—On a quarterly basis.

**Senator McLUCAS**—So you could provide me with the first quarter of this year's data?

**Ms Rosevear**—I am not sure if it is available; I do not have it on hand but I can check for you.

**Mr Stuart**—We would be able to provide you with the most recent full quarter.

**Senator McLUCAS**—I am looking for trends to try and work out if there is a trend I need to understand. Is it fairly easy to provide that data, say, for the last two years?

**Ms Rosevear**—There certainly is data available on a quarterly basis, so we can provide that to the last complete dataset. I am just not sure at the moment, because there is a bit of a lag time. We have to wait for data to come in from all states and territories.

**Mr Stuart**—I will boldly predict that it will show increases in recommendations for community care packages at home and EACH because both of those programs have been growing over the period.

**Senator McLUCAS**—Which goes back to matching care recipient to—

**Mr Stuart**—If EACH did not exist in a region a year or two ago then there will not have been recommendations for it a year or two ago.

**Senator McLUCAS**—I understand. EACH has got its own special arrangements but CAPCs has been around for quite some time. Can you separate them by aged care planning region; is that the way they are collected?

**Ms Rosevear**—I have to check that. I think it is by ACAT area.

**Senator McLUCAS**—If it can be done by planning region that would be great, but I recognise ACAT regions do not match.

**Ms Rosevear**—No, they do not correlate. I think we looked at mapping ACAT information to aged care planning region previously, and we found that it was not possible with the current data collection. But I will check that.

**Senator McLUCAS**—Especially in the cities because people will be getting an assessment—

**Ms Rosevear**—Many of the ACATs work in hospitals, for example, and a hospital will service a particular area which may not be in the planning region.

**Senator McLUCAS**—Does the data also reflect the point Mr Stuart made a moment ago that people will be assessed for a range of different services. So an individual might be assessed for—sorry, you made the point—low-care respite and CACP.

**Ms Rosevear**—That is right. You may have one person whose assessment outcome is respite plus or minus low-care residential, plus or minus Community Aid Care Package and perhaps they may also recommend HACC services. So they will determine what the care needs are of the care recipient.

**Mr Stuart**—I think there are more recommendations in the dataset than there are people.

**Senator McLUCAS**—That is what I am trying to ascertain. I do not want to count up the number of recommendations and work out that three quarters of Australia has got an ACAT assessment.

**Mr Stuart**—There will be more recommendations in the dataset than there are people.

**Senator McLUCAS**—Will I be able to ascertain when I read it how many individuals we are talking about?

**Ms Rosevear**—I believe we have data on how many individuals have been assessed, yes.

**Senator McLUCAS**—How is the probity review of the aged care approvals round going?

**Mr Stuart**—It is progressing. The minister has made a decision to extend the terms of reference, and we are negotiating with the provider at the moment about that extension to the terms of reference, and so this review will now take a little longer. The minister is asking them to pay particular attention to the transparency of the decision-making process and also to the timeliness and efficiency of the process.

**Senator McLUCAS**—I understand you are negotiating to change the terms of reference with the consultant. Is it possible to provide the committee with a copy of the original terms of reference and the changed terms of reference?

**Mr Stuart**—Yes, absolutely.

**Ms Rosevear**—We have a document that says what the new terms of reference are as agreed by Minister Pyne, and the additional terms over the original ones are highlighted in bold. Would that be acceptable?

**Mr Stuart**—I think that would meet your needs. We can give you a document today that shows you the change on one document.

**Senator McLUCAS**—Who is the consultant?

**Ms Rosevear**—It is RSM Bird Cameron.

**Senator McLUCAS**—I do not know them as a company Do they understand aged care?

**Ms Rosevear**—In their tender they demonstrated, yes, that they did understand the aged-care sector. That was one of the requirements they needed to meet.

**Mr Stuart**—Their particular expertise is in probity and decision-making processes.

**Senator McLUCAS**—That is good. When is it expected to be completed?

**Mr Stuart**—That is a matter for further decision, so it depends on the time required to address the additional terms of reference. We would also like to have a workshop with aged-care providers and we cannot do so while the application process for aged-care places is still on foot.

**Senator McLUCAS**—Because there would be a potential conflict.

**Mr Stuart**—Because we would be discussing criteria in great detail—

**Senator McLUCAS**—What people are currently doing.

**Mr Stuart**—of how they should be addressed and how the department treats them with a small group of providers. But we could not have all providers in the room, so our view was that to do so while the application process is on foot would give a potential advantage to a small group of providers and we cannot do so.

**Senator McLUCAS**—When is the current round complete?

**Mr Stuart**—The applications for residential care places close in the middle of June.

**Ms Rosevear**—Yes, 15 June.

**Senator McLUCAS**—And so after that you would be able to run a workshop.

**Mr Stuart**—That is right.

**Senator McLUCAS**—I understand Campbell consultants were commissioned in 2004 to look at the impact accreditation has had on the quality of care since its inception. Is that work completed?

**Ms Smith**—Yes, you are right: Campbell Consulting was employed at the end of 2004 to do the review of the impact of accreditation. That process is nearly at the end. The project had a number of subprojects, and that is now being integrated into a final report. We are also getting final input on the project from the technical reference committee which was set up to guide the process and, once the project is finished, that report will be made available to the minister.

**Senator McLUCAS**—And the time frame for that?

**Ms Smith**—We are expecting the report will be made available to the minister this financial year.

**Senator McLUCAS**—This current financial year.

**Ms Smith**—Yes.

**Senator McLUCAS**—Within a month or so.

**Ms Smith**—Yes.

**Senator McLUCAS**—And then it is up to the minister whether that gets released.

**Ms Smith**—The expectation is that the report will be released, but once he has had a chance to consider it.

**Senator McLUCAS**—Costings on the Aged Care Australia website please—I do apologise for this jumping up and down.

**Ms Bromley**—The briefing that I have here says that the total cost for developing agedcareaustralia.gov.au was $2.9 million.

**Senator McLUCAS**—Over what years was that?

**Ms Bromley**—From 2004-05, 2005-06 and 2006-07—over three years.

**Senator McLUCAS**—So that $2.9 million completes in this current year?

**Ms Bromley**—Yes. There is some ongoing allocation for its maintenance, but certainly not for its development.

**Senator McLUCAS**—What is the maintenance cost?

**Ms Bromley**—Approximately $300,000 per annum.

**Senator McLUCAS**—And that is outsourced?

**Ms Bromley**—Some of it is outsourced and some of it is done internally.

**Senator McLUCAS**—What is the split there?

**Ms Bromley**—That I do not have with me.

**Senator McLUCAS**—Generally, is it half and half, or 60-40?

**Mr Stuart**—We can come back and tell you later, if you really want to know.

**Senator McLUCAS**—I do not really want to know.

**Ms Bromley**—There are some internal staffing costs and we do use external expertise, so it is a split between the two.

**Senator McLUCAS**—Yes, in the same way that everyone manages their website. Can I have the costings on Commonwealth Carelink, please?

**Mr Stuart**—Which costings were you seeking in particular?

**Senator McLUCAS**—What is allocated for Commonwealth Carelink in 2005-06, 2006-07 and then the budget and forward estimates.

**Ms Killen**—The budget for Carelink was $16.4 million in 2005-06 and $16.7 million in 2006-07 and is $17.8 million for the coming financial year.

**Senator McLUCAS**—So it is $17.8 million in 2007-08, the next financial year?

**Ms Killen**—Yes.

**Senator McLUCAS**—And the out years?

**Ms Killen**—That is the only information I have.

**Senator McLUCAS**—Is it a lapsing program?

**Ms Killen**—No.

**Senator McLUCAS**—So those figures will continue?

**Mr Broadhead**—As previously advised, it is not generally the case that we provide detailed forward estimates beyond the coming budget year in respect of program subcomponents. The government publishes it at what is called the function level, I believe, but does not go below that in respect of individual subprograms. On that, I can actually clarify

that, in respect of the CAP, it is provided for in the forward estimates at the level at which it reaches in the final year, which is seven per cent of basic subsidy. So there are figures in the forward estimates which equate to seven per cent of the estimate of the basic subsidy going forward, but I am not able to provide the actual dollar figures for that.

**Senator McLUCAS**—So it is around $360 million?

**Mr Broadhead**—Actually I would like to come back to that. The $368.9 million figure that you quoted was the final year figure of the four years looking out from 2004.

**Senator McLUCAS**—Is that a cumulative figure?

**Mr Broadhead**—No, it is the correct figure at that time. It was I think $368.9 million. That was the estimate for 2007-08 in the 2004 budget papers. Since then, of course, there will have been a number of estimate variations to basic subsidy and policy decisions which have varied the estimates of basic subsidy. So I expect—I do not have a figure—that next year CAP would actually be more than $368.9 million because I expect that in particular the changes that have been announced as part of the Securing the Future package will increase total outlays and therefore seven per cent of that subsidy will be higher than it was expected to be back in 2004. What you have there was the fourth year estimate in the 2004 budget papers, $368.9 million. I expect that it is actually higher, but I do not have a specific figure.

**Senator McLUCAS**—If you could provide that figure to me for the 2007-08 year, that would be helpful.

**Mr Broadhead**—Again, I do not know—we have a figure in our budget papers for subsidies; we do not break out, as far as I am aware, the components of that. Therefore, to work out seven per cent of a component—I do not have that information with me. But it would be of the order of $368 million but a higher figure, simply because outlays have increased.

**Senator McLUCAS**—It is interesting that we cannot ask that question because it is in the operational ongoing funding.

**Mr Broadhead**—The figure would be included in the estimate for subsidies, which is published in the PBS, but the make-up of that does not break out at the component level. It is not my decision.

**Senator McLUCAS**—Going to your point, Mr Broadhead, about our not being able to ask questions about the forward estimates, you might want to have a look at FaCSIA's policy. Certainly, FaCSIA provided me with quite detailed forward estimates for various programs.

**Mr Broadhead**—I am happy to discuss it further but, as I understand it, it is a general position across portfolios. I cannot speak for what FaCSIA may have done. I am just trying to stick to what I understand to be the guidance that we have been given.

**Senator McLUCAS**—Can I ask formally: can I have the 2008-09, 2009-10 and 2010-11 for Commonwealth Carelink, please?

**Mr Stuart**—We will take that on notice.

**Senator McLUCAS**—Current contracts for Commonwealth Carelink—how do they operate? How do they run?

**Ms Killen**—Following the request for application process that was undertaken in 2005, Commonwealth Carelink centres reapplied in that process and it was used to combine Commonwealth Carelink centres with the Commonwealth carer respite services. They now operate as combined centres. They are under three-year contracts that will expire at the end of the next financial year, so in June 2008.

**Senator McLUCAS**—Out of those funds, what proportion is used for advertising? Is the advertising money in that amount?

**Ms Killen**—Yes, the advertising is from that budget.

**Senator McLUCAS**—Let us look at, say, the current year—$16.7 million. What is the split between advertising and funding for services?

**Ms Killen**—I probably should say that advertising for this program is undertaken mainly in newspapers, generally in regional newspapers, as the main role of the centres is to provide information and so we need to ensure that the community know that that is where they go for information about community care. In 2006-07, the expected national expenditure will be $1.269 million on advertising.

**Senator McLUCAS**—I thought it would be more than that. The aged care information line—what are the costings for that program?

**Mr Stuart**—We believe that they are departmental costs paid from within our division's departmental budget. We can come back to you with that in a little while.

**Senator McLUCAS**—Thank you. What I would like provided is the same information that I asked of the Commonwealth Carelink program.

**Mr Stuart**—Which is the budget for?

**Senator McLUCAS**—2005-06 through to the budget and forward estimates.

**Mr Stuart**—Okay. We may not have a forward estimate for that because it is departmental.

**Senator McLUCAS**—Fair enough. Moving now to more specific issues, what is the most recent data we have on residential aged care vacancies?

**Mr Broadhead**—As I recall, we provided you with an answer on notice which gave a breakdown of occupancy or vacancy, one being the mirror of the other, after the last estimates session. That would be the most recent information.

**Senator McLUCAS**—That is the most recent, is it?

**Mr Broadhead**—Yes.

**Senator McLUCAS**—That was by aged care planning region, wasn't it?

**Mr Broadhead**—Yes; as I recall, it was.

**Senator McLUCAS**—Do you have it with you, Mr Broadhead?

**Mr Broadhead**—I hope I have a copy of it here. Actually, the one that we have here was for community programs only. I cannot recall whether we provided you with one for residential as well.

**Senator McLUCAS**—I recall having one, but I think it was some time ago.

**Mr Broadhead**—Yes, I think it might have been an earlier session. We have a breakdown of places, which I think we have provided, but perhaps while I trawl through my papers—

**Senator McLUCAS**—After morning tea I will re-ask that question. I think it is better to do it that way. Fire safety certification, please—could you give me an update on the number of facilities that are yet to meet the 1999 certification instrument.

**Ms Smith**—Was that the number of services that do not meet the 1999 instrument? As at 25 May, there were 131 services.

**Senator McLUCAS**—At 31 December 2006, there were 202, so that is a reduction. December 2005 was the deadline for compliance, as I recall.

**Ms Smith**—That is correct.

**Senator McLUCAS**—Are we just letting these 131 services continue? What are we doing?

**Ms Smith**—The services that are in that category have major building works underway.

**Senator McLUCAS**—All of them?

**Ms Smith**—Yes. So they are being individually case managed by our state and territory offices and they have all given our offices timetables for when those building works will be completed. That is being closely monitored to make sure that they are keeping up with that progress.

**Senator McLUCAS**—I think that is what we were told last time I talked about fire certification, that we were closely monitoring them. Yes, there has been a reduction, but we still have 131 services in Australia that do not meet the standards. That was said in 1999, and they were to be complied with by 2005. I wonder whether you could provide the committee with a breakdown by state of non-compliant facilities.

**Ms Scheetz**—I have the figures by state; I just need to add some of the figures up for you. Do you want me to do that now, or would you like me to come back to you?

**Senator McLUCAS**—If you are happy to add them up—are they at planning regional level?

**Ms Scheetz**—They are at state and territory level.

**Ms Smith**—They are divided into when the building works will be finished. There are a couple of lines for each state.

**Senator McLUCAS**—That is perfect. Do you have a time line for each state?

**Ms Scheetz**—Yes.

**Senator McLUCAS**—That is what I am actually looking for—what is the time line that we expect these 131 facilities to be fire safety compliant.

**Ms Scheetz**—Would you like me to work through that now? The advice we have to date is that, by the end of this financial year, 30 June, 102 of those facilities will have completed their building works. Would you like that breakdown by state?

**Senator McLUCAS**—No, you can provide that on notice. You can hand that up later, if that is okay. So 102 out of 131 will have completed building works.

**Ms Scheetz**—Yes.

**Senator McLUCAS**—That does not mean achieving fire safety.

**Ms Scheetz**—They will then need to be assessed.

**Ms Smith**—Just to go back to the earlier point we made about the 131 services, those services are all—except for one service—compliant with local fire and safety regulations.

**Senator McLUCAS**—Yes, that is a distinction there. I was getting to that.

**Ms Smith**—Yes, I just wanted to put that on the record.

**Ms Scheetz**—This is the higher standard. So 102 services have told us that they will complete building works by the end of June and they will then need to be assessed to ensure those building works do comply with our instrument. By the end of December this year, there will be a further 12; then at the end of June 2008, there will be six. And at the end of 2008 there will be 11. That is the 131.

**Senator McLUCAS**—So the last time was at the end of?

**Ms Scheetz**—The end of 2008.

**Senator McLUCAS**—December 2008?

**Ms Scheetz**—Yes.

**Senator McLUCAS**—That is the remaining four?

**Ms Scheetz**—That is the remaining 11.

**Senator McLUCAS**—And that adds up to 131?

**Ms Scheetz**—Yes.

**Senator McLUCAS**—If you could split those out for me by state, that would be helpful. The point you were making, Ms Smith, about there being one facility in Australia that is not compliant with local government fire safety—where is that?

**Ms Scheetz**—That facility is in New South Wales.

**Senator McLUCAS**—Where is it?

**Ms Scheetz**—I do not know that we can be specific about where the facility is. The facility is under the order of the local council. They had identified some fire safety issues in their usual monitoring of the service. It is actually a building with historical status, so it has issues to do with the building. The local council had asked that service to do a number of immediate improvements, which they have done, and they are on a timetable until the end of this year to make other improvements. But they are being very closely managed by the local council authorities.

**Senator McLUCAS**—Have they ever been compliant under the local government requirements?

**Ms Scheetz**—They were compliant 12 months ago.

**Senator McLUCAS**—Is that because there has been a change in the way the local authority assesses, or because the local authority's regulations have been increased?

**Ms Scheetz**—I am not aware of the reason that they have moved into non-compliance.

**Ms Halton**—Certainly I can tell you, because I know this for other reasons, that in New South Wales—a number of the councils actually have changed, have toughened up considerably their fire regulations. What a number of those councils are actually doing is working through any building which is other than for domestic purposes, applying what is now an increased standard. So, without knowing the particular area—and I will have a look at it—I am aware that a significant number of New South Wales councils have done that in the last probably 18 months.

**Ms Scheetz**—I can say that it is not in a metropolitan area.

**Senator McLUCAS**—Everyone in the country is now worried. What will be the penalties for failing to meet the 1999 fire safety requirements?

**Ms Scheetz**—If homes fall below the state and local government requirements for fire safety, they are subject to whatever penalties they impose. With our higher standards, it relates to their certification status. At the moment the homes that do not meet the 1999 instrument do not meet the certification requirements, but because all of these homes have been continuing to make improvements they are certified under the 1997 instrument and we have agreed that they will continue to be certified. We have included some incentives in the Securing the Future package to encourage homes to move more quickly to meet these targets and, from the end of March 2008, the payments for the increased accommodation subsidies and resident charges will not apply to the homes that have not met these arrangements. So that is an incentive for people to move more quickly into meeting the targets.

**Senator McLUCAS**—According to your timetable, that will only affect 10?

**Ms Scheetz**—Yes.

**Senator McLUCAS**—I just wonder why you need another incentive. We have already given these facilities an amount of money per bed in the facility.

**Ms Scheetz**—The purpose of that funding was not for this, obviously. It was to encourage higher building standards. But one of the conditions of that was that they initially need to meet the 1999 instrument and the 2008 requirements as well.

**Senator McLUCAS**—All right. That is the end of that issue.

**CHAIR**—It seems an act of vandalism to interrupt your tour de force, Senator McLucas, but we will break now for some coffee.

**Proceedings suspended from 10.36 am to 10.56 am**

**CHAIR**—We are presently dealing with outcome 4, aged care and population ageing. Senator McLucas, perhaps you would not mind if I interrupted your flow and asked a few questions. I want to ask questions about the state of the aged care workforce and an assessment of how healthy that workforce is in terms of numbers in the industry, capacity to recruit and retention. Do you have any information about that?

**Mr Stuart**—Yes. The government has implemented a range of workforce-focused programs in the last few years. In fact, I spent about five years away from the aged care sector and returned in the middle of last year and I think the government's concern with workforce

and implementation of workforce programs is probably one of the key areas of significant change. We have access to some data about overall workforce numbers, which is ABS data and survey data, and we should be able to tell you a little more about that as well. We could start with a description of the government's programs for workforce, if you would like to do that.

**CHAIR**—I was trying to get a picture of what the state of play is with respect to recruitment and retention. I recall during the inquiry that this committee conducted into aged care that there were considerable concerns expressed about the disparity between pay rates for nurses, for example, in aged care and those in the hospital sector. Is there any information about whether there is still a crisis in the sector with respect to that, or has the problem eased?

**Mr Stuart**—There do remain on average pay disparities between acute care and residential care for nursing wages, but the Australian government does not regulate that at all—certainly not through the aged care program. We provide funding to aged care homes and they are at liberty to hire staff in the marketplace and to pay them as they wish to pay them. So the disparities that exist are to a significant extent historical and we do not have particular sway over that. I guess our approach over the last few years has been to do two things: one is to significantly increase funding to aged care homes, including for the payment of workforce, with some specific measures; and the other is to run scholarship and other promotion programs for the aged care workforce.

**CHAIR**—Are the measures that you referred to before to upskill workers in this sector likely, in your opinion, to have a positive effect on retention rates or capacity to attract people into that sector?

**Mr Stuart**—Yes, absolutely. We are aware of particular providers who undertake significant training of their workforce—in fact, sometimes using the programs that the government has put in place—and who say that they are very happy with their workforce. But it tends to rely on models of employment which are more permanent and less casual, which have higher training levels associated with them and which provide a career path for individuals through that particular aged care concern, from unskilled through semi-skilled and into higher skilled work and, potentially, into management opportunities.

**CHAIR**—Is the government in a dialogue with the industry about these issues in any way? Is there some kind of mechanism for discussing it and articulating those issues in terms of strategies that embrace both government and the sector that delivers those services?

**Ms Nicholls**—There is an aged care workforce committee that has been established and has been running for a number of years, and that is one of the mechanisms by which the department liaises with the industry in relation to the issues that they see around workforce and that also guides us in terms of some of the programs we roll out and what certificates and training we might target in the various programs that we are running. In addition, it is probably worth mentioning that this year we will be undertaking a census and a survey of the aged care workforce. One was undertaken in 2003 by the National Institute of Labour Studies, and it reported in 2004. That survey only looked at the residential aged care workforce. The one that is being undertaken this year will look at both the residential aged care workforce and the community aged care workforce. This is being developed in consultation with the industry

and with the education sector, and they are very excited about this. We would anticipate that the census and survey will go out in about October this year and that we would have data in 2008 which will inform planning and give a better perspective on what is occurring. It will give us, for the first time, longitudinal data in relation to residential care and it will give us some consolidated data, national data, in relation to community aged care.

**CHAIR**—Can you give me an example of the sorts of questions that might be asked there? Will there be questions about happiness in the setting or job satisfaction?

**Ms Nicholls**—The sort of information that will be collected is the number of staff by the category of work that is performed. It will look at the sex, the age, the demographics in terms of ethnicity, pattern of employment contracts—so we will know whether it is short- or long-term employment—whether they are part-time, full-time or casual. It will look at the workforce mix. It will pick up issues about wages and also about current skills and qualification levels. It also picks up issues about home and family life, why people choose to work in this sector and what are the issues that they see.

**CHAIR**—That is good. Thank you very much for that.

**Senator McLUCAS**—Just while we are on workforce, what is the current disparity between the wages for nurses in acute care and residential care?

**Mr Broadhead**—I cannot give you an exact answer to that question because it varies according to jurisdiction, according to the particular arrangements that may apply in respect of the pay rates that are paid by providers to workers in different facilities and so on. So there is not a single exact answer to that question, I am afraid.

**Senator McLUCAS**—You do not have the national figure.

**Mr Broadhead**—The national figure would only be a comparison of averages, I expect. I do not believe I have it to hand.

**Senator McLUCAS**—Does the department track that?

**Mr Broadhead**—We do track movements as best we can, recognising that they are subject to, or they have been in past, a range of different awards and particular enterprise agreements and so on and so forth. We have some information from a number of sources on those sorts of movements.

**Senator McLUCAS**—Which way is it heading?

**Mr Broadhead**—That is again very difficult. For example, personal care workers in New South Wales got six per cent increases in 2005-06, but that would not be the same as what happened in other jurisdictions. It would not be the same necessarily for nurses as for personal care workers. So it is a very complicated picture that you are asking for in terms of movements. I could not tell you.

**Senator McLUCAS**—Is the disparity with registered nurses in acute care increasing or decreasing?

**Mr Broadhead**—I am not aware. For example, in Tasmania I believe it was all but eliminated at one stage.

**Senator McLUCAS**—Nationally.

**Mr Broadhead**—I do not have the—

**Senator McLUCAS**—Is it not true that when CAP was introduced the disparity between aged care nurses was $170 a week. For a nurse who worked in residential care at the beginning of the conditional adjustment payment, the disparity in wages was $170 a week. Currently, a nurse who works in aged care gets paid on average $235 a week less than her similarly qualified colleague who works in acute care; is that right?

**Mr Stuart**—Are these national averages that you are quoting?

**Senator McLUCAS**—Yes.

**Mr Stuart**—We would have to check that. We would have to check that as well in the context of overall rising wages. I do not think we could answer that now.

**Senator McLUCAS**—If you could come back to us and confirm those figures, that would be helpful. I have some questions about the undergraduate nurse scholarships. You were going to refer to them earlier. They have been going for only a short time.

**Ms Nicholls**—The nursing scholarships for residential care have been going since the 2002-03 budget.

**Senator McLUCAS**—How many people have graduated under this proposal?

**Ms Nicholls**—I am not sure whether I can actually give you the figures about graduations. I can give you the figures in terms of the number of places that have been allocated, if that is sufficient.

**Senator McLUCAS**—Do you have those figures there?

**Ms Nicholls**—Yes. As at 30 April a total of 1,143 undergraduate scholarships and 618 continuing education or postgraduate scholarships have been awarded. That includes the scholarships that were awarded for 2007. Obviously, that includes a number where they will not have been completed. Because the undergraduate courses run for a number of years, there will be a number that are in train.

**Senator McLUCAS**—Is it possible then to find out the number of graduates who were recipients of an undergraduate aged care nursing scholarship?

**Mr Stuart**—I am not sure we can easily do that, because it depends on the journey through education of the particular nurses that we have given scholarships to. Given that it is a relatively recent program, there will be many more in process than there are completed by the nature of the thing. I am not certain if we track the individual careers of those people. I think we would probably have to contact the training providers to find that out.

**Senator McLUCAS**—I am not asking where they are working now; I am asking how many have graduated. How many people have been supported by the Commonwealth with a scholarship for their period of time at university and have completed it?

**Mr Stuart**—We may be able to get that information through the Royal College of Nursing, which is the service provider that organises this for us. They may be able to tell us. We will give them a ring during the day and see what we can do for you; otherwise, we will need to take that on notice for a later response.

**Senator McLUCAS**—Thank you. How many of those graduates, when we know the figure, are working in residential aged care?

**Mr Stuart**—We will see what we can do.

**Senator McLUCAS**—You might be able to find that?

**Mr Stuart**—It depends on what records there are. I am unaware exactly of what information is being kept on this. That may prove to be a difficult question.

**Senator McLUCAS**—Yes, I think it right. I do not know how we would track whether or not someone ends up working in residential care. The answer to question on notice EO6059 indicated that the department has received, since July 2006, 23 allegations of abuse in aged care facilities, four of which have resulted in charges being laid. Can we have an update on those figures, please?

**Ms Smith**—As at 28 May the department had received a further 27 allegations, which makes a total of 56 allegations this financial year. Of those 27 additional allegations, one has resulted in charges being laid.

**Senator McLUCAS**—That brings to five the number of events where charges have been laid in this financial year?

**Ms Smith**—I think the previous figure was seven and now it is eight.

**Senator McLUCAS**—When you receive allegations of elder abuse in aged care facilities, what does the department do?

**Ms Smith**—The department's focus is on ensuring that the approved provider has done all of the appropriate things to respond to the allegation, that the allegations have been reported to the police, that the home has put in place measures to support the victim and offer any counselling or medical attention, and that there is no further risk to that resident or to other residents. If, for example, it is an issue concerning the behaviour of another resident, the alleged perpetrator's behaviour management plan is reviewed and steps are taken to ensure that that behaviour is better controlled.

**Senator McLUCAS**—Of that total of 56 allegations of abuse, what is the split between allegations where the perpetrator was a resident and allegations where the perpetrator was a non-resident?

**Ms Smith**—There have been 33 allegations involving staff-on-resident, 20 resident-on-resident, one involving a relative or a visitor on the resident, and two unknown.

**Senator McLUCAS**—Two are unknown because the perpetrator is unknown?

**Ms Smith**—The perpetrator has not been able to be identified.

**Senator McLUCAS**—And of the eight charges that have been laid, how many of those have been through the legal system?

**Ms Scheetz**—My understanding is that seven are still before the legal system. One of them has actually gone through and completed a court case and was found not guilty.

**Senator McLUCAS**—Do you track those legal cases?

**Ms Scheetz**—We are in touch with the police so, insofar as we get the information from the police, we do. Generally to date they have kept us informed of the dates of hearings and things.

**Senator McLUCAS**—Thank you both. Mr Broadhead, in the modelling that was done for Securing the Future and the increase of the ratio of community aged care packages, what modelling was done to ascertain the impact on residential aged care occupancy levels with the increased allocation of community aged care packages?

**Mr Broadhead**—We have done some data modelling of the relationship between the provision of community care and residential care. In general, the findings of that have been that many people who have community care still go into residential care. About half of all people who receive a community aged care package will nevertheless go into residential care subsequently, so it is not a simple case of one displacing the other. However, of course having received care in the community in general we expect them to go into residential care at a different level of dependency than they might had they gone into residential care to begin with, in other words, had the community care not been available and they had gone into residential care. In general, however, there is no firm correlation between larger amounts of community care and occupancy and low care. So, in other words, it tends to be the way in which people find their way into residential care rather than something that undercuts the provision of low-level care in the work that we have done. This is using small area comparisons and so on, so I am not claiming that it is a perfect analysis but it is the best I think that can be done in the circumstances.

By the way, I should also raise the matter of the revision to the ratio from 20 to 25 community care places. Four of the additional places are actually Extended Aged Care at Home places and that again is a slightly different effect. We have only had about 2,000 Extended Aged Care at Home places prior to this and this will add another 1,600 over the next four years. So we do not have the numbers yet to know exactly how the provision of high-level care at home might affect people's entry to and use of residential care. There are too many other variables when you have only got a few of them across the country. We have looked at it, we do not expect any deleterious impact, if you like, upon low care as a result of this. We expect more people to be cared for; we expect that it will continue to be the case that many of the people going into community care will nevertheless go ultimately to residential care. This is a shift at the margin rather than a doubling of the number of places.

**Senator McLUCAS**—And given the waiting lists that currently exist, that increase in the community aged care packages essentially just shifts things along in time and allows those people who are currently waiting to go into residential care, access while they have some community care services.

**Mr Broadhead**—We believe that there would be people who would otherwise go into low care who may take a community aged care package. I understand that you referred to waiting lists, you would be aware that we do not maintain waiting lists. We know about the times between assessment and entry to care but there are many reasons for why people do not go into care immediately upon assessment and it is not necessarily the case that they are waiting. So it is a more complex matter here about people's preferences for where they are cared for, how they are cared for and so on. The increased provision of community care will impact on

that, will have an effect on that, but it is not really simply a case that there is all these people waiting and they will end up in community care while they wait. I do not think that is a valid summary of the situation. People's preferences are to be cared for at home and this will enable more of them to have that.

**Ms Murnane**—We have a very strong demand for community care. That is what people prefer and more community care places settle that preference. They also incidentally—although this is not its purpose—might in some places, because you really do have to look at this in different ways in different parts of Australia, provide relief, satisfy the need or lead to a smoother entry into residential care. But the main reason propelling this policy is the accord with people's wishes.

**Senator McLUCAS**—Yes, I do not dispute that at all. But I was looking for the modelling about what it will mean. Will it mean a decrease in waiting time and has that been modelled?

**Mr Stuart**—In respect of low residential care, the predominant effect, we suggest, would be that people who would prefer not yet to enter residential care are enabled to stay longer in the community. That reflects in part as a longer period with an ACAT assessment before entering residential care but our view would be that they are not necessarily waiting; they are delaying as long as possible because they wish to remain at home.

**Senator McLUCAS**—Mr Broadhead, you said that the department collects data on the time between ACAT assessment and entry into care. Is that disaggregated by assessment and provision of a CAPS package as well?

**Mr Broadhead**—I believe it has been published by the institute of health and welfare, there has been a report on it.

**Senator McLUCAS**—That was some time ago. Does the department collect that data on a regular basis?

**Mr Stuart**—No, that was a one-off project based on linking of data that is not usually captured together. It requires a drawing together of information about individuals who eventually do enter residential care and their experience of community care packages. So that was a particular one-off exercise that we learnt a lot from, but as far as I am aware it has not been repeated.

**Senator McLUCAS**—You said earlier, Mr Stuart, that the numbers of people who are on waiting lists are not kept; is that true?

**Mr Broadhead**—As I understand it, providers may have taken names of people who are interested in entering their facility at some point in the future and people may have themselves down, as it were, or there may be people who have gone to a number of providers expressing interest shopping around essentially, choosing where they go. We do not maintain a list. We know people who have been assessed and we know the time between assessment and entry, where people do enter care. But we do not have a list of people who have been assessed and are waiting as such. Again, I am trying to be careful in the use of terminology. As my colleague has said, people often get assessed against the day, as it were, but do not want to enter residential care immediately. So they are not waiting, they are just keeping their

options covered. So you cannot say that they are waiting as such—some may be, others may not.

**Senator McLUCAS**—You say, Mr Broadhead, that you do collect data on the period of time between assessment and provision of a care service, whether it be community or aged care. Can you provide that data to us?

**Mr Stuart**—Yes, we can. It is regularly published, I believe, in the Productivity Commission's report every year.

**Senator McLUCAS**—But that is the only place I get it, in the report on government services. Do you collect it on a more regular basis than annually?

**Mr Broadhead**—I have to go and talk to the people who deal in it, but I believe it comes in as part of the data that we collect routinely in the operation of the program. In other words, it accumulates on a periodic basis. As to how often we then produce tables out of it, that I believe is an annual process. We do it each year but we do not do it every month as far as I am aware.

**Senator McLUCAS**—You do it annually for the Productivity Commission.

**Mr Broadhead**—I think we would do it annually, yes. We produce it annually as far as I am aware. We provide it to the report on government service provision that the Productivity Commission conducts.

**Senator McLUCAS**—So the last data would have been the 2005-06 year?

**Mr Broadhead**—Yes, the report comes out early in the year so I imagine it would be the financial year 2005-06. The review comes out around the beginning of the subsequent year, doesn't it?

**Senator McLUCAS**—That is right. Maybe at the end of the financial year I will ask for the most recent data, rather than waiting till January. Do ACAT teams collate waiting lists?

**Mr Broadhead**—Again, not that I am aware of. ACATs are state government operated. We provide funding for the operation of the Aged Care Assessment Program and, delightfully, they conduct the way they do things variously in different places. Some are hospital based, some are community based and so on and so forth. But there is no central requirement for them to maintain lists of people who are seeking entry to care that I am aware of.

**Senator McLUCAS**—We might follow that up later.

**Ms Murnane**—We have looked at this many times and we have found that waiting lists in the context of aged care do not actually signify very much at all.

**Senator McLUCAS**—I understand the point you are making; it is similar to child care.

**Ms Murnane**—I think there are particularities about aged care that distinguish it even from child care.

**Senator McLUCAS**—There is no intentional delay in child care, whereas there is in aged care—where people, as Mr Broadhead said, may have their assessment but prefer not to take up the option that may be in front of them.

**Ms Murnane**—Or to search for other options, either among residential care or community care. To my knowledge, which is the same as Mr Broadhead's, ACATs do not keep waiting lists because it is not something that comes into their purview—a waiting list per se. They can tell us how many people they assessed and what they assessed them as needing, and we have those statistics.

**Senator McLUCAS**—Yes, which I have asked for. How does the department measure the number of therapists, including physiotherapists and occupational therapists, that go into residential aged-care services?

**Mr Stuart**—If we are talking about staffing, then the survey that Fiona was talking about would go some way to answering that question. If we are talking about just private community providers that may visit an aged-care home then I do not think we have that data.

**Senator McLUCAS**—It goes to the move from the RCS to the ACFI, and you would be aware of the concern, particularly from the physiotherapists, that the way that ACFI is constructed, in their view, does not encourage facilities to use the services of a physiotherapist. If you do not know how many therapists are attending aged-care facilities, how can we measure whether or not the shift from RCS to ACFI will, in fact, impact on their provision of service?

**Mr Broadhead**—In general, we do not fund specific components of care.

**Senator McLUCAS**—I understand that.

**Mr Broadhead**—So that would apply in this instance. Rather, the program relies on the outcome standards under accreditation and the associated processes to ensure that care is provided in line with people's requirements. In moving from the RCS to the ACFI, the ACFI does provide more funding for care than has been provided under the RCS and distributes that funding differently. But we would continue to rely on the quality and outcomes processes to ensure that care is provided as it should be, rather than attempting to itemise funding arrangements through a payment mechanism.

**Senator McLUCAS**—I understand that the government has indicated to the physiotherapists association that in their view there will be no change regarding physiotherapists attending aged-care facilities. I am wondering how that can be measured.

**Mr Broadhead**—At the moment we do not have the data, as my colleague has said, to know, for example, whether a visiting physiotherapist, or a visiting therapist of any kind—people who are essentially in private practice—may attend a facility under an arrangement with the facility or under an arrangement with residents. We might have some data through the workforce survey about people who are on staff, but that would not be comprehensive across all possible ways in which therapies are delivered. So we would look at the quality and outcome standards and ensure care continues to be provided in a way that meets those standards and the requirements under the act. That is what the government relies on.

Currently, under the RCS, people have to be reappraised every 12 months. There are those who would argue that where somebody has improved and has had their care needs diminished by the application of therapy, the result is that when they are reappraised they will go down a classification in some instances. So, in a sense, some would argue—I am not putting this

position—that that approach penalises people who rehabilitate. Under the ACFI, there is no mandatory reappraisal after 12 months. To the extent that a person's functioning is improved through the application of therapies, there is no automatic diminution of the funding provided. So this does provide in a sense a financial incentive to optimise people's functioning which was not previously available.

**Senator McLUCAS**—I understand that, and I understand the APA's concern is about how to measure and monitor whether or not that in-built incentive actually does turn into rehabilitative care through the use of therapies.

**Mr Stuart**—We monitor quite a lot in aged care, as you know, and as much as possible on the data front we try to collect information which is an administrative by-product, and some other data through regular surveys, which really has an overriding requirement, such as the overall workforce survey. Of course, there is a kind of balance to be struck between our level of curiosity and the workload on the aged-care home.

**Senator McLUCAS**—I am not proposing that another form be invented, Mr Stuart.

**Mr Stuart**—We can agree on that.

**Senator McLUCAS**—I understand two aged-care facilities have been sanctioned for late repayment of accommodation bonds. There was a change in legislation recently that changed the time that a facility had in which to repay an accommodation bond after a resident leaves a facility. What is the time now that a provider has to repay?

**Mr Scott**—Generally, the time frame to refund bonds is now 14 days after departure. The main difference is in the situation of death, which is then two weeks after receipt of probate or letter of administration.

**Senator McLUCAS**—In these two cases involving one provider, Consolidated Land Holdings, how many people did not have their accommodation bond repaid within the appropriate time?

**Mr Scott**—Over the course of a couple of financial years, the figure would be in the order of 50 residents. That would range from literally a few days to a couple of months. In some of those situations the late repayment prior to the new time frames for repayment of bonds would have reflected probate being received after the old two-month time period. Prior to 31 May last year the time frame for refunding bonds after death was a flat two months. In some situations probate would have been received after the two months had expired.

**Senator McLUCAS**—Of those 50 events of late repayment of bonds, some of them were because probate had not been achieved?

**Mr Scott**—That is correct.

**Senator McLUCAS**—How did this come to the attention of the department?

**Mr Scott**—Through a couple of mechanisms. As you might be aware, we have an annual prudential compliance statement, which includes a work sheet that outlines repayments that were made outside the statutory time frames. For all providers it is lodged within four months of the end of the financial year; for most providers that is around 31 October each year—those operating on a standard financial year. That would be the main mechanism through which we

would identify late bond repayments. In this situation we also received several complaints through the complaints resolution scheme. So we were aware of late repayments during the 2006-07 financial year through the complaints resolution scheme.

**Senator McLUCAS**—What are the sanctions that have been applied?

**Mr Scott**—The sanction that has been applied is revocation of approved provider status unless a financial adviser was appointed. The sanction was imposed on 19 March this year and the financial adviser was appointed on 23 March.

**Senator McLUCAS**—Have all bonds outstanding been repaid?

**Mr Scott**—Yes, all overdue bonds, according to the information that we have been provided, have been repaid.

**Senator McLUCAS**—So the sanction of the financial adviser being appointed, how long did that happen for?

**Mr Scott**—We have required Consolidated Land Holdings to appoint a financial adviser for a period of 12 months with a view to ensuring that the systems are put in place to ensure that bonds are repaid within their statutory time period and that those solutions are sustainable.

**Senator McLUCAS**—Is this the first time a provider has been sanctioned for non-repayment of bonds?

**Mr Scott**—It is my understanding that it is the first time that a sanction has been imposed solely for prudential reasons. I am not sure whether in the past there may have been a combination of quality of care and prudential where a sanction may have been imposed.

**Senator McLUCAS**—Apparently in the *Manly Daily*, a spokeswoman from the Department of Health and Ageing said, 'Consolidated Land Holdings had a history of late repayments of accommodation bonds'. I am sure that was not you.

**Mr Scott**—No, as a general rule I try not to talk to journalists!

**Senator McLUCAS**—But somebody from the department said there is a history. What is the history? When did we first know that this company was a regular offender in this area?

**Mr Scott**—The department issued notices of noncompliance for this provider for a couple of slightly overdue bonds in the 2003-04 financial year. They were repaid quickly. Further notices of noncompliance were issued for 2004-05 but it was late 2005 or early 2006 when that action was taken. Those bonds—or any outstanding bonds that had not been repaid—were repaid and the provider had undertaken to put in place procedures and arrangements to ensure that they met their statutory timetables in future. So the principal history of noncompliance was over the 2004-05 and 2005-06 financial years.

**Senator McLUCAS**—What would the attitude of the department be to another breach of non-repayment of accommodation bonds in the appropriate time frame.

**Mr Scott**—We would have to look at the particular circumstances of any further overdue repayments. But we have made it very clear to the approved provider that, in light of their performance as an approved provider and in meeting the requirements imposed on them over the last two financial years, we would not look favourably on any further problems arising. As

part of the issue of the sanction, we also required attendance of the approved providers' key personnel to appear under oath to provide us with information about the procedures they were putting in place to deal with the situation. We also took the opportunity to reinforce the seriousness of our views of their situation.

**Senator McLUCAS**—How do you do that?

**Mr Scott**—Under section 93 of the Aged Care Act, authorised officers are able to require key personnel to appear before them under oath to produce material and to answer questions.

**Senator McLUCAS**—Is that regularly used?

**Mr Scott**—Again, my understanding is it is not very regularly used.

**Senator McLUCAS**—Is this the only time in your knowledge it has been used?

**Mr Scott**—No, there have been times in the past that it has been used.

**Senator McLUCAS**—Let's go to Mrs Kerry Bishop who was allegedly acting in a key role which she was not entitled to and the investigation and the referral of the matter to the Department of Public Prosecutions. Can you give me an update on that case Mr Stuart?

**Mr Stuart**—Yes, I can. When we last spoke I advised you the matter was with the prosecutor for consideration and it is still with the prosecutor for consideration.

**Senator McLUCAS**—So no change.

**Mr Stuart**—No significant change on that, no.

**Senator McLUCAS**—Has the prosecutor been in discussion with the department?

**Mr Stuart**—I believe, yes, with our audit and fraud area.

**Senator McLUCAS**—So it is continuing?

**Mr Stuart**—Yes.

**Senator McLUCAS**—The new Aged Care Commissioner has been appointed and we welcome that appointment, Ms Parker. How many investigations since 1 May have been undertaken by the Office of Quality and Compliance?

**Ms Scheetz**—534 are being undertaken. They have not been completed. So we have received 534 calls that could be potential breaches.

**Senator McLUCAS**—So how many have been undertaken of those 534 potential investigations?

**Ms Scheetz**—441 have been finalised.

**Senator McLUCAS**—How long on average do the investigations take?

**Ms Scheetz**—These ones have taken just under four days, but I suspect it is not a very sustainable figure. A lot of those cases which were finalised quickly may well have been provision of information, misunderstandings et cetera. So with only four weeks into the program we cannot put much stock in those figures. Our objective in this program is to finalise as many cases as quickly as possible so that they do not drag on. But I do not think that figure is reflective of a longer term figure.

**Senator McLUCAS**—It is a lot more than what I thought would require attention in that short period of time. Is that your view as well?

**Ms Scheetz**—We expected there to be a fair number of calls. People have been aware that we have a new system and we have been encouraging people to come forward with information so we are not surprised with the numbers. We were geared up for those sorts of numbers.

**Senator McLUCAS**—Does every investigation warrant a visit to an aged care facility?

**Ms Scheetz**—No.

**Senator McLUCAS**—What is the split of attendance at an aged care facility and being able to deal with it essentially over the phone?

**Ms Scheetz**—In relation to the calls we have received we have done 168 visits.

**Senator McLUCAS**—What is the average length of a visit when you are doing an investigation?

**Ms Scheetz**—We do not have that information; it depends on what the issue is.

**Senator McLUCAS**—Do you advise the facility that you are coming to investigate an allegation?

**Ms Scheetz**—Some of the visits we do unannounced, if that is required in relation to the nature of the complaint. Generally though where an unannounced visit is not warranted we would ring the provider and let them know that we have received a complaint and that we will be coming out to do a visit.

**Senator McLUCAS**—Of those 168, how many were announced and how many were unannounced?

**Ms Scheetz**—Roughly 50/50.

**Senator McLUCAS**—How many have resulted in upholding the complaint?

**Ms Scheetz**—Notices of required act?

**Senator McLUCAS**—Yes.

**Ms Scheetz**—At this stage we have issued 12 notices.

**Senator McLUCAS**—Without going through each of them, what is the theme that is emerging?

**Ms Scheetz**—It might be a little early to have themes.

**Ms Smith**—It might be better if we took that one on notice.

**Senator McLUCAS**—Can you answer it this way: how many relate to staffing levels? I am just picking an issue out of the air.

**Ms Smith**—I do not think I could give you a precise figure based on the information I have at the moment.

**Senator McLUCAS**—I am trying to ask a question that will elicit what the department is requiring people to do.

**Ms Smith**—In terms of the commonly reported issues, they are: health and personal care, the physical environment, consultation and communication, medication management and choice and dignity. So they are the five most commonly reported issues.

**Senator McLUCAS**—And they are in order of frequency?

**Ms Smith**—That is in order, yes.

**Senator McLUCAS**—In terms of the notices of required action, given those same headings, is it possible to give me a feel for what the department has required people to do following those investigations?

**Ms Smith**—The notices of required action are in relation to a specific complaint and I do not have with me that level of detail that would enable me to give you a broadbrush view, but we could take that on notice and see what we can provide.

**Senator McLUCAS**—Thank you. I think you know what I am looking for. I do not want to know that you have asked that facility to do that thing; it is a general thing. How is the complainant informed of the result of the investigation?

**Ms Smith**—The aim of the scheme is to keep the complainant and the approved provider informed throughout the course of the investigation. So there are both phone calls and written correspondence that indicate to the person how their complaint has been dealt with and what the outcome is.

**Senator McLUCAS**—Within what time frame?

**Ms Scheetz**—We do not have legislated time frames. We certainly write at certain points. When a complaint is finalised or when there is key information to provide to complainants, we will do it as soon as possible once decisions are made.

**Senator McLUCAS**—When you have undertaken a visit, whether it be an unannounced visit or not, how do you explain to the provider what you have come to have a look at? Do you give the provider an understanding of the nature of the complaint?

**Ms Scheetz**—It depends on whether the complainant has asked for a confidential or an anonymous investigation to be done. So it will depend whether we are at liberty to disclose specifically what we are looking at in relation to the complainant. Where it is an open complaint we will talk to the provider about what the issue is and how we propose to undertake the investigation. Obviously, it can involve talking to staff or talking to the provider, the residents of course, and potentially their families. So it certainly will depend on the nature of the complaint.

**Senator McLUCAS**—Once an investigation has occurred and a finding has been made, how do you communicate that back to the provider?

**Ms Scheetz**—If there is a breach we would provide the notice of required action. There is scope within our arrangements for conciliated outcomes. Obviously, the provider would be part of that solution, so they will be aware of what is happening and we will write at the end of that to confirm what the agreement is between the parties.

**Senator McLUCAS**—What is the time frame between conclusion of the investigation and reporting back to the provider about the result?

**Ms Scheetz**—We will advise the provider as soon as we can of the decision, in the way that we do with the complainants.

**Senator McLUCAS**—How many conciliated outcomes have you had?

**Ms Smith**—We do not have that information with us. We can take it on notice—bearing in mind there has only been one month since the scheme started.

**Senator McLUCAS**—Yes. But there have been 441 investigations completed. I wonder if you have this information: in how many have you found that the complaint has no base?

**Ms Smith**—Sometimes what these complaints end up being is a genuine misunderstanding or lack of communication between the resident or their family and the provider. Sometimes—

**Senator McLUCAS**—Having no base was the wrong language. How many have you found are able to be resolved with a bit of clarification of the position of both the complainant and the provider?

**Ms Smith**—I do not have that level of detail with me as to the reason for finalisation without going to an NRA, but we can endeavour to check that for you.

**Senator McLUCAS**—Okay, can you provide some breakdown on that. I do not want to know what the complaint was about, but I want to know whether or not it could be resolved quickly because of a misunderstanding. There are 12 NRAs and then there might be some others that have been able to be conciliated. Do you accept all complaints?

**Ms Smith**—We accept all complaints that are within scope. Sometimes people will call the aged care complaints investigation line with something that is actually a guardianship issue, for example, that is outside the department's power to do anything about. We also have the capacity to not take an investigation forward on various grounds. Those grounds include where matters are the subject of legal proceedings, where it has previously been the subject of investigation or where it is frivolous and vexatious. There may be one or two other criteria. So the general thesis is that we will accept all complaints within scope.

**Senator McLUCAS**—And some will be found to be frivolous and vexatious in the process of the investigation?

**Ms Smith**—That is correct.

**Senator McLUCAS**—What is the feel for how that is travelling?

**Ms Scheetz**—We do not have any sense of that.

**Senator McLUCAS**—Do your officers undertake spot checks? The language is different—it is an 'unannounced visit'.

**Ms Smith**—Our complaints investigation officers are authorised officers under the aged care act and they are able to make unannounced visits to facilities.

**Senator McLUCAS**—I think you will recall that this committee, in the legislation report, did not recommend a time for a formal review of the operation of the new program because the minister indicated that review would begin as soon as it started. I know we are only a month down the track, but how is that commitment for ongoing monitoring and review put into practice?

**Ms Smith**—There was a new database to support the new scheme which is yielding good information about the sorts of cases that we are getting and how they are being resolved. Those statistics are being looked at on a state and territory office level in terms of their own calls and then at the central office level we are having a very close look at it. We only have 28 days worth of figures thus far, but certainly it is something that Ms Scheetz and I are keeping a very close watch on. We have a capacity within central office to monitor on an individual case level what is occurring in each of our state and territory offices and we also have a group that will be trying to do more proactive and strategic work looking at our figures to identify trends.

**Senator McLUCAS**—So you have established a group that meets regularly?

**Ms Smith**—We have established a group of staff within the office, one of whose central functions is to look at the data we are getting and try to identify trends.

**Senator McLUCAS**—It is more about the monitoring of the operation, not what is occurring. Are there systems in place that ensure that the objectives of the changes are going to be achieved? Will that group have that role as well?

**Ms Smith**—That group will have that role. We are getting together all of our state officers who manage this program. We have a meeting scheduled of that group next week and one of the things we will be discussing with them is what sort of evaluation framework we need to put in place to ensure that we can keep an eye on this as it goes forward.

**Senator McLUCAS**—How many complaints have been received about the office procedures to this point?

**Ms Smith**—I am not aware that any complaints have been received thus far, but I can check that with the Aged Care Commissioner. None have come to my attention as having been received.

**Senator McLUCAS**—I may have phrased that wrongly: complaints about the way investigations have proceeded—if you can find out for me if complaints have been registered.

**Ms Smith**—None have been brought to my attention.

**Senator McLUCAS**—People have until the end of the financial year to have either achieved or shown evidence that they are going to receive police checks.

**Ms Smith**—The dates are that from 1 March 2007 new staff and volunteers had to have police checks. Existing staff have to have had a police check or have lodged an application with police by 1 June 2007 and all existing volunteers have to have had a police check or lodged an application by 1 September 2007.

**Senator McLUCAS**—And you are monitoring those dates and the roll-out of those deadlines?

**Ms Smith**—Yes, and then by 30 September all approved providers have to submit a declaration to the department that they have met the police check requirements.

**Senator McLUCAS**—So from your information you think staff and volunteers will achieve those deadlines?

**Ms Smith**—That is our understanding, yes.

**Senator McLUCAS**—Have you had any conversations with state police forces about their ability to deal with the numbers of applications they must be receiving?

**Ms Smith**—Our state and territory offices have been meeting with the relevant police services in their jurisdiction. That has been occurring for a few months now both in relation to the police check requirement and also in relation to the compulsory reporting requirement. Those discussions have been going well. We have not had any information that there are going to be huge issues from a police perspective in processing those checks.

**Senator McLUCAS**—Do you also have any feel for how many aged care providers have required their existing staff to pay themselves for a police check?

**Ms Smith**—My impression, based on discussion with providers, is that in the large majority of cases providers are meeting the cost for existing staff.

**Senator McLUCAS**—But not all.

**Ms Smith**—I could not tell you whether that is the case in 100 per cent of situations, but that is the impression I have; that it is the vast majority.

**Senator McLUCAS**—But you would have had complaints from aged care workers—

**Ms Smith**—We have not had large numbers of complaints from aged care workers, no.

**Senator McLUCAS**—That is the end of that area. Can I go to the inquiry conducted by Minister Pyne into the allocation of bed licences in the south coast aged care planning region?

**Ms Halton**—When we find the relevant officers, we can.

**Senator McLUCAS**—Why was the focus of the review to 'elements of the decision that went to the relative merits of two applicants' Superior Care and Lifestyle Care rather than what I thought the review would look at—that is, the compliance of the process with the outcome which was to provide the bed licences to Superior Care?

**Mr Stuart**—I should just qualify before I answer that question by saying that I was, amongst others, a subject of that review rather than the author of it and, therefore, a witness to that review. I think the context there was that it had appeared in the public arena that this was a story of two houses, of two providers, in a particular place and that the kind of public presentation of the story appeared to be that there was one provider who was bed-ready and had missed out and another provider who had obtained places, and there were allegations of impropriety about that. So, from the way that it had been presented in the public arena, it did appear to be a story about those two providers.

**Senator McLUCAS**—But there were other applicants for those bed licences.

**Mr Stuart**—There were 14 applicants in that region.

**Senator McLUCAS**—But they were not the subject of the review either. The joining of Lifestyle Care into this review was as a result of media attention rather than due process.

**Mr Stuart**—No, I think—

**Senator McLUCAS**—I know this is quite hard for you to answer, Mr Stuart, because, as you said, you were one of the subjects of the inquiry as well.

**Mr Stuart**—That is right.

**Ms Murnane**—I can answer that. The first media attention on this issue in Queensland was very early this year. When I read about it—which was the first time we knew there was an issue—I spoke to the head of the Queensland office, to the relevant branch head and to Mr Stuart. I also spoke to the minister's office and I assured myself that there was no impropriety. Following that, there was a lapse of quite a lot of time and then it became a very large issue again, and it was then that it was clear that a much deeper probe was going to be required. However, it is not true to say that the first time this came to our attention, when it was not really significant—you could have missed it if were you just a casual reader of the press at that stage—that it was of no interest to us. It was of interest to us and it was something I followed up on at the time, but not to the extent that it was later followed up on when it became a very large issue indeed.

**Senator McLUCAS**—I was going to the framing of the report, Ms Murnane. Who wrote the report? Who did the investigation?

**Ms Murnane**—The investigation was done by David Learmonth, the Deputy Secretary of the department.

**Senator McLUCAS**—Whose decision was it not to interview the former minister and Mr Egan?

**Mr Learmonth**—It was my decision.

**Senator McLUCAS**—On what basis did you make that decision?

**Mr Learmonth**—One of the issues at question was whether there was any undue influence in relation to that planning round placed on the officers whose conducted it. There are essentially two groups of parties here: those who conducted the round within the department, and the conduct of the round falls solely within the province of the department and its officers; and the person or persons who may have attempted to influence that, whether it had been consistent with the then allegation against Minister Santoro or conceivably any agent on his behalf. The approach I took was essentially a logical one which said that, if I identify every person who had any material role whatsoever in determining the application and making the recommendations and I determined from each and every one of them that there was no influence by anybody, I have categorically and necessarily therefore ruled out influence. There is thus no need to try and speculate or identify who and on what basis they may have attempted to influence that process. I spoke to everyone and ruled it out.

**Senator McLUCAS**—Did you speak to departmental officers in the Queensland office?

**Mr Learmonth**—More than that. One of the first things I did was to identify each and every officer throughout the entire chain of assessment, quality assurance, recommendation and decision making in connection with these applications and speak to each and every one of them personally.

**Senator McLUCAS**—Thank you for that. There is a conflict between the review which states that applications were ranked and short-listed by virtue of scores applied to each criterion and estimates from February when, Mr Stuart, you and I and Ms Rosevear was speaking where Ms Rosevear said:

We do not actually add up the numbers.

And you said, Mr Stuart:

To allocate a numerical system across all criteria would seem to suggest that it is okay to be very strong in some areas but very poor in others as long as your overall score is okay. We do not use that kind of a system.

What system do we use?

**Mr Stuart**—Both of those statements are true. We have a system in which we rank every applicant against every criterion that is relevant. There are, from memory, 13 criteria and we score each of those criteria on a five-point scale from very good to poor. But what we do not do is add up 13 lots of five numbers and produce a digit at the end and say, 'That is the answer then'. What we do is apply judgement to the balance of those scores and ask ourselves what is really important. I think the point I was trying to make in February and still hold to strongly is that, if particular providers disqualify themselves by being very poor in relation to one or two criteria, they should not be recommended for aged-care places because they score well in other areas. So we are looking for overall solid performance rather than a balanced figure at the end of a computation process.

**Senator McLUCAS**—There seems to be a conflict between the evidence given to estimates and the statement in your report.

**Mr Learmonth**—I am unfamiliar with the evidence given to estimates in this respect, I am sorry.

**Senator McLUCAS**—I will just read it out. The conflict is, seemingly, that in your report it says:

Applicants were ranked and shortlisted by virtue of scores applied to each criterion—

and then, as Mr Stuart has reconfirmed, there is a ranking system but you do not add up 13 lots of five numbers to come up with an answer. There seems to be a conflict between your comment and what Mr Stuart is saying.

**Mr Learmonth**—Perhaps if I read from other sections of my report, I think it resolves that conflict. I say, 'Applications are scored against each relevant criterion using a rating on a one to five scale. The points are not aggregated on a strict algorithm, not least because not all criteria are relevant to each application. For example, an applicant might not need to restructure its model of service to improve viability and would not need to address this criterion. Rather, in comparing applications against others in a region, assessors look at the strength of the ratings across all criteria relative to the other applicants. I go on to say, 'All of the criteria are important and must be addressed' and I quote from a section of the *Aged Care Approvals Round Essential Guide* and say:

There is no guarantee of success in the Round because one of the legislative provisions or one of the key issues, (for example, 'bed readiness'), is well addressed. All applicants will need to address all of the relevant provisions and all of the relevant key issues.

So it is a balancing judgement having regard to the circumstances. Not all of the criteria are relevant to each application therefore you simply cannot use an algorithmic formula like approach.

**Senator McLUCAS**—I want to go not so much to the report now but the assessment of the application by Superior Care and what was undertaken in that assessment. Was council zoning information included in Superior Care's application for bed licences?

**Ms Rosevear**—Yes, the application stated that the land was multizoned and that the provider had an option over the land so that was taken into consideration.

**Senator McLUCAS**—So you received advice that the land was multizoned. Do you assess what that means or do you just take that at face value.

**Ms Rosevear**—The Queensland office who assess applications know what the zoning requirements mean within the various planning regions. In relation to the Gold Coast, it does not exclude its use for aged care but there does need to be an impact statement, so the Queensland office was aware of that.

**Senator McLUCAS**—Did they make contact with the Gold Coast City Council and make an assessment of the planning instrument over that land?

**Ms Rosevear**—I do not know the answer to that question.

**Senator McLUCAS**—Can you find out please?

**Ms Rosevear**—Yes.

**Ms Rosevear**—You say aged care is an allowed development in that area; my contact with the Gold Coast City Council did not indicate that.

**Ms Rosevear**—What that multizoning means is that it does not exclude it; it requires an impact assessment in order to do that. In that particular area, I think there are another three aged-care services and one only 850—

**Senator McLUCAS**—Are they all under the planning instrument that this particular block of land is in?

**Ms Rosevear**—They were all multizoned at the beginning of the process.

**Senator McLUCAS**—There is a particular planning instrument over this particular block of land; are you aware of that?

**Ms Rosevear**—No, I am not but I can take your question.

**Senator McLUCAS**—We do not have a prescriptive town planning system in Queensland, so you are quite correct to say that it was not an excluded development but it is not a preferred development under the planning instrument in operation there. Did the officers assessing the application know that when they made the decision?

**Ms Rosevear**—I would have to check with the officer in question.

**Mr Stuart**—Our understanding is that they did. Our understanding is that the Queensland office do understand what the zoning requirements are in Queensland.

**Senator McLUCAS**—Yes. There is a particular planning instrument in this area because of the flood-prone nature of the area. Did they realise that there was this instrument—I forget the name of it—in place over the land that was being assessed?

**Mr Stuart**—We will have to check that particular issue.

**Senator McLUCAS**—Did the officers assessing that particular application ask Mr Egan if he had had a prelodgement meeting with the Gold Coast City Council?

**Mr Stuart**—Again, I am not aware of that at the table today.

**Senator McLUCAS**—Is it the normal course of action for officers, particularly in Queensland, where that is the process, to have a prelodgement meeting and ask applicants that question?

**Mr Stuart**—The consideration process we go through for the allocation of places is comparative. I think that, as we explained at the February hearings, we do not often find it necessary to conduct research about individual applicants—I mean further research beyond the information which is provided as part of the application. My understanding is that Superior Care provided a range of information which was unexceptional.

**Senator McLUCAS**—I am sorry—it was—

**Mr Stuart**—It was unexceptional—not unusual—and was considered on that basis.

**Senator McLUCAS**—That is my concern. It is a multizoned piece of land that is unexceptional. That is reasonable. The question I am asking is: what did the officer assessing the application do to ascertain whether or not there was something that should have been revealed by that information?

**Ms Murnane**—That is not something we can go into.

**Senator McLUCAS**—Why not? Why can't you ring the Gold Coast City Council and ask them whether an aged care facility could be constructed at this particular site?

**Ms Murnane**—What we rely on is the application being in an area consistent with our planning framework—which it was—and the person who gets the in-principle approval then has two years to execute that approval—that is, to have an aged care home in place. Where that aged care home is exactly is not something that we are required to consider in the approval.

**Senator McLUCAS**—You require the application to be linked to an address.

**Ms Murnane**—It is linked to an address, which is the address of the person who is applying. We do not require the application to be on a particular piece of land that is zoned in a particular way.

**Senator McLUCAS**—My understanding is that you do.

**Mr Stuart**—No. The applications we get range very widely in terms of how far progressed they are. Aged care providers understand that there is an advantage in being relatively bed ready because it is relevant in relation to a particular criterion. But that is only one criterion of the 13. We get applications from providers that range from expressing an intention that after places are allocated they will start looking for land to established buildings on established sites.

**Senator McLUCAS**—I am sorry, Ms Murnane, you are correct. My confusion there is that most do have an address attached to the application.

**Ms Murnane**—I would not say it was most, actually.

**Ms Halton**—No, I would not either. It would not be my experience.

**Mr Learmonth**—This is a real balancing of risk on both sides. There are applications that come from those with no land all the way up to those who have an operating facility and everything in between of some land, an option over land, various levels of planning approval—

**Ms Halton**—And an idea of where it might be.

**Senator McLUCAS**—If we are trying to get something in Builyan, I do not really care where.

**Ms Halton**—Precisely.

**Senator McLUCAS**—I do not want to know what street number in Builyan.

**Ms Halton**—Precisely.

**Senator McLUCAS**—But, if you are in the Gold Coast, where it is highly competitive, and bed readiness is one of the criteria then I would expect that the department would take some steps to find out, given the highly competitive nature of this process, whether or not what is written on that bit of paper in the application form is in fact true. My suggestion is that we do not do that—or certainly we do not do it well enough.

**Ms Murnane**—Bed readiness was considered. It is not a compulsory criteria. If bed readiness as well as all of the other criteria come together, that is a very good thing. However, you have to consider here the assessments that were done not only of that application but also of the competing applications. The application of the successful applicant was found against all of the criteria to be taken in a balanced way to be the application that was considered the best at the time. That is what Mr Learmonth review was doing—it was looking at that process.

**Mr Learmonth**—Senator, your comments underscore an inherent tension here in that it is a very competitive area and that the risk for potential providers and applicants is that the further along they move from the continuum of having no land through to an operating facility is the extent to which they bear risk that they will have invested but will get no return on that, because they are unsuccessful. As you say, the Gold Coast is highly competitive. It is unsurprising therefore that different providers in different regions will make judgements about their own risk in this regarding how much investment they will make and how much up-front money they will put at risk—essentially on spec, because there is no guarantee that they will be successful at the other end. The department is very experienced in being able to judge that. Amongst the criteria, the providers, as well as the department, know that this is a balancing exercise—that the further they make an investment up front and move themselves down that continuum, the better they will score on bed readiness compared to others but the more money they will have at risk because there is no guarantee of the process. Wherever they score on bed readiness, all of the other criteria matter as well.

**Senator McLUCAS**—You are right about risk. The risk that the elderly people on the Gold Coast have is that the government makes an assessment that they will allocate it to that provider who cannot deliver the beds in two years. That is the alternative side of that risk.

**Mr Learmonth**—There are numbers of risks. There are any number of risks that can materialise in this. There are providers that might look good in a range of respects, but their financial underpinning might be such that it would put the residents' continuity of care et cetera at risk in due course. There are a number of risks to be balanced in this regard.

**Senator McLUCAS**—How has Mr Egan progressed in his delivery of those residential aged-care beds?

**Ms Rosevear**—At the time of the application, Superior Care said they planned to make the places operational in 18 to 24 months, they held a secure option over the land and they had contracts for sale for the properties on which it was proposed to construct the service. They had experience in bringing new services online twice before, because they had built two new services. That was the basis on which the department was quite comfortable that they were able to make the places operational and online. I have no information at this time as to what steps they have taken but we can certainly look into that.

**Senator McLUCAS**—Do you usually monitor that?

**Ms Rosevear**—Yes, we do. We require a quarterly report on how provisional allocations are going.

**Senator McLUCAS**—Have we had a quarterly report from Mr Egan yet?

**Ms Rosevear**—I am not certain but I can check that for you.

**Senator McLUCAS**—That would be good. If we could find that out after lunch, that would be helpful. That report would have been due in about March?

**Ms Rosevear**—Yes, I will check with the Queensland office.

**Senator McLUCAS**—Thank you. I would like to go now to the allocation of 15 low-care bed licences in the 2005 allocation round for the far north coast aged-care planning region in New South Wales to Ex-Services Home, Ballina at Currajong Street, Evans Head. Are you aware of that allocation?

**Mr Stuart**—Yes, we are aware of that one.

**Senator McLUCAS**—Are you aware that it is contaminated land?

**Mr Stuart**—We are now aware that it is contaminated land, yes.

**Senator McLUCAS**—You are now aware. You did not know when you approved those bed licences?

**Mr Stuart**—No. The circumstances with that allocation are complex and interesting. A lot was learned after the allocation was made. Essentially, the Ex-Services Home, Ballina was allocated low-care places in the 2005 round for a facility to be located at Evans Head. The site was owned by the Richmond Valley Council, and the Ex-Services Home had been negotiating with them. The Richmond Valley Council identified a site. That site then became unavailable. The Richmond Valley Council then identified this site.

**Senator McLUCAS**—Can you just step back again. The first allocation was when?

**Mr Stuart**—In 2005.

**Senator McLUCAS**—I thought there was a previous allocation.

**Mr Stuart**—No.

**Ms Rosevear**—There were two allocations to the ex-servicemen's home. There were 40 places allocated in 2001 and a further 15 in 2005.

**Senator McLUCAS**—Have they been constructed?

**Ms Rosevear**—No, and the issues are with respect to land. The first site was crown land, which the council and, I believe, the Aboriginal organisation were comfortable with being used for an aged-care service, but down the track it was determined to be a site of environmental significance and therefore was not able to be used. The council and the provider then located a second site. The second site, also on crown land, was later discovered not to be able to be used because of native title issues that they could not resolve.

**Senator McLUCAS**—These are the 40 beds that were originally allocated in 2001. They have tried twice to find a block of land for them to go on?

**Ms Rosevear**—There is not a large amount of land available in the area and they have been working very closely with the council to try and find an appropriate site to build a new service. The council then, in combination with the New South Wales Heritage Office, prepared a plan of management over the third site. They requested a consultant to prepare this document because they proposed to use it for residential aged-care services and retirement village purposes. That plan of management was endorsed by both the council and the New South Wales Heritage Council, but later on they commissioned a contaminated site investigation and that is when the problem of the contaminated site presented. That was made known to the council in November 2006.

**Senator McLUCAS**—And the 15 that were allocated in 2005 were allocated to the contaminated land?

**Ms Rosevear**—They were allocated in respect of the same service that got the original 40 allocations, so it became 55 places on a site that was identified by the Richmond Valley Council as one that could be used to build this, but then it turned out they were not able to.

**Senator McLUCAS**—When the department assessed that application, was any assessment done of the land that was proposed to be used?

**Mr Stuart**—At the time that the allocation was made there was an endorsed plan of management for the relevant land, with council sign-off and council involvement, and involvement by the New South Wales Heritage Council.

**Senator McLUCAS**—This is for the aerodrome land that is contaminated?

**Mr Stuart**—That is correct.

**Senator McLUCAS**—So you knew that you were allocating to contaminated land?

**Mr Stuart**—No. What I am saying to you is that the department allocated 15 places in respect of an aged-care service that was going to be built on land and that that construction had the active involvement and support of both the Richmond Valley Council and the New South Wales Heritage Council. Even if the department had rung the council and said, 'Is this land okay?'—the council was obviously involved in the entire process.

**Senator McLUCAS**—So even councils make mistakes.

**Mr Stuart**—I think that there are things that sometimes emerge in the process of getting ready to build that cannot be foreseen.

**Senator McLUCAS**—I think with a former Defence Force airstrip you would be reasonably assured that it might have a few problems.

**Mr Stuart**—I understand that there is a thought there might be unexploded ordnance on this ex-airfield and I do not quite understand myself why there would be unexploded ordnance on an airfield.

**Senator McLUCAS**—The report says, 'They dropped them'.

**Mr Stuart**—It might pose a danger to shipping.

**Ms Halton**—Unless it was a bombing run, you would not expect there to be unexploded ordnance on it.

**Senator McLUCAS**—The Richmond Valley Council contamination site investigation says that there is a minor potential for explosive ordnance—that is, bombs—including pyrotechnics to be present as a result of RAAF activities. I do not know that that is an appropriate place to put our vulnerable elderly people.

**Mr Stuart**—Indeed, and there is a process of reconsideration, I imagine, about the siting of this aged-care service. In this particular case, we are very pleased with the involvement of the local council, which would normally give us a faster pathway to construction. In this particular case there have been a series of obstacles that have emerged about particular sites that have been chosen.

**Ms Halton**—Let us be clear about this. An allocation was made in respect of a piece of land identified by the council as suitable. It was not made to a piece of land potentially contaminated by unexploded ordnance and pyrotechnics. That was never a feature of the allocation. I would not want this misinterpreted or misreported. I can see the headline now. The truth of the matter is that this came to light afterwards and the council was obviously as surprised about it as we were, probably more so.

**Senator McLUCAS**—I think it would be fairly expected that a former RAAF army base would have heavy metal contamination and would have contamination from fuel spills. These are fairly predictable things—that land that has been used in this way will not be pristine. In fact, we now know that the Department of Defence is having to pay for the clean-up.

**Senator Patterson**—But the nursing home is not going to be built there, so why is it an issue now?

**Senator McLUCAS**—That is the issue. The nursing home may be built there, but my question is: when? If we are talking about bed readiness—we had an allocation of 40 beds in 2001 and another allocation of 15 beds in 2005 and there are over 400 beds in that region undersupplied—I cannot see a time when this facility will be built. Bed readiness means two years.

**Ms Halton**—And there is a separate question here, which you are quite right to ask. Allocation was made on a certain basis and there were legitimate reasons why that did not

happen at the time, at what point is the decision taken to reallocate to somebody else? That is a fair question to ask.

**Senator McLUCAS**—I am not advocating reallocation. I am sure that the ex-service home provider is trying very hard to achieve an outcome.

**Ms Halton**—Absolutely.

**Senator McLUCAS**—But for the department to be allocating beds to a former RAAF-Army base I think means that our processes of assessment need a bit of tightening up.

**Senator Patterson**—Rubbish.

**Senator McLUCAS**—It is not rubbish.

**Senator Patterson**—Absolute rubbish.

**Ms Murnane**—You are asking a lot of this process, and I think you paralyse this process if we have to make up our minds about every piece of land that is nominated. When a piece of land is nominated it may not end up the final piece of land. If we were to require each and every applicant to have approval before they applied, that would involve them moving up the investment chain.

**Senator McLUCAS**—I am not suggesting that by any stretch. When the former minister made that allegation it was absolutely untrue. I am suggesting that, when making the decision about providing beds to a particular applicant, one telephone call to the local council on the Gold Coast—admittedly, in this case they would have said, 'Yes, please support their application'—would have identified potential problems with the allocation of beds to that particular lot of land.

**Ms Halton**—Okay. But let us go back to that issue because this is germane to the whole argument. Your essential point, therefore, is that the relative position of that provider would have changed vis-a-vis—this is, Gold Coast—other providers. I do not think actually that case has been made.

**Senator McLUCAS**—I am not trying to make that point at all.

**Ms Halton**—So I do not understand the point that you are making.

**Senator McLUCAS**—What I am trying to say is that, once all of those processes Mr Learmonth has described have been gone through and a decision is made to give it to an applicant, one further step should be there—that is, to make an assessment whether the veracity of the claim in the application can be upheld: can an aged-care facility be built on the land that this applicant is saying it will be built on?

**Ms Murnane**—Whether that question was material would depend on the weighting on which that piece of land was.

**Senator McLUCAS**—No, I am making a different point, I am making a separate point.

**Ms Murnane**—If our staff started to get involved in this, we would not be able to bring the rounds to a conclusion in a timely way, that people expect.

**Mr Learmonth**—I also wonder what they might have been told if they had rung.

**Senator McLUCAS**—Let me tell you what I was told when I rang. I rang up Gold Coast City Council and asked to speak to the planning department. I asked about the lot that Mr Egan has an option over, 'Can an aged care facility be built there?' The answer was 'Probably not, under the planning instrument'. If your staff had done that, that would have set off an alarm bell.

**Ms Murnane**—I do not agree with that. My understanding of local council processes—and they are all different—is that the view of a local council bureaucrat might not necessarily prevail anyway. If we were to make a decision on that basis and documented it, we could be challenged under the act for taking into account matters that were not material to the decision.

**Senator McLUCAS**—So that means, if you extend, that you can write anything in your application in terms of what may or may not be built on a block of land because you won't check it.

**Mr Stuart**—We look at the documentary evidence.

**Senator McLUCAS**—The documentary evidence provided with Mr Egan's application did not indicate, on my understanding, that an aged care facility could be built on that lot of land.

**Mr Stuart**—We are having two interwoven discussions. We are having one discussion about an issue of principle. On the issue of principle we are indicating to you that it is not possible for the department to second-guess every applicant's position in relation to land or to undertake our own due diligence investigation in relation to land. It would be prohibitive in respect of resources and timetable. The other issue is a question of fact as to the exact issues in relation to a particular block of land in Queensland. We have undertaken to come back to you after lunch and tell you about progress on that particular block.

**Senator McLUCAS**—Queensland's planning instruments, the integrated planning act—I forget the terminology—is not a yes or no; everything has to be assessed.

**Ms Murnane**—Yes, I understand that.

**Senator McLUCAS**—It is different to, say, the New South Wales planning act. So you are right. You cannot ring up and say what is an approved use and a non-approved use. The planning instrument does indicate what will probably be approved and what will probably not be approved. The planning instrument over that land does not identify aged care.

**Ms Murnane**—If on every other criteria this proposal was coming up and we were to document that as the reason to knock it off, we could be challenged because we would be taking one person's view over the phone—I am not saying it will. There are certainly reasonable grounds to believe that other people in that planning office could have a different view.

**Senator McLUCAS**—No, it is a matter of reading the instrument, Ms Murnane, It is not making the judgement, it is reading the instrument and explaining to the non-planner what it means.

**Ms Murnane**—As I have said many times, you are assuming that this was the tilting point, that this was the most important thing.

**Senator McLUCAS**—If you do not get the beds it is a bit of a tilting point. Are we going to get these beds in two years? That is the question.

**Ms Halton**—Let's look at this another way. There are some things with every application that are absolutely Yes/No buttons. If you do not get a yes on it, you are out.

**Senator McLUCAS**—If you do not have financial stability and strength you should be out.

**Ms Halton**—Exactly. So there are certain criteria in looking at any of these applications where basically if you do not get a tick in the box you are instantly discarded. Assuming you get a tick in every box, then it is a question of relativities.

In terms of the relativities, the question of bed-readiness is one of the distinguishing criteria, but bed-readiness comprises a number of things, one of which is: have you got a track record and do we know that you have pulled this off before? Ultimately, having experience suggests that you will be able to do it again. As has already been said, there is a graduation in terms of bed-readiness. You can say, 'I have an existing building and I can move people in tomorrow' through to Biloela—a five-point scale. The issue, when they assess each application, is which of these things is dropped dead and which of these things has verification and which of these things will turn the outcome of the process. The point that is being made here is that that block of land would not, as I understand it, have turned this application. You have suggested that the department should ring and check. Ms Murnane is absolutely correct—to take a suggestion over a telephone from a planning officer and then disregard what has been said would be open to challenge.

**Senator McLUCAS**—I am not suggesting that you disregard it. I am suggesting that alarm bells may have been rung.

**Ms Halton**—You check the things that will turn the application from a yes to a no or a no to a yes. In this case, as I understand the process, with the assessment and the relative ranking of all of these, this was not the turning factor. Even if this application had had no specific block, because they have a track record in delivery they would still have scored in respect of having relative capability to deliver inside the two years.

**Proceedings suspended from 12.41 pm to 1.46 pm**

**CHAIR**—The committee resumes its consideration of Health and Ageing. We are continuing with outcome 4. Have we got more on the exploding nursing homes issue to explore, Senator McLucas?

**Senator McLUCAS**—Someone said to me 'a room with a boom', but I cannot claim that phrase. No, I have no more to ask about it.

**Ms Halton**—We had bad puns on this side last night and now we have bad puns on that side!

**Senator McLUCAS**—Mr Stuart, you might have some information for us.

**Mr Stuart**—I do. I have some information to come back to you with. On the info line, the source of funding is administered not departmentally. It comes from a source called Aged Care Program Support, which is an administered source. The estimated 2006-07 expenditure

is $1 million, and to date we have had 85,000 calls for the year. So we expect to finish at about 95,000 calls for the year.

**Senator McLUCAS**—Sorry, the allocation for 2006-07 was $1 million?

**Mr Stuart**—One million.

**Senator McLUCAS**—And that is administered money?

**Mr Stuart**—It is administered money from a source called Aged Care Program Support, which is a very small but somewhat flexible funding source.

**Senator McLUCAS**—Thank you.

**Mr Stuart**—Senator, I just want to backtrack on a couple of things quickly. The total departmental funding for strengthening community care quality is $5 million. This includes $300,000 in capital. We told you, I believe, $4.7 million. That was not including the capital component. So the total is $5 million for 2007-08.

**Senator McLUCAS**—Sorry, Mr Stuart, can you remind me of the program again?

**Mr Stuart**—This was the community care quality measure.

**Senator McLUCAS**—Okay.

**Mr Stuart**—And we were talking about the first year, 2007-08. I told you that the total was $4.7 million. The total is $5 million. The $4.7 million is departmental related staffing costs and the additional $0.3 million is in capital for fit-out.

There is another issue I can tell you more about. This is in relation to the undergraduate scholarship scheme and postgraduate scheme. So far we are advised that 195 undergraduates and 185 postgraduates have completed their studies. I am also told that the new contract with the Royal College of Nursing stipulates that they will track the graduates for 18 months after graduation.

**Senator McLUCAS**—So, of those 195, we do not know how they are being employed?

**Mr Stuart**—We do not know where they have gone. They were subject to the old contract. In the new contract for those who are now going through their studies, we have asked the College of Nursing to track them for 18 months to ascertain where they go, but of course we do not have that data yet.

**Senator McLUCAS**—When does the new contract come into force?

**Mr Stuart**—My note says February 2007.

**Senator McLUCAS**—So it has just been renegotiated. How will the college do that, Mr Stuart?

**Mr Stuart**—We are asking them to remain in touch with the students who have gone through the scholarship places.

**Senator McLUCAS**—And that cannot be retrospective for currently enrolled students. So it is only those who are enrolled this year.

**Mr Stuart**—It is for the period of the contract and will apply to all of those who graduate from now.

**Senator McLUCAS**—So at the end of this year we will be able to start tracking whether or not these people go into aged care?

**Mr Stuart**—That is right.

**Senator McLUCAS**—There is no compulsion for them to go into aged care if they have had an undergraduate aged-care scholarship?

**Mr Stuart**—We do select the scholarship students on the basis of their interest in aged care.

**Senator McLUCAS**—Sure, but there is no compulsion.

**Mr Stuart**—There is no compulsion. We have also had a look at the first quarterly report in relation to Superior Care and the block of land in south-east Queensland. The quarterly report contains information which is obtained under the Aged Care Act and is therefore protected information. But I would like to be helpful, so what I think I should tell you is that the provider is on track to deliver in accordance with the time lines that were set out in their application and which we expect them to meet.

**Senator McLUCAS**—That is all you can tell me?

**Mr Stuart**—I think so.

**Senator McLUCAS**—That is all we had outstanding. Can I go to the 151 unallocated aged-care bed licences in the 2006 aged-care approvals round. I think you have told us before that a number of aged-care beds are kept back in each round so that things that happen can be fixed up as they come along. That is my shorthand.

**Ms Rosevear**—The 151 places in this case were allocations that were recommended, so they were recommended to the delegate at the same time as all the other places were but could not be allocated because approved provider applications had not been finalised. At the time that the minister wrote to the successful applicants and the department wrote to the unsuccessful applicants, on the same day we wrote to five or six applicants to say that a decision on their application had been deferred pending resolution of their provider status.

**Senator McLUCAS**—Were those five or six made public? The approval of beds to those—

**Mr Stuart**—No, Senator, we cannot make that public. The way it works is like this: the providers often lodge applications for approved provider status or changes in approved provider status at the same time as they lodge their application for places. The act provides certain amounts of time for the department to consider those applications for approved provider status and for us to go back and clarify information with the applicant and then for the applicant to submit further information. Sometimes, although we try to do our best to have these processes coincide, we are in a position where we are ready to announce the allocation of places ahead of having completed all of the considerations on approved provider applications. That is what happened with some providers in relation to these 150-odd places.

We have not actually made an allocation to those providers. We are not legally entitled to make an allocation or to announce it because we cannot make an allocation to someone who is not an approved provider for that particular kind of care. So we have to defer both the

actual allocation and the announcement of the allocation until we have concluded the approved provider checks. It may be when we complete the approved provider checks that they are all fine and we can allocate places to them. It may also be that one or two are perhaps not fine and we cannot allocate places to them, so we could not announce them at the same time as the balance of the round.

**Senator McLUCAS**—I understand that you cannot announce them at the same time that everyone else was announced, but subsequent to that, once approved provider status has been determined, is there a point where you announce the subsequent set of approved allocations?

**Mr Stuart**—Yes. We generally wait until they are all concluded and then we sweep them all up together and add them to the website and the minister then writes to the successful applicants.

**Senator McLUCAS**—And that has not happened yet?

**Mr Stuart**—No, it has been completed in respect of all of those places.

**Senator McLUCAS**—I have not found that on the website, so who were the successful applicants for those 151 beds?

**Ms Rosevear**—The website was updated about six weeks ago to include the following providers. There is the Spanish Latin American Welfare Centre in Victoria, which received 15 Community Aged Care Packages and a community care grant of $35,000. There is the Independent Health Care Service Pty Ltd in Tasmania, which received 13 EACH dementia packages. Homewood Care Pty Ltd in Sydney received 36 residential aged-care places. Huon Eldercare in Tasmania received two EACH dementia packages. Varsity Aged Care in Queensland received 70 residential aged-care places and ACC Services in Tasmania received 15 community aged-care places.

**Senator McLUCAS**—Fifteen?

**Ms Rosevear**—Fifteen, yes.

**Senator McLUCAS**—CACPs?

**Ms Rosevear**—Yes.

**Senator McLUCAS**—So that is 35 residential care to Homewood.

**Ms Rosevear**—Thirty-six to Homewood Care Pty Ltd.

**Senator McLUCAS**—And 70 to Varsity.

**Ms Rosevear**—Yes.

**Senator McLUCAS**—So there are still 50 outstanding.

**Ms Rosevear**—No, that should add up to 151.

**Mr Stuart**—There were 70 residential places to Varsity Aged Care; did you get that down?

**Senator McLUCAS**—I have 70 to Varsity and 36 to Homewood. In the press release that announced the packages in December of last year, 151 places included residential places.

**Mr Stuart**—Residential and community.

**Ms Rosevear**—That is right. It included all places.

**Senator McLUCAS**—Let us go to the Varsity allocation—70 residential aged-care beds to Varsity. They did not have approved provider status at that time. So that is why you could not announce their—

**Ms Rosevear**—That is right.

**Mr Stuart**—That is right. We had not completed the consideration of their approved provider application.

**Senator McLUCAS**—The company is called Varsity Aged Care, is it?

**Ms Rosevear**—Pty Ltd.

**Mr Stuart**—Yes.

**Senator McLUCAS**—Who are the directors of that company?

**Ms Rosevear**—I do not have that information on hand, but I can get that for you.

**Senator McLUCAS**—Are you aware that a director of Varsity Aged Care, Mary Ann McKenzie, is also a director of McKenzie Aged Care?

**Mr Stuart**—Yes, based in Victoria, we understand.

**Senator McLUCAS**—The ACAR document says that ACAR is underpinned by three reference documents: determination and allocation of places; identify certain criteria to be considered in assessing applications—for example, management expertise; and experience and past conduct as a provider. It further says that, having regard to this provision, applicants should be aware that if they are an existing approved provider and have had recent sanction action in place for any service, this will be taken into account in the assessment process. Did the department, when taking into account the application from Varsity Aged Care, recognise that the director of Varsity Aged Care was also a director of McKenzie Aged Care, which is a sanctioned facility in Victoria?

**Ms Rosevear**—Yes, the department was aware when it took its decision to grant approved provider status and to allocate places to Varsity that there were some key personnel in common with the McKenzie Aged Care Group and that the McKenzie Aged Care Group operated a home that was subject to sanctions in 2003.

**Senator McLUCAS**—A facility that failed 25 out of 44 accreditation standards.

**Ms Rosevear**—But it has subsequently been accredited for a three-year period.

**Senator McLUCAS**—How then can you take into account the past record of an approved provider and allocate 70 beds to an entity, or part of an entity, which has been sanctioned? Where is the logic?

**Ms Rosevear**—We allocated places to an entity that shares some key personnel. In looking at the record, we looked at the record of homes that had been associated with those key personnel and there had not been any concerns for three years. So we would look back. Had there been concern within the three-year period, then they would have not rated as highly against that criterion.

**Senator McLUCAS**—But this was all known by the department when the approval was given?

**Ms Rosevear**—Yes.

**Mr Stuart**—I should point out, of course, that it is not the same approved provider. There is a sharing of some key personnel between the two approved provider entities. But, yes, the department was aware of that information and took it into account in assessing the applicant against the criteria.

**Senator McLUCAS**—Is the Varsity application bed-ready?

**Ms Rosevear**—The Varsity application, I believe—against the ability to make places operational in a timely manner, which is the particular criterion for which we give a two-year time frame—actually met that criterion but it has not yet been built, no.

**Senator McLUCAS**—No, it was only allocated in January or something.

**Ms Rosevear**—It did demonstrate though—which is what is required in applications—an ability to make the places operational within the time frame required in the act.

**Senator McLUCAS**—How many entities, even with shared key personnel, have been allocated bed licences after a sanction event has occurred?

**Mr Stuart**—Senator—

**Senator McLUCAS**—This is a sanction event. This is not someone who has not complied with 44 out of 44. It is a sanction event.

**Mr Stuart**—No, I understand. We ask state and territory office staff, in making their recommendations to central office, to highlight to us any circumstances of that kind specifically and I receive a report. There are a small number, but there are a small number of aged-care homes to which we will allocate additional places even though there may have in the past been sanctions and what we look to there is the overall balance of circumstances. There were a small number that were brought to my attention in the most recent year and we asked some further questions about those. The sanctions had expired in those cases some time ago. There had been either significant changes in key personnel or very significant improvement in those services. By and large, they were homes that were in areas where it is difficult to allocate places to providers and have them successfully put on the ground.

**Senator McLUCAS**—You cannot characterise the Gold Coast as difficult to allocate places—

**Mr Stuart**—No, I am not making that particular statement here, but in this particular case the sanctions action was distant both in years and to an entity which was not the same approved provider. So there was not a very direct line between the sanctions action and the establishment of the new service—some very significant differences in key personnel, including care staff, and also a period of years that had elapsed in respect of the Victorian service and significant improvement in the Victorian service.

**Senator McLUCAS**—The report from Queensland to head office did identify the relationship between McKenzie Aged Care and Varsity Aged Care?

**Mr Stuart**—Yes, it did.

**Senator McLUCAS**—There were 14 applications, I understand, in the south coast planning region—whatever the region is called.

**Ms Rosevear**—Yes, south coast.

**Senator McLUCAS**—The others must have been pretty bad.

**Ms Rosevear**—They were not as competitive.

**Senator McLUCAS**—They were not as competitive. So is three years the magic length of time that you have to have a clean slate before you can reapply?

**Mr Stuart**—We do not have a lock-step metric on that, but what we do is look to the performance of the homes since sanctions. We do not think that a past sanctions action ought to damn a service forever if it makes very significant strides and gets its act together. There has to be a kind of an understanding of development and credit given for that. We look to what has happened in the intervening time.

**Senator McLUCAS**—You can understand why unsuccessful applicants have rung me in this case, though? They are competing against a part of an entity that has had a sanction.

**Mr Stuart**—There are some key personnel in common.

**Senator McLUCAS**—But you can understand why unsuccessful applicants in this particular case would feel a bit miffed that they missed out?

**Mr Stuart**—I think you are asking me to express a personal view.

**Senator McLUCAS**—And that would be inappropriate. Parliamentary Secretary, I have a question for you that you may not be able to answer.

**Senator Mason**—Fire away.

**Senator McLUCAS**—Were any of the directors of Varsity Aged Care or the McKenzie Aged Care Group associated with fundraisers held for the Liberal Party by the former minister?

**Senator Mason**—I do not know.

**Senator McLUCAS**—Could you find out for me, please?

**Senator Mason**—I will try, yes. I will take that on notice.

**Senator McLUCAS**—I have some questions for the agency now. Mr Brandon, could you update the committee on the number of unannounced support contacts and unannounced review audits that have occurred since January 2007?

**Mr Brandon**—I am able to tell you that in the year to date the agency has conducted 2,584 unannounced visits, of which 1,135 have occurred since 1 February this year.

**Senator McLUCAS**—So we are on track for one spot check per facility per year?

**Mr Brandon**—Yes.

**Senator McLUCAS**—That would mean we have about 500 to do between now and the end of June?

**Mr Brandon**—No, those figures were at the end of April.

**Senator McLUCAS**—When did the year start in terms of one unannounced spot check per year?

**Mr Brandon**—The year we are counting is 1 July 2006 out and we have two regimes. There is the regime that was in place before the changes to the regulations late last year. There have been 1,135 since February under what I describe as the new legislation or the revised legislation, and whatever the difference is between that and 2,584 happened before then. In terms of the other part of your question, as at 30 April we have done 60 unannounced review audits.

**Senator McLUCAS**—The 12 assessment modules are now available. I have had a look at them. How do you go about selecting which of the 12 modules you will use during a spot check?

**Mr Brandon**—The state case management committees schedule the visits. They look at the previous records we have of the home, what history we have of them and recent support contact records. They identify whether one or more of those modules are used. We frequently use more than one module. It is not one module per visit because we are spending considerable time on site doing unannounced support contacts.

**Senator McLUCAS**—What is the average length of time that you are onsite?

**Mr Brandon**—I cannot tell you that because we have not finalised the year yet. I can tell you that we are planning an average of 1.45 days per support contact.

**Senator McLUCAS**—1½ days?

**Mr Brandon**—Yes, 1½ days.

**Senator McLUCAS**—In terms of the findings of the spot checks, is there some data that you could provide the committee that tells us what you are finding?

**Mr Brandon**—We have not done an analysis of the findings of unannounced visits specifically. We will do that at the end of the financial year.

**Senator McLUCAS**—You are not collating data?

**Mr Brandon**—We are collating data on which homes we went to, when we were there, how long we were there and what we looked at. Our plan is that at the end of the financial year, when we have a year's full data, we will then examine that and create whatever reports we are able to.

**Senator McLUCAS**—What is the process for a facility where you find things that you are not happy about?

**Mr Brandon**—In a support contact the assessors make the assessment, look at what they are looking at and they then write a report. If there are issues concerning compliance, that report goes back to the facility and they have a chance to make a response to us. The response, the support contact record and any other information we have, including the history of the home, is taken into account by a decision maker, who is appointed by me, in each state office to determine further courses of action. The further courses of action can be a review audit or another support contact either immediately or at some time in the future.

**Senator McLUCAS**—Of the spot checks that you have undertaken, how many have resulted in some further course of action?

**Mr Brandon**—I do not have that piece of information. I can see whether I can get it for you, but not today. I would have to take that on notice. Our main focus is actually getting the work done and reviewing our performance at the end of the financial year.

**Senator McLUCAS**—You say 'getting the work done'. Do you mean actually undertaking the spot checks?

**Mr Brandon**—Undertaking our accreditation activities—that is, support contacts, site audits, review audits and the education activity.

**Senator McLUCAS**—Hopefully, if you do find things that are not to your liking, you do not wait to act on them.

**Mr Brandon**—No. Maybe I misled you there. What I was saying was that the analysis of the data on the whole sector will happen at the end of the year. As I was trying to explain before, once we do a support contact we then send a record to the home and they then send their response back to us. The decision maker then looks at the response and the information we have from the department, the history of the home and support contact record and determines a further course of action. That course of action could be a support contact or a review audit or a scheduled visit at some time in the future.

**Senator McLUCAS**—If you could find the total that required further action, that would be useful.

**Mr Brandon**—There is a figure I can tell you which might be helpful. I can tell you that in the year to date—this might answer the question, in fact—we have found 307 homes to have some noncompliance.

**Senator McLUCAS**—That is out of how many? I am a bit lost with the numbers.

**Mr Brandon**—That would be out of the total visits.

**Senator McLUCAS**—Out of the year to date figures?

**Mr Brandon**—To April. There is another set of figures. The total number of visits for the year to date is 4,622. At those 4,622 visits we have found 307 homes to have some noncompliance. During that period 319 homes have been put on a timetable for improvement. The 319 is bigger than 307 because some of those carried forward from the previous work. We did the work in 2005-06. So that is 4,622 visits of which 307 homes were found to have noncompliance and 319 were put on timetables for improvement.

**Senator McLUCAS**—So some facilities have clearly had more than one visit?

**Mr Brandon**—That is correct.

**Senator McLUCAS**—There are only 3,000 aged-care facilities in Australia.

**Mr Brandon**—That is correct.

**Senator McLUCAS**—And 307 are noncompliant.

**Mr Brandon**—Yes, 307 were found to have some noncompliance during the period up until 30 April.

**Senator McLUCAS**—Ten per cent—that is helpful. I appreciate that. All of the 307 homes that have some element of noncompliance would have a further course of action requirement?

**Mr Brandon**—The process is that if they have noncompliance we put the homes on a timetable for improvement. The vast majority achieve compliance during that timetable for improvement. Our process is that, if it is one noncompliance area, we will do the visit towards the end of the timetable for improvement. If there is a lot of noncompliance we might do three or four visits through the period, but we have very close monitoring. The level of monitoring is determined on a case-by-case basis. That is why I am always a bit reluctant to say, 'We would do this,' or 'We would do that,' because we actually have a state case management committee and a national committee which looks at every home and provides a particular management of that home.

**Senator McLUCAS**—How are you ensuring consistency of assessment processes for the spot checks?

**Mr Brandon**—I suppose the short answer is our internal quality improvement arrangements, our own quality control arrangements. We have people whose job it is to check reports for internal consistency and check that the assessors are reporting according to the template. We use observers on audits as a strategy to observe how the assessors behave. We also look to see, if a home has had a change in its compliance rate over a reasonably short period of time, whether we can identify the cause of that change. Included in looking at that is to see whether we actually got it right. The objective is to have accurate assessments.

**Senator McLUCAS**—Wyndham Manor aged care facility had a decision from the agency not to accredit after a second episode of serious risk in December 2006. What has happened to this facility?

**Mr Brandon**—My understanding is that that facility now has a new approved provider.

**Senator McLUCAS**—Is it still called Wyndham Manor?

**Mr Brandon**—No, it is called Uniting Aged Care—Manor Lakes, and I think there is a report on our website.

**Senator McLUCAS**—That is why we could not find Wyndham Manor.

**Mr Brandon**—Sorry?

**Senator McLUCAS**—We could not find it on the website.

**Mr Brandon**—You could not find Wyndham Manor?

**Senator McLUCAS**—No, because it has a new name.

**Mr Brandon**—What we normally do is the old report goes into the archives. The new one goes over the top. So, yes, that would be correct.

**Senator McLUCAS**—How many other facilities have had their accreditation revoked in 2006 and in the current year?

**Mr Brandon**—I think I might have to take that on notice, unless one of my colleagues down the back knows. I think the answer to your question is that decisions to revoke in 2005-06 were two and in 2006- 07 was one.

**Senator McLUCAS**—Thank you. In February estimates I asked about the number of complaints that are referred from the department to the agency over time. The answer

indicates that from 2003 to 2006 the number has grown from 559 through to 2,083. It is quite a consistent increase in complaints that are referred from the department across to the agency. Is the department plotting that and trying to work out why that is occurring?

**Ms Smith**—Senator, it does not reflect an increase in complaints. What the department tries to do is make sure that any information that comes to our attention is also drawn to the attention of the agency if we feel it has systemic or other implications that they need to be aware of.

**Senator McLUCAS**—So it is an increase in systems management or improvement in systems management between the department and the agencies.

**Ms Smith**—I think it is ensuring that the department and the agency are sharing all relevant information to ensure that any instances of poor care are identified and acted upon.

**Senator McLUCAS**—Are you expecting now with the office of quality and compliance being established that some of the issues that you would have previously referred to the agency might be managed in-house?

**Ms Smith**—I think when an issue comes to the department's attention through the complaints scheme there is invariably an issue of specific concern to an individual and the department's role is to investigate that and identify how it can be resolved. Those issues of specific concern to an individual can also be of more systemic or general concern to other residents at the facility. So I do not think we can assume that just because the department has investigated the specifics of a case it would not need to get looked at by the agency. I suppose what we are hoping though is that the department will have through its investigation more comprehensive information that they could then refer to the agency.

**Senator McLUCAS**—Okay. Do you try to categorise the issues that you refer to the agency into groups to make some judgement about the nature of complaints that are being made?

**Ms Smith**—We do have a process of prioritising those referrals I suppose in terms of whether this is an issue that is just for information or whether it is an issue with a degree of urgency that requires the agency to look at it within a very short period of time, for example.

**Senator McLUCAS**—And do you count the ones in the different categories, or is that just simply the way you ask them to be responded to?

**Ms Smith**—I would have to check how we record those referrals, Senator. I am not personally familiar with the number in each category. I would have to check that.

**Senator McLUCAS**—Mr Brandon, do you categorise the referrals you get from the department?

**Mr Brandon**—No, we do not categorise them.

**Senator McLUCAS**—You just act on them?

**Mr Brandon**—That is right.

**Senator McLUCAS**—Good. An article in the *Courier-Mail* in April this year said that an agency audit found that the safety, health and wellbeing of about 90 residents in an aged care

facility called Netherlands Retirement Village was at risk. When will the audit report and the sanction report be available on the websites?

**Mr Brandon**—The most current site audit report concerning Netherlands Retirement Village in Capalaba in Brisbane—I trust that is the one you are talking about—was conducted in July 2006; the decision in September 2006 and the report will be on the website. There is no reason why the site audit report from August of last year would not be on our website.

**Senator McLUCAS**—Can you just run through those again please, Mr Brandon?

**Mr Brandon**—The site audit was conducted in July-August of 2006 and the decision was made in September 2006 and it was a decision to accredit for 10 months to expire in August of this year. There is no reason that I can see that that report would not be on our website.

**Senator McLUCAS**—I am sure someone will be looking furiously now and if they still cannot find it we will come back to you.

**Mr Brandon**—Please.

**Senator McLUCAS**—Thank you. I go to the issue of Broughton Hall, which has been in the news recently. Broughton Hall received 44 out of 44 expected outcomes in July of 2006. What was the nature of that audit?

**Mr Brandon**—There was a site audit on 3, 4 and 5 April 2006 in relation to an application for a further period of accreditation.

**Senator McLUCAS**—That was an accreditation audit?

**Mr Brandon**—Correct.

**Senator McLUCAS**—And that is when they achieved 44 out of 44 expected outcomes.

**Mr Brandon**—That is correct, as they had done in the previous audit—in fact, in the previous two audits. They had achieved 44 out of 44 in July 2000, May 2003 and, of course, in April 2006.

**Senator McLUCAS**—Subsequent to the very sad deaths of a number of people over Easter, I understand, Mr Brandon, you were asked to do another audit. When was that?

**Mr Brandon**—The agency did a support contact at Broughton Hall on Sunday, 15 April, followed by a review audit which commenced on Tuesday, 17 April following a referral from the Department of Health and Ageing on the Monday.

**Senator McLUCAS**—That was a full review audit.

**Mr Brandon**—Correct.

**Senator McLUCAS**—And what did that find?

**Mr Brandon**—I can summarise it by saying that the audit found substantial noncompliance. I think they are still within their appeal period, so I cannot really talk much about the detail because it would be protected information.

**Senator McLUCAS**—That is right, Mr Brandon. It would be protected information under the act, would it not?

**Mr Brandon**—Correct.

**Senator McLUCAS**—Yes. Why is it that Minister Pyne announced the result of those audits?

**Mr Brandon**—I am not in a position to answer that, Senator.

**Ms Murnane**—There are provisions in the act that in the event that the department gauges there are significant matters that the public would benefit from knowing—that the result would be beneficial because there has been a lot of attention and a lot of conclusions drawn from an event—that information can be released. That is what was deemed by the secretary's delegate in this case. That was done before Mr Pyne's statement was released.

**Senator McLUCAS**—The act is quite clear, isn't it?

**Ms Murnane**—The act is clear, yes.

**Senator McLUCAS**—And the secretary can deem that in the public interest. So what is the formal process for that to occur?

**Ms Smith**—The process is that the secretary or a delegate of the secretary has to sign an instrument indicating under which provisions of the act that information is being released and the nature of the information that is being released.

**Senator McLUCAS**—Did that occur?

**Ms Smith**—Yes, that did occur.

**Senator McLUCAS**—When did that occur?

**Ms Murnane**—Certainly it cleared before it was released. We might have to check.

**Ms Smith**—I would have to check the precise dates. But, in relation to the information that was released into the public domain, there was an appropriately signed instrument before any information was released.

**Senator McLUCAS**—Minister Pyne released a statement on 24 April talking about your review audit, Mr Brandon. That is when he released information about noncompliance. Had Broughton Hall had an opportunity to respond to the review audit findings in that period?

**Mr Brandon**—Senator, I do not know the dates because I am not part of the departmental process. What I can tell you is that, since the support contact we commenced on Sunday the 15th right through to today, we are having very close and frequent discussions with Broughton Hall's management and Benetas management.

**Senator McLUCAS**—I understand that. Yes, that is quite appropriate and should occur.

**Mr Brandon**—I do not know the key dates in relation to that.

**Senator McLUCAS**—But in relation to the review audit that occurred from Tuesday, 17 April through to 23 April, when was Benetas provided with a copy of that audit report?

**Mr Brandon**—The review audit report?

**Senator McLUCAS**—Yes.

**Mr Brandon**—The exit interview was held on 23 April. So that is when they get all the detail.

**Senator McLUCAS**—And under the act they have seven days to make a written response.

**Mr Brandon**—They provide a response to us and then the decision maker takes that into account with all of the other things.

**Senator McLUCAS**—Could I have a copy of the instrument from the secretary that identifies what the public interest would have been?

**Ms Murnane**—I want to take advice on that. I think we will take advice on that.

**Senator McLUCAS**—I am trying to ascertain what is the public interest.

**Ms Murnane**—I understand.

**Senator McLUCAS**—This was a terribly tragic event and it was important that the minister did make commentary, but this is quite an unusual step to have to take.

**Ms Murnane**—I think we have forgotten now that Broughton Hall was in the media, both the press and the electronic media, every day. Conclusions were being drawn and it was important that residents, relatives and the public knew that, although the action was going through a process, action was being taken. I have not got the minister's release before me but, as I recall, he said very clearly that the home now had seven days in which to comment.

**Senator McLUCAS**—I am just trying to ascertain what the public interest was. If we could get either a copy of the instrument or an understanding of what the public interest was then that would be useful.

**Ms Murnane**—Okay.

**Senator McLUCAS**—Minister Pyne said in the *Age* newspaper on 25 May—so this is some time later:

> I'm disappointed that they (the failures) are the serious ones and they also go directly to the outcome of five deaths in Broughton Hall…

How do we know that the failures directly led to the deaths of those people at Broughton Hall?

**Ms Murnane**—I was just looking at the act, Senator. Could you repeat the question?

**Senator McLUCAS**—Minister Pyne is quoted in the *Age* newspaper as saying:

> I'm disappointed that they (the failures) are the serious ones and they also go directly to the outcome of five deaths in Broughton Hall…

How do we know that the failures identified in Mr Brandon's agency's assessment led directly to the deaths of those individuals?

**Ms Murnane**—There was a misinterpretation of that at the time. The minister, in response to that, said that the final say, the determination on what caused the deaths, was the coroner's and that we would not know that until the coroner's findings were made public.

**Senator McLUCAS**—That is correct.

**Ms Murnane**—Yes.

**Senator McLUCAS**—Did Minister Pyne release a statement clarifying that?

**Ms Murnane**—He said it. He said it on radio.

**Ms Halton**—He said it on 25 April, yes.

**Senator McLUCAS**—I have been saying 25 May. I think it was 25 April.

**Ms Halton**—Yes, he did. He released a statement which went to that. No doubt you have a copy of it. We can give you a copy if you need it.

**Senator McLUCAS**—I may not have that.

**Ms Halton**—We will take a photocopy and give you one, if you like.

**Senator McLUCAS**—Ms Murnane, when you are looking at the release of that information and why it was in the public interest, can I get an understanding of why the department made the determination that making the information available would increase or lessen the risk to the health, safety and wellbeing of the residents?

**Ms Murnane**—Senator, I can give you an answer to that now. The answer is that there was speculation in the media on a daily basis about what was happening in this home. There was knowledge that the agency was undertaking a review audit. When that is happening, it is important that the responsible agency and the minister responsible for the care of residents in 3,000 establishments make it known progressively what is happening, why it is happening and where in the process we are. That was the reason.

The other thing that was happening is that information was getting into the press in other ways, and Broughton Hall themselves made information available about the preliminary findings of the review audit. Remember that these were the findings of the assessors. They were not the final findings, and the minister made that clear.

**Senator McLUCAS**—Yes. How often has that instrument been used since 1997?

**Ms Murnane**—I could not tell you that, but it has been used under this act and under the National Health Act previously for the reasons that I have just described.

**Senator McLUCAS**—Mr Brandon, this goes to the question of consistency of audit processes that we have talked about before. Given on two previous occasions Broughton Hall has received 44 out of 44 expected outcomes and then, I understand from the media, failed 12, did you go back and have a look at the previous audits and make a judgement about whether or not the 12 non-compliance events could have been in existence at those previous audits?

**Mr Brandon**—Not at this stage, because our focus has been on working with Broughton Hall to improve their level of compliance. You might recall that I have told you before that we have risk indicators. We have certainly identified a significant turnover in staff at Broughton Hall and in the Benetas group since the audit—which, I might add, was 12 months previously, which is a long time in aged care. Maybe it was 11 months. It was in April.

**Senator McLUCAS**—April 2006.

**Mr Brandon**—Yes. It is just on 12 months past, which is a long time in aged care.

**Senator McLUCAS**—You are not suggesting that we have review audits annually, are you?

**Mr Brandon**—It is not for me to suggest anything, Senator.

**Senator McLUCAS**—I do not think you are, Mr Brandon, to be kind.

**Mr Brandon**—Thank you.

**Senator McLUCAS**—If a year is a long time between audits in aged care, are our systems working?

**Mr Brandon**—I think our systems are working because without the activity of the accreditation agency none of the stuff we are talking about here in relation to compliance would ever get to the public arena.

**Senator McLUCAS**—I am not suggesting we throw accreditation out.

**Mr Brandon**—There is activity that happens between audits that looks at various things, but until we do a detailed analysis of both audits I am not in a position to give you any statements about the accuracy or otherwise of those audits.

**Senator McLUCAS**—When the instrument was drawn up essentially giving permission for this protected information to be released, is it a requirement that the home is told that this is about to happen?

**Ms Murnane**—It is not. I am getting advice on this. I said to you that there are a number of clauses in the act that give us the power to release information or to authorise the release but I was not sure which one was used in this circumstance, and that is what is being done now.

**Senator McLUCAS**—I understand that there is no requirement for the minister to make contact with the facility, but can I find out if he did?

**Ms Murnane**—Yes.

**Senator McLUCAS**—He did? No, you will find out.

**Ms Murnane**—I think we will have to find out whether he did.

**Ms Smith**—Certainly there was very regular contact between our Victorian state office and the Broughton Hall facility.

**Ms Murnane**—We can find out. In this particular instance, they were told that that release was coming out.

**Senator McLUCAS**—Thank you. That is all I have on Broughton Hall. A final issue I would like to talk about is the innovative pool funding program.

**Mr Stuart**—I thought you said 'innovative pool' earlier on, Senator.

**Senator McLUCAS**—I think I might have.

**Mr Stuart**—You were going to come back to it and here we are.

**Senator McLUCAS**—I did. I am consistent. I think you told me that Innovative pool funding was underspent, given the qualification about what that means in this program.

**Mr Broadhead**—It is lower than estimated rather than underspent.

**Senator McLUCAS**—Yes, we have had that discussion.

**Mr Broadhead**—So we have just revised the estimate. We made an initial estimate at the beginning of the year or thereabouts as to the amount of money that would flow. This varies according to actual occupancy. We have had some pilots terminate, finish, complete, and so the estimate has been revised accordingly.

**Senator McLUCAS**—The number of services established under the innovative pool is not a lot. I wonder if you could run through them with me.

**Mr Broadhead**—I do not have a figure for how many have been established since the inception of the innovative pool, but there were 17 pilots running as at 25 May this year being funded through the innovative pool and there were 348 places in total being funded through that mechanism.

**Senator McLUCAS**—The funding for these programs was to cease.

**Mr Broadhead**—Generally they are time limited pilots. They are exploring a particular issue, so there is a fixed period of time for which they operate. There is an evaluation, generally speaking, and once they discontinue there may or may not be a program that follows through. So, for example, the intermittent care rehabilitation service projects I think could be argued to have led to the transition care program, which is now up and running. There were lessons learnt in the first that contributed to the development of the second. That is not always the case.

**Senator McLUCAS**—Some of the projects, though, were really very much along the lines of the young people in nursing home COAG event.

**Mr Broadhead**—Yes.

**Senator McLUCAS**—I am referring in particular to Carnegie Hall.

**Mr Broadhead**—Yes.

**Senator McLUCAS**—So, whilst it was established as a pilot program, it was to conclude funding this year, I understood.

**Mr Broadhead**—The MSV Carnegie pilot was about young people with disabilities in aged care. It has been extended for 12 months to enable further discussions with the Victorian government about securing funding for the pilot participants.

**Senator McLUCAS**—Could it be funded out of the young people in aged care money?

**Mr Broadhead**—That is money within state control, essentially; but, yes. We had two pilots where we provided transition funding, if you like, for young people who were in aged care due to disability. We did it in South Australia and Victoria. This was in the nature of funding to assist people make the transition from aged care to disability services.

**Senator McLUCAS**—What was the South Australian one?

**Mr Broadhead**—Again, I might have some information on that but these were time limited. From memory, I think there were 15 places funded in South Australia and four in Victoria. The one in South Australia has concluded; but, with the one in Victoria, there has been certainly a view taken by the Multiple Sclerosis Society that the level of resources on offer from the Victorian government to provide disability services support to those clients may not be as much as it desired.

**Senator McLUCAS**—The South Australian one has concluded?

**Mr Broadhead**—I think so, yes, from memory.

**Senator McLUCAS**—So what has happened to the people who were—

**Mr Broadhead**—They have transferred to disability services care, outside the aged-care system, funded by the South Australian government, I believe. As I said, this was a transition program. It was not about funding things in aged care; it was about providing funding to assist people make the move from aged care to disability services. So the continuing service provision was to be done through disability services.

**Senator McLUCAS**—Did the South Australian model have an accommodation element to it?

**Mr Broadhead**—I could not tell you off the top of my head. I would have to take that on notice, but I am happy to provide some information about that.

**Senator McLUCAS**—Do not take that on notice, please, Mr Broadhead. Rather, could you provide me with a list of all of the funded projects under the innovative pool?

**Mr Broadhead**—Yes.

**Senator McLUCAS**—And their status?

**Mr Broadhead**—Yes.

**Senator McLUCAS**—And the total Commonwealth money for each of those programs?

**Mr Broadhead**—Certainly.

**Senator McLUCAS**—When I say 'status' I mean, for example, if you know that they have been transferred to disability services in South Australia, could you provide that information?

**Mr Broadhead**—I am happy to.

**Senator McLUCAS**—I can put the rest of my questions on notice given that I have cribbed 20 minutes of time. I would like to thank the officers.

**ACTING CHAIR (Senator Moore)**—On that basis, that concludes outcome 4. We now move to outcome 11, Mental health.

**Ms Murnane**—Could I just go back to answer a question that Senator McLucas asked during the aged care hearing. Senator, we have the instrument and I am happy to table that. The instrument was under section 86.9(1) of the Aged Care Act 1997. The relevant subclause there is subclause (l).

**Senator McLUCAS**—Can I just find my briefing notes. Sorry, what section was it?

**Ms Murnane**—Section 86.9(1) gives the secretary the power to make publicly available the following information about an aged-care service.

**Senator McLUCAS**—Thank you.

**Ms Murnane**—I will table the instrument.

[2.53 pm]

**ACTING CHAIR**—We will now move to outcome 11. There are going to be a number of people asking questions but we will get rid of the standard ones first. I would like to start by thanking the department for the little updates on the website. I think that is very useful. I noticed the last one was yesterday, which is particularly effective and it is very useful for this

process. It is a good mechanism. I notice that there have been a lot of hits on that page, which shows that there is interest in the area.

We want to get some basic funding figures, because we know, Mr Smyth—and we have been through this before—that you and FaCSIA are sharing responsibility under the COAG plan but also that Health and Ageing had pre-existing programs that were there before the COAG plan, which has come in over the top. We would like to get on the record some confirmation of the expenditure and how that is being put against the programs. I am not going to ask for future years. I do not want to hear that answer again. Can we get a breakdown of the separate programs for 2006-07 and 2007-08? Just let me know if I miss one because—as you have told us—some of them are operating across different parts of the organisation.

Beginning with mental health services in rural and remote areas, can we get an idea of how the budget is going in 2006-07 and what the expenditure projection is for 2007-08?

**Mr Smyth**—The budget for this financial year for the rural and remote measure is $3.561 million.

**ACTING CHAIR**—That is for 2006-07?

**Mr Smyth**—That is for 2006-07, correct.

**ACTING CHAIR**—And for 2007-08?

**Mr Smyth**—For 2007-08 the funding is $13.5 million. Can I just give you an explanation as well, Senator?

**ACTING CHAIR**—Absolutely. It is easy to do them as we go rather than go back to them, so if you can give me the explanation on that one that would be good.

**Mr Smyth**—There was an announcement for a drought assistance package made in the federal budget for $30-odd million. That is actually a transfer of funding that has been made from the education and training component of the Better Access initiative. The original funding was around $84 million. It has now been made $54 million, and I can explain the reasons around that if you would like as well.

**CHAIR**—Sure.

**Mr Smyth**—What has happened there is that there has been an allocation of around $10.1 million for a new drought assistance measure through divisions of general practice for community capacity building and the provision of counsellors et cetera into drought affected communities. The amount of $20 million has been added, at $5 million per year over the next four years, to the rural and remote measure. So that rural and remote measure was originally around $51.9 million and it is now $72 million over the period.

**Senator MOORE**—But it is a transfer of funds rather than new money?

**Mr Smyth**—That is correct.

**Senator MOORE**—We will go through these because I think it would be useful to have explanations across a few of them. Do you have a graph or some other format that you can give me all this information in?

**Mr Smyth**—I will have to take that on notice.

**Senator MOORE**—I know, but I think you will have it.

**Mr Smyth**—I do not actually have a graph format.

**Senator MOORE**—I think it would be very useful to have one in your program as well so that we can actually use that as a benchmark for future estimates. It seems to be a useful mechanism to have a format with all of these things in it so that we can update it at different estimates. It actually makes it easier when we are talking.

**Senator WEBBER**—There is a big parcel of funding for that new drought initiative. What in that package of funding is actually going to address the workforce shortage problems that we have in those communities? It is great to talk about funding for capacity building and better outcomes, but when you have the workforce shortages that we have in my home state—you cannot even find GPs out there—what within that initiative is going to address that concern?

**Prof. Calder**—The funding will be for cross-counselling services, for developing access strategies to bring in workforce services and to provide training for workforce and community leaders around capacity building. It is expanding capacity through education and training and support measures.

**Senator WEBBER**—I guess my question is: who is going to do that? I have drought affected communities, and there is no doubt they are in crisis—and this is a great initiative, but they do not have the personnel out there to train them to build their capacity. Are these telephone counselling services? So people would have to ring Perth?

**Mr Smyth**—They are actually on-the-ground people.

**Senator WEBBER**—They are on-the-ground people?

**Mr Smyth**—Yes, and the money will pay for the provision of counselling services through divisions of general practice.

**Senator WEBBER**—So when there is no division and there is no real GP—

**Mr Smyth**—It will be a counsellor for that $10 million—

**Senator WEBBER**—So you are going to go and find the counsellor and put them in the community?

**Mr Smyth**—The divisions of general practice will be engaged to undertake that task.

**Senator WEBBER**—So they are going to find some counsellors and put them out in the wheat belt?

**Mr Smyth**—That is correct.

**Mr Kalisch**—And they were confident that they could do that.

**Senator WEBBER**—I will remind them of that.

**Prof. Calder**—There is funding for additional nursing positions as well. There will be recruitment strategies.

**Senator MOORE**—The budget explanation actually says it will provide for 'allied and mental health nursing professionals, such as social workers,' which I think is possibly—

**Mr Smyth**—That is the $20 million transfer. Then there is the $10 million measure.

**Senator MOORE**—Then there is the next one of $10.1 million. I am interested in the terminology in this. It says this measure will provide for greater access to 'allied and mental health nursing professionals, such as social workers'.

**Mr Smyth**—Yes.

**Senator MOORE**—I am not quite sure whether social workers would like it to be phrased in that way. It mentions social workers, psychologists, occupational therapists and Indigenous health workers in drought affected communities.

**Mr Smyth**—That is correct.

**Senator MOORE**—So they are the professionals that the divisions of general practice have said that they are going to be able to find; is that right?

**Mr Smyth**—The measure that you are talking about, the $20 million transfer, which is our rural and remote measure, is not just specific to divisions of general practice. There are also Aboriginal medical services that are able to be funded under this program and also the Royal Flying Doctor Service. It is not specific to divisions of general practice.

**Senator MOORE**—That $20 million is not going to general practice but the $10.1 million is?

**Mr Smyth**—Yes, that is correct.

**Senator WEBBER**—So RFDS is going to get some of the funding too?

**Mr Smyth**—They may.

**Senator WEBBER**—I do not have a problem with it.

**Mr Kalisch**—If they put up a good proposal.

**Senator MOORE**—So the $10.1 million is for the divisions of general practice. Are they seeking the same work groups as the previous one?

**Mr Smyth**—No, they are not. They are looking at crisis counselling services.

**Senator MOORE**—And what kind of professional background would crisis counselling service personnel have?

**Mr Smyth**—They would need to have tertiary qualifications in counselling.

**Senator MOORE**—Specifically counselling?

**Mr Smyth**—Yes.

**Senator MOORE**—So would psychologists, occupational therapists and Indigenous health workers who have those qualifications qualify for that money as well?

**Mr Smyth**—I would have to take that on notice. The funding was mainly around counselling services and on top of that there is the additional funding for those specific allied and nursing groups that are able to do the services that people could be referred to by the counsellors should they be exhibiting signs of mental illness.

**Senator MOORE**—So it will be a referral service?

**Mr Smyth**—They would have to go through a GP and then to the allied provider or the nursing provider.

**Prof. Calder**—That measure provides training, so it is expected to grow the workforce capacity over the four years of the measure.

**Senator MOORE**—So that covers the first one. For mental health nurses there is a $191.6 million budget.

**Mr Smyth**—That is correct.

**Senator MOORE**—Over how many years?

**Mr Smyth**—Over four years.

**Senator MOORE**—Starting?

**Mr Smyth**—Starting 1 July this year.

**Senator MOORE**—So 2007-08?

**Mr Smyth**—That is correct.

**Senator MOORE**—So I would imagine you have spent none of that yet?

**Mr Smyth**—No.

**Senator MOORE**—So what is the expected expenditure in 2007-08 of that four-year plan?

**Mr Smyth**—It is $23.354 million.

**Senator MOORE**—And that is for training?

**Mr Smyth**—That measure is actually for service provision. So it is actually to fund nurses that can be located in general practice psychiatry rooms under psychiatrists or in divisions of general practice.

**Senator MOORE**—So the presumption of that particular program is that the personnel are there and you are just going to fund their salaries to go into that area. It is not for training mental health nurses?

**Mr Smyth**—It is not for training. There are separate measures for training.

**Senator MOORE**—That is what I thought—further down the track.

**Mr Smyth**—That is correct.

**Senator MOORE**—I turn to improved services for people with drug and alcohol problems and mental illness—capacity-building grants of $73.9 million.

**Mr Smyth**—That sits in another outcome area. I just do not have those figures. I have the ones that sit under outcome 11 and outcome 5 in my area. I do not have the actual funding for those.

**Senator MOORE**—Can you get that for me?

**Mr Smyth**—Absolutely.

**Senator MOORE**—The reason I am asking you is that I have actually gone through and found anything—I am sure if I have missed any you will help me out—that has something to

do with mental health. I did this on the basis of previous discussions we have had about it being a composite package and that the department works in concert with other people. Anywhere I found the words 'mental health' I have put it down. If you could give me some form later with asterisks beside the ones that refer to budget initiatives, that would be good.

**Mr Smyth**—That measure actually starts 1 July as well.

**Senator MOORE**—I see that as a part of a whole package. Is that how you see it as well, even though it goes into a different outcome? Is that how you see it operating?

**Mr Smyth**—We see all of these COAG measures as being a collaborative arrangement within the department and across government, for that matter. As you know we have a number of governance mechanisms within the department and across government to ensure we have a consistent approach.

**Senator MOORE**—That question is coming up.

**Mr Smyth**—I am sure it is. I look forward to it!

**Senator MOORE**—I turn to funding for telephone counselling, self-help and web based support programs of $56.9 million.

**Mr Smyth**—That is correct. The amount of $5.4 million was allocated for 2006-07 and $11.129 million is allocated for 2007-08.

**Senator MOORE**—And the funding program for that is four years?

**Mr Smyth**—It is a five-year program.

**Senator MOORE**—Did it start in 2006-07?

**Mr Smyth**—It started in 2006-07, with a budget of $5.4 million in 2006-07, the current financial year.

**Senator MOORE**—Is that providing telephone counselling through other services? It is not a departmental service?

**Mr Smyth**—It is not a departmental service.

**Senator MOORE**—Who has the money? I would imagine this would have been tendered?

**Mr Smyth**—There were two specific organisations that were mentioned, Lifeline and Kids Help Line, under this. They have both received contracts. The Lifeline contract went out late last year for around $18 million.

**Senator MOORE**—Over a period of time?

**Mr Smyth**—Over five years.

**Senator MOORE**—So some of that $5.4 million was the first stage of that program?

**Mr Smyth**—That is correct.

**Senator MOORE**—I think there was over $4½ million odd for the Kids Help Line contract, which was signed earlier this year.

**Prof. Calder**—We are now working with the sector to look at gaps and provision and quality and standards for provision. So we have got a collaborative discussion going with the broader sector around those issues.

**Senator MOORE**—Is the funding divided between telephone counselling, self-help and web based support? Within the full program of $56.9 million, is there an allocation for each of those components or is it just a bucket and you see what is out there?

**Mr Smyth**—It is a bucket.

**Senator MOORE**—I know that is a technical term!

**Mr Smyth**—A rather crude technical term.

**Senator MOORE**—In relation to web based support, I know Senator McLucas asked questions of another program about the web process, so are these specialised web services for mental health separate to the department's web base?

**Mr Smyth**—That is correct.

**Senator MOORE**—How is that supposed to work?

**Prof. Calder**—Again, we are looking at what is out there, what the gaps are, what can be strengthened in terms of what is already provided, who the providers are and what we can do to address them.

**Senator MOORE**—So it is not necessarily new programs?

**Prof. Calder**—Not necessarily.

**Senator MOORE**—It could well be funding things that are working. We are particularly interested in that, because that was the kind of evidence we got in the Senate inquiry from a number of pre-existing web services. It is looking at that kind of information.

**Prof. Calder**—Yes.

**Senator MOORE**—Has any of that money been expended to web support yet?

**Prof. Calder**—No, not yet.

**Senator MOORE**—How is self-help defined? What constitutes self-help under this heading?

**Mr Smyth**—There are a number of very good web based programs out there at the moment.

**Senator MOORE**—So this is back to the self-help web stuff?

**Mr Smyth**—That is correct. So a psychologist or a GP might advise the patient to actually utilise some of those programs in between some of their clinical sessions.

**Prof. Calder**—Equally, people may find them in their own regard.

**Senator MOORE**—So it is maintaining high quality. Would the department then contract those people for a certain amount of money which would then come back to some form of interrelationship between the organisation and the department and the various monitoring that would go on with that? Is that how you see it working?

**Prof. Calder**—When we have got a sense of what more needs to be done and where it needs to be done, then we would obviously look for organisations to be the providers of those services. That will again depend on the issue. We might have a tender process; we might grow an existing service.

**Senator MOORE**—Did you have a tender process for the two telephone counselling services?

**Mr Smyth**—For Kids Help Line and Lifeline?

**Senator MOORE**—Yes.

**Mr Smyth**—No, they were direct funding approaches because they were specifically mentioned in the budget.

**Senator MOORE**—Okay. So there was no need for any assessment of those pre-existing processes, but the expectation is that with the next round there could be some form of tender process?

**Mr Smyth**—Absolutely. It could be a bit of both actually. I suppose there could be some direct approaches made to organisations that have a unique capacity or capability, as well as an open tender process.

**Senator MOORE**—Do you fund any of those services now?

**Mr Smyth**—One of the services, I suppose, is depressioNet, which was funded a couple of years ago to the tune of around $300,000 a year.

**Senator MOORE**—And did that cease?

**Mr Smyth**—No, it is still going.

**Senator MOORE**—So that particular link is still existing under previous expenditure.

**Mr Smyth**—That is right.

**Senator MOORE**—Now we come to my personal favourite: the Better Access to Psychiatrists, Psychologists and General Practitioners measure for $538 million.

**Mr Smyth**—Now around $507 million.

**Senator MOORE**—That is because of the transfer.

**Mr Smyth**—The money under that measure, with regard to the Medicare items, as you know, is a special appropriation that is uncapped, so there are a number of components to that. There is the PBS component, there is an MBS component, and the one that we are really tracking in the main is the education and training component. I can give you the budget figure for that, which is now $54 million over the five years.

**Senator MOORE**—That is $54 million for the education component of that particular program?

**Mr Smyth**—The education and training component. For this financial year, the figure is $2.705 million.

**Senator MOORE**—That is actually the first fully operational year, isn't it?

**Mr Smyth**—That is correct.

**Senator MOORE**—So 2007-08?

**Mr Smyth**—No, that is 2006-07.

**Senator MOORE**—Okay, 2006-07. So how much of 2006-07 was operational with that component? All of it?

**Mr Smyth**—We will fully expend that $2.7 million by the end of this financial year.

**Senator MOORE**—Did that start in July 2006?

**Mr Smyth**—It started really as of 1 November with the commencement of the Better Access—

**Senator MOORE**—1 November?

**Mr Smyth**—1 November 2006.

**Senator MOORE**—That is what I was trying to get at. So it is not a full financial year?

**Mr Smyth**—Not a full financial year figure.

**Senator MOORE**—When we asked these questions in the last round of estimates, it was too soon to get any sense of the expenditure or what was happening, so the expenditure for 2006-07 of $2.705 million—

**Mr Smyth**—That is just the education and training component of this measure. It does not relate to the MBS items.

**Senator MOORE**—And that is not a full year but how much has been spent in 2006-07?

**Mr Smyth**—That is how much will be spent in 2006-07. There is still some money to be allocated this year, but we are in the final stages of the contract negotiations.

**Senator MOORE**—You had better sign those cheques quickly!

**Mr Smyth**—Absolutely.

**Senator MOORE**—That is 2006-07. What about 2007-08 for the education component?

**Mr Smyth**—That is $8.589 million.

**Senator MOORE**—And is the education component of that for the professionals?

**Mr Smyth**—That is correct.

**Senator MOORE**—Does that follow the same format as Better Outcomes, or a similar format to Better Outcomes?

**Mr Smyth**—It will be much broader than Better Outcomes, to be honest. We will also—

**Senator MOORE**—Who is doing that training?

**Mr Smyth**—At the moment we are in the final stages of contracting with a group that is called the mental health professionals association, which is the four key colleges responsible for mental health activities—the College of Psychiatrists, the College of General Practitioners, the Australian Psychological Society and the Australian College of Mental Health Nurses. They have formed—

**Senator MOORE**—Does that cover everybody?

**Mr Smyth**—No, it does not. But they have formed a unique professional group to look at the development and implementation of education and training from I suppose more of a clinical and multidisciplinary and interdisciplinary perspective.

**Senator MOORE**—Who misses out? Which college misses out?

**Mr Smyth**—OT and social workers are not included in that group, but our contracting arrangements with the mental health professionals association will set up a reference group that will include those others as well, including carers and consumers and the Divisions of General Practice as well.

**Senator MOORE**—So it is a training consortium?

**Mr Smyth**—It is a consortium really to develop the education and training package for this particular program.

**Senator MOORE**—And you are just finalising the contract with them now?

**Mr Smyth**—That is correct.

**Senator MOORE**—So where has the $2.705 million that has already been spent gone to?

**Mr Smyth**—There was some funding provided for the launch of the measure in terms of getting material ready that could be utilised by the professional associations that are involved, so OT, social workers, mental health, the Australian Psychological Society, Divisions of General Practice and various colleges. We are also looking at other preliminary resources that are made available to make practitioners aware of the components of the Better Access initiative.

**Senator MOORE**—Is that like a PR component?

**Mr Smyth**—No, it is material that is informative for the practitioners who are responsible for treating consumers and referring them as to what the items are for, how to conduct GP mental health care plans et cetera—all of those information and orientation packages that are required when you launch a large program such as this.

**Senator MOORE**—I will not take the time now, but can you give me some information about what that includes?

**Mr Smyth**—I am more than happy to take that on notice and provide that for you.

**Senator MOORE**—That would be good. Because you are just finalising the contract now with the specialist group that will own this program into the future, what you have described to me is not in fact the training materials; it is preliminary material to launch it. Is that right?

**Mr Smyth**—It is more information and orientation material.

**Senator MOORE**—Was that done in house?

**Mr Smyth**—No, it was contracted out to those particular bodies, but it was obviously—

**Senator MOORE**—So they got the contract to do the information before they started?

**Mr Smyth**—After 1 November we sat down collaboratively with them and we worked jointly on putting together the material.

**Senator MOORE**—They got a down payment?

**Mr Smyth**—They did have a minor down payment; it was not a lot of money.

**Senator MOORE**—If you can tell us what is involved in that, that would be useful.

**Mr Smyth**—Sure.

**Senator MOORE**—Is that set of information public? Can we get copies of that?

**Mr Smyth**—Yes, it is public.

**Senator MOORE**—That would be great. It is not on the website?

**Mr Smyth**—It would be on their websites. It is on the Australian General Practice Network website; it is on the College of Psychiatrists website; it is on the APS website.

**Senator MOORE**—And the full set of materials would be on each of their websites?

**Mr Smyth**—That is correct.

**Senator MOORE**—So we would be able to find what some of that money went to?

**Mr Smyth**—That is correct.

**Prof. Calder**—We can give you one of the websites if you would like.

**Senator MOORE**—Sure.

**Prof. Calder**—It is www.gpcare.org.

**Senator MOORE**—So $2.7 million this financial year, $8.5 million next financial year and then the full amount over the five years is $54 million. That is to the best of our knowledge now?

**Mr Smyth**—That is correct.

**Senator MOORE**—And then what about the MBS component? We were particularly interested in that the last time, and we agreed then that it was too soon between November and February to get much of an idea of the MBS component.

**Mr Smyth**—We have the number of services that have been delivered.

**Senator MOORE**—We might leave that, because I understand that Senator Allison will go into that in detail. So you can give us the MBS information later. How about the PBS?

**Mr Smyth**—I do not have that information, no—not at this stage.

**Senator MOORE**—When would you expect that we would be able to get that data? I know it belongs to other programs, but I thought you would keep an eye on your ownership of that bit.

**Mr Smyth**—It would be, I suppose, when the data is actually published under the PBS. I am not sure how disaggregated that information is. That would be obviously the Pharmaceutical Benefits Division.

**Senator MOORE**—We will get back to you on that. Expanding the National Suicide Prevention Strategy, $62.4 million.

**Mr Smyth**—In 2006-07, the funding was $17.312 million.

**Senator MOORE**—Yes.

**Mr Smyth**—In 2007-08, $18.952 million.

**Senator MOORE**—What is the time frame for that program?

**Mr Smyth**—It is a five-year program.

**Senator MOORE**—Beginning—

**Mr Smyth**—As you know, that program has been running for a number of years, and this money came over the top and almost doubled the size of the program. So the COAG component started on 1 July last year.

**Senator MOORE**—So that injection of funding was in 2006-07. Has the COAG ownership of this program taken it over so it is now actually the COAG component?

**Mr Smyth**—It is still part of the National Suicide Prevention Strategy.

**Mr Kalisch**—To some extent what the COAG money did was just really boost the existing program, but it is still managed in the same way.

**Senator MOORE**—So when the COAG evaluation—and we will talk about that later—happens about how the whole program is working, will they consider the whole of the National Suicide Prevention Strategy as part of their evaluation?

**Mr Kalisch**—It is going to be difficult to just evaluate—

**Senator MOORE**—That is what I thought.

**Mr Kalisch**—the extra component of funding.

**Senator MOORE**—So my expectation would be that part of the whole COAG process of looking at mental health would include this program area in total?

**Prof. Calder**—Yes, it would.

**Senator MOORE**—I take Mr Kalisch's point: you cannot evaluate half of it.

**Prof. Calder**—We will be evaluating the National Suicide Prevention Strategy in itself, but overall COAG will inevitably pick it up.

**Senator MOORE**—What about the new early intervention services for parents, children and young people initiative?

**Mr Smyth**—This financial year it is $455,000.

**Senator MOORE**—Yes.

**Mr Smyth**—And next financial year, $1.602 million.

**Senator MOORE**—What is the time frame?

**Mr Smyth**—Again, it is five years, but the bulk of this program really commences next financial year. It has been preliminary lead-up work that has been undertaken this year.

**Senator MOORE**—What have you actually done in that program up until now, because it is very early in the process? Have any tenders been let?

**Mr Smyth**—As I understand it, the work that has been undertaken to date has been a lot of consultation with community and children's sector groups and also the development of an undergraduate and VET pre-service teacher-training mental health curriculum as well.

**Senator MOORE**—So that is for teachers?

**Mr Smyth**—That is correct. As you know, we have MindMatters, which looks at secondary schools, and Kids Matter is mainly predominantly in primary schools. This measure is even looking at earlier measures than that.

**Senator MOORE**—Does MindMatters come out of this particular component, or is it a separate one?

**Mr Smyth**—It is a separate one.

**Senator MOORE**—So you are coming at it from the position of an education component. Is that going to be across the country or only in some states?

**Mr Smyth**—It will be a national program.

**Senator MOORE**—And the support for day-to-day living in the community initiative, $46 million?

**Mr Smyth**—This financial year, $3.875 million.

**Senator MOORE**—Yes.

**Mr Smyth**—And next financial year, $8.662 million.

**Senator MOORE**—Is it right that that is going to kick in in a bigger way later on in the program, because $46 million for the first two years—

**Mr Smyth**—It significantly ramps up over the period of the program. We are in the final stages of making an announcement on the 49 areas that we are targeting for that funding.

**Senator MOORE**—And are there any tenders out there yet for that area?

**Prof. Calder**—We have been in negotiations with areas that have tendered, and we hope to make an announcement fairly soon.

**Senator MOORE**—This financial year is pretty close—

**Prof. Calder**—Yes, by the end of this financial year.

**Senator MOORE**—By the end of this financial year the first round of successful tenders will be announced.

**Prof. Calder**—Yes.

**Senator MOORE**—How many in the first round?

**Prof. Calder**—Forty-nine.

**Senator MOORE**—Across the country?

**Prof. Calder**—Yes.

**Senator MOORE**—Have I missed any program areas?

**Prof. Calder**—I do not think so. I have been trying to keep track.

**Senator MOORE**—I just wanted to make sure that I have not missed any.

**Mr Smyth**—There is the additional education scholarships program as well.

**Senator MOORE**—That is the scholarship named after a gentleman?

**Mr Smyth**—The Puggy Hunter Memorial? That is the Indigenous component, which is another area.

**Senator MOORE**—That is another area we are going to get into.

**Mr Smyth**—That is right, and I think that question is probably best answered when you get to OATSIH.

**Senator MOORE**—So there is the general education scholarships area, and that has its own allocation under that heading? We have already talked about a number of education training components to previous programs, but there is a separate one altogether just on education scholarships. Tell me about that one.

**Mr Smyth**—It is $2.1 million this financial year.

**Senator MOORE**—Yes.

**Mr Smyth**—And $5.656 million next financial year.

**Senator MOORE**—Is that a five-year program as well?

**Mr Smyth**—Yes.

**Senator MOORE**—And these are for undergraduates?

**Mr Smyth**—There were 75 scholarships that were allocated each financial year under this measure. The scholarships are in the final stages of being awarded, and they will be backdated to the commencement of this tertiary year for the recipients of those scholarships. So the full-time scholarship is around $10,000.

**Senator MOORE**—Per person?

**Mr Smyth**—Per person, and we are looking there at mental health nursing and also clinical psychology.

**Senator MOORE**—Medicine?

**Mr Smyth**—No.

**Senator MOORE**—Just those two?

**Mr Smyth**—Those two groups.

**Senator MOORE**—How about the social workers and the OTs?

**Mr Smyth**—No.

**Senator MOORE**—Not yet?

**Mr Smyth**—Not yet.

**Senator MOORE**—Have you any more programs? I found outcome 6 very useful in the way they produced a format, which we had yesterday, which did all that for us. It listed all the programs, and then we were able to work through, I think, very easily—not that we have not worked very well so far on this, but it was just simple. They did it in one of those many intradepartmental working groups that you are a member of. That is a very useful action, because it lists every program that that particular area covers and also cross-references to which outcome owns it. So that kind of process would be useful.

**Mr Smyth**—The other initiative that was not mentioned is alerting the community to links between illicit drugs and mental illness. I think the secretary mentioned yesterday that the department would be tabling a consolidated list of campaigns related to this issue.

**Senator MOORE**—Yes, I have that one.

**Prof. Calder**—And there is one other, mental health in tertiary curricula, which is being addressed by the nurse education task force.

**Senator MOORE**—Yes, a total of $5.6 million allocated.

**Prof. Calder**—That is correct.

**Senator MOORE**—Is that a five-year program, Professor?

**Prof. Calder**—Yes.

**Senator MOORE**—And it is 2006-07, 2007-08 and so on?

**Prof. Calder**—I do not think we have the breakdown of that one.

**Senator MOORE**—How do the mental health nurse education task force and the scholarships work? Do they work together?

**Prof. Calder**—They are separately managed and undertaken but the stakeholders are much the same.

**Senator MOORE**—I would imagine they would be.

**Prof. Calder**—So there is overlap and it is very complementary.

**Senator MOORE**—Mr Smyth, how are we going with the mental health nurse education—the mental health in tertiary curricula expenditure?

**Prof. Calder**—Let me just look for that one, Senator.

**Mr Smyth**—Senator, the other one I should mention—not to forget them—is the Mental Health Council of Australia. They were the recipients of a million dollars over five years.

**Senator MOORE**—You would never forget them, Mr Smyth; they are the Mental Health Council. They got funding under the COAG process for what?

**Mr Smyth**—They did. They got an additional $200,000 each financial year over five years, which is additional funding to their base CSSS funding.

**Senator MOORE**—There was an expectation of that $200,000 about things they do for you, was there not?

**Mr Smyth**—There were not specific program components to that. It was base funding for them under the CSSS. So it is really, I suppose, to enhance the capacity and the capability of the Mental Health Council to engage with us in the sector to provide advice on the implementation of the COAG initiatives.

**Mr Kalisch**—Senator, as we have been describing each of these measures, there are very extensive stakeholder engagements. With some of the smaller organisations, this is going to create difficulties unless we enable them to have that capacity.

**Mr Smyth**—Senator, mental health in tertiary curricula, in this financial year, is $600,000.

**Senator MOORE**—For 2006-07 it is $600,000.

**Mr Smyth**—And $64,000 for 2007-08.

**Senator MOORE**—And it is a five-year program starting in 2006-07?

**Mr Smyth**—That is correct, Senator.

**Prof. Whiteford**—Senator Moore, there is one other if you are—

**Senator MOORE**—If I could sit here long enough! Yes, Professor.

**Prof. Whiteford**—We are also obviously keen to increase the number of psychiatrists and specialists, and we would like to advise you that $13.5 million over four years has been allocated. It is not part of the COAG mental health package but part of the workforce package.

**Senator MOORE**—Sure. But once again it has that crossover, does it not?

**Prof. Whiteford**—It has a crossover.

**Senator MOORE**—So from our point of view, even though it is not part of COAG, it is part of mental health. So it is 13.4 across four years—

**Prof. Whiteford**—It is 13.5 across five years. It is $1 million in 2006-07 and $3.5 million in the next financial year.

**Senator MOORE**—How does that operate, Professor?

**Prof. Whiteford**—We are working with the College of Psychiatrists to increase the number of training positions, including training positions outside public teaching hospitals. We are working with them to look at their measures for accrediting overseas-trained doctors and building a capacity within the College of Psychiatrists to improve the way in which they train psychiatrists, given that we have been concerned about ensuring that there is enough access to psychiatrists. Better Access provides financial mechanisms through the MBS, but we need the workforce to grow as well.

**Senator MOORE**—Is there any component of that funding that is linked to having psychiatrists working outside metropolitan cities?

**Prof. Whiteford**—Not in that particular measure that I know of, Senator.

**Senator MOORE**—Before I go on to the next couple of questions, while we are on that, is there anything in any of the components that is focused on getting psychiatrists away from metropolitan centres?

**Prof. Whiteford**—I will ask Mr Groth.

**Mr Groth**—For the measure that Professor Whiteford was just speaking about, we have engaged with the College of Psychiatrists. One of the things that we are encouraging that college, among others, to do is to look at training potential outside of the public tertiary teaching hospitals. That includes rural and remote settings. We have engaged with them and have explicitly asked, in relation to your question, that they consider the options of where that could occur.

The college have been very helpful in telling us where they currently have accredited places, and a number of those sit in private settings and non-tertiary teaching hospitals outside. They already have those, and we are looking to encourage them to expand them. We have also asked them to look into other options that might need to be supported in how we can promote trainees undertaking rotations in those settings.

**Senator MOORE**—Is there any funding linked to that encouragement, Mr Groth?

**Mr Groth**—It is within the million dollars for this current financial year that we have been speaking about.

**Senator MOORE**—So that kind of process is not in that last package?

**Mr Groth**—There is not a dedicated amount within that funding pool for that purpose, but we are explicitly looking for a response on that front.

**Senator MOORE**—Good.

**Mr Kalisch**—Senator, you would be aware, at least in terms of the health workforce programs that we run, that we do have a number of initiatives for medical training places as well as now the new announcements for dental training places in terms of the rural clinical school model, where people do get rotations and experiences outside of metropolitan areas.

**Senator MOORE**—Within the MSOAP, are you aware of whether there are any psychiatrists who operate within that program?

**Prof. Calder**—We do not have that information, Senator.

**Mr Smyth**—It certainly does cover psychiatrists. I do not have the numbers on that, Senator.

**Senator MOORE**—It was a question I neglected to ask last night, to my shame, so I just wanted to get that on record.

**Mr Smyth**—Yes, absolutely.

**Senator MOORE**—I am going to have to go back and read my handwriting, so I pass on to somebody else.

**Senator WEBBER**—Can I just ask one question about the million dollars that was mentioned just before?

**CHAIR**—Is your understanding of 'one' my understanding of 'one'?

**Senator WEBBER**—It will be exactly the same, I promise you. Just this once it will be exactly the same. With that million dollars, how is it going to work? The standard formula that applies with these things—and I am sure that Senator Adams will back me up—is that when we are in Western Australia we get 10 per cent, so $100,000 is not going to get me much of increased anything when it comes to psychiatry services in Western Australia.

**Mr Groth**—Senator, the way we are approaching the development of this with the college is that it is more of a national issue at this point. The rollout and the commencement of places is due to occur in January 2008. What we are doing ahead of that is improving the capacity. We certainly are asking the college to have a spread across Australia including rural and remote areas, as I have said before.

With some of the other funding, we are working with the Rural Doctors Association of Australia to provide advice on a range of specialities including psychiatry. Other funding is going toward consumer attitudes and those sorts of things that have a national impact. So we have not allocated funding on a state-by-state basis amongst that one million. It does not follow a COAG formula or anything like that.

**Senator WEBBER**—We will have a more detailed discussion after the break.

**CHAIR**—Very good. I am impressed!

**Proceedings suspended from 3.35 pm to 3.54 pm**

**CHAIR**—We were in the midst of outcome 11, I think—mental health.

**Senator MOORE**—Professor Calder, we are going to move around a bit in order to get as much of the information as we can, and we do want to go back to Aboriginal programs later in the questioning. I am wanting to clarify issues about Defence Force and veterans' mental health issues. Are they covered at all in the programs that you oversee? Is there special funding for their issues? Do they count under the general COAG focus on mental health in Australia?

**Prof. Calder**—No.

**Senator MOORE**—So in terms of the funding elements, they do not. That is clear. How about interrelationships in terms of IDCs and also sharing the knowledge and best practice? On the basis that Health and Ageing leads on so many of the working groups, is there anything there that picks up the issues around veterans and their families?

**Prof. Calder**—We do have an interdepartmental committee for the COAG measures, and that includes the Department of Veterans' Affairs. They sit on that.

**Senator MOORE**—We have gone through some of these services and in at least four of them you would think that some veterans would have interest and veterans' families, which is the other aspect, would have interest in being part of them or actually working with them. Is there any kind of way that happens or is that just not able to work?

**Prof. Calder**—Through the IDC each department knows about all measures and can keep itself informed and engaged within them. But equally all of the services and programs are accessible to the population. So veterans would be able to access a range of measures in their own right in the community.

**Senator MOORE**—With regard to the rural health ones in particular, the information we have is that there have been some significant issues with veteran servicing in remote Queensland because of where people live. DVA services are struggling to actually provide services for those areas. In terms of the specialist programs that come under your area for rural and remote servicing and personnel development, is there a linkage directly with DVA or is a veteran or a member of a veteran's family just another person in—and I will not use any example today—that part of the world?

**Prof. Calder**—The latter, yes. But through the interdepartmental committee any particular issues could be raised and discussed around access.

**Senator MOORE**—Is this the interdepartmental committee just between Health and Ageing and DVA or a wider one that looks at mental health?

**Prof. Calder**—It is all departments relevant to this measure. I do not have a list of those that attend—

**Mr Smyth**—I do have a list of that, Senator.

**Mr Kalisch**—It includes Health and Ageing as the chair, the Department of Employment and Workplace Relations, the Department of Education, Science and Training, FaCSIA, Attorney-General's, Prime Minister and Cabinet, DVA—

**Senator MOORE**—Human Services?

**Mr Kalisch**—Human Services, yes. Both Human Services and Centrelink are represented.

**Senator MOORE**—Child Support?

**Mr Kalisch**—No.

**Senator MOORE**—DOTARS?

**Mr Kalisch**—No.

**Senator MOORE**—And DOTARS—

**Mr Smyth**—Prime Minister and Cabinet, Attorney-General's, Treasury—

**Mr Kalisch**—And Treasury, yes. So it is quite a wide cast. It meets around about every six to eight weeks.

**Senator MOORE**—Just in the FaCSIA component, does that include special consideration of OIPC or is it just one group from FaCSIA?

**Mr Kalisch**—The representation is up to FaCSIA, but they generally send Evan Lewis as their main representative.

**Senator MOORE**—From the mental health area?

**Mr Kalisch**—From the mental health branch.

**Senator MOORE**—I am just thinking of the Indigenous component.

**Mr Kalisch**—It is really up to the agencies to take forward that—

**Senator MOORE**—But there is no particular consideration of someone bringing in the component of Indigenous services across all these other areas?

**Mr Kalisch**—I am not aware of anyone coming from the OIPC area of FaCSIA in the time that I have been chairing it.

**Senator WEBBER**—I thought we might start with a couple of general questions about the operations of the new programs. I was wondering if someone could just give me an overview with all of this new activity that is going on—long overdue activity—how the non-government sector has responded to these initiatives and what mechanisms there are for NGOs and consumers and carers to be involved. I know we have got all the professional colleges and so on covered, but there is a whole range of other people out there and I would

be interested in an overview of how they are included and how they are responding to the initiatives.

**Mr Smyth**—Senator, there are a few levels here. In terms of what we do with the non-government sector, we have a stakeholder reference group that meets quarterly. That includes 10 particular members—the colleges that we have talked about, the Indigenous Strategies Working Group, the Mental Health Council of Australia, the Australian Mental Health Consumer Network, ARAFMI carers and the Australian General Practice Network. So we are engaging a lot in the non-government sector at that level. We also recently have held a workshop with regard to the education and training component of the Better Access initiative where we included much broader representation, including organisations like Wesley Mission et cetera from the non-government sector, to get their input as well.

The COAG measures are also the subject of discussion at the Mental Health Standing Committee. As you know, there is carer and consumer and Mental Health Council of Australia representation there. Each of the COAG state and territory working groups has various different arrangements for the engagement of the non-government sector. As you know, in Queensland they are sitting at the table, and that is the only jurisdiction that has them sitting at the table. In the Northern Territory we meet with all of the stakeholders the day before to discuss all of their issues and then bring those to the table at the official COAG meeting the following day. Each state and territory group has different arrangements for the engagement of the non-government sector. So we have those formal mechanisms. There are also a lot of informal mechanisms that we utilise at the program level for the engagement of the non-government sector.

**Senator WEBBER**—So how far down does that go? We had a conversation with FaCSIA the other night about the roll-out of their initiatives and they can talk to me a lot about consultation and involvement at that peak body level. But when it comes to making the announcement for and the involvement of delivery of services, say, in Albany, I do not know that peak body consultation with carers and consumers in Canberra helps me a lot in terms of determining the priority for those funding and service deliveries in that specific community. So how far down does that penetrate? What involvement do those other groups, particularly consumers and carers, have in determining funding priorities?

**Mr Smyth**—What we do at the working group level is that we have had 40 of those working group meetings across Australia since August of last year. We rely quite heavily on the input of the states and territories as to their local knowledge of what is going on in the jurisdiction that is fed up through their various stakeholder groups. We also rely quite heavily on our state and territory officers who have very, I suppose, far-reaching networks on the ground in their local jurisdiction to provide advice to us. If it is necessary for us in particular areas to go and talk to particular organisations about the capacity that exists in that local area prior to our considering funding then we do that, although taking into account that if we are going to tender arrangements that can sometimes be a little bit difficult because of issues of conflict of interest.

**Senator WEBBER**—It is just that I know of a handful of consumers who are from the peak who are very tired because they obviously have challenges in their own lives anyway, otherwise they would not be seen as being consumer reps, but there are two or three of them

that are consulted and they are the standard consumer reps. I think we need to have a program that perhaps builds some of them up a bit more and includes them more at that base level rather than just going to the same two or three exhausted faces, and you could probably say that for the carer organisations too.

**Prof. Calder**—Senator, we are very alert to that. We have the stakeholder reference group that Mr Smyth has referred to and that has the peak bodies on it, both the Mental Health Council of Australia and consumer networks. We are talking with them about capacity development both in skills and numbers of consumers and carers to work with this measure both at the national and local levels. As Mr Smyth said in the consultations around roll-out of the programs, we work very closely with our state offices and through them have good information from local areas around gaps and areas of priority. In the next six months we will be working very closely with the consumer part of the sector to look at skills development for consumers under the education and training measure.

**Senator WEBBER**—I suppose we will have another conversation in six months time—perhaps it will not be quite six months time because I have a feeling something else will happen between now and then so it might be an entirely different conversation. But at the moment we are confident that, although there is always room for improvement, we have the input that we need to ensure the services will hit the mark out there in the community.

**Mr Smyth**—We are confident of that but, as you highlight, there is clearly room for improvement and room to build greater capacity in that sector.

**Senator WEBBER**—I turn to one of Senator Allison's longstanding issues, the suicide prevention program. To my mind, the way recent events have been portrayed in some media has been distressing. With suicide prevention and dealing with the stigma of mental illness, you only have to look at programs like *60 Minutes* to see that we are obviously not getting very far in dealing with these challenges. Given the intensity of the media in recent months reporting the number of suicides and what have you, are we doing enough to reduce the number of copycat suicides? Are we doing enough to re-educate major media outlets about the way they educate us about these issues?

**Prof. Calder**—I would not want to comment on 'enough' because I think you have made the point. We have a strategy to work with the media around responsible reporting, particularly to address copycat suicides. That has been ongoing. We are obviously committed to maintaining that and working with various media organs to ensure there is responsible reporting and an understanding of the implications of reporting.

**Mr Smyth**—We obviously fund two major programs in this area: the Mindframe initiative, which Senator Allison alluded to yesterday, and also SANE Australia runs StigmaWatch. I know that after the issue you are referring to in Victoria, which generated a lot of media attention, the mindframes media initiative through the Hunter Institute in Newcastle fielded a lot of questions from journalists. SANE StigmaWatch also responded with what it thought was I suppose areas where the reporting was not as responsible as it could have been and it is working with those media outlets. We are obviously funding those programs on an ongoing basis and watching very closely the reporting that occurs.

**Senator WEBBER**—I find it alarming and distressing that an organisation that markets itself as a responsible current affairs show could think it was legitimate to broadcast that episode nationwide. Have we therefore looked at re-evaluating how we are addressing it, renewing our efforts and putting more effort into it?

**Mr Smyth**—We are halfway through an evaluation of the media reporting since about 2001. SANE StigmaWatch is undertaking that activity and we hope to have a report in the coming months. We will have a look at that when we receive the report.

**Senator Mason**—There were other people involved who made constructive comments about the performance of *60 Minutes*. I think Mr Kennett had a lot to say about it and it was good and very constructive.

**Senator WEBBER**—Absolutely. In issues like this I find myself agreeing with Mr Kennett an awful lot, which I am sure he finds just as disconcerting as I do. It is just as well we do not support the same football team or there would be a real problem. I am sure Senator Allison will want to follow up on this issue. With a lot of the suicides that are reported, particularly the high-profile suicides, there is a lot of reporting about the prevalence of alcohol abuse. So are we doing anything specific to address that part of the challenge within our community?

**Prof. Calder**—Under the Suicide Prevention Strategy, we fund community based projects. Invariably they have a multifactorial approach to their strategies within their communities, so we support strategies that address community identified areas of need. We do not have a specific strategy to do what you are suggesting because we are working with communities around their identified priorities.

**Mr Smyth**—As you know, there is also assistance through the non-government sector to drug and alcohol organisations in relation to mental illness that is run in another part of this department that will start on 1 July. That will look at building the capacity of those non-government organisations around drug and alcohol areas to improve their awareness and ability to treat people with a mental illness. So that program through a number of grants will commence on 1 July.

**Senator WEBBER**—What about in terms of general public education and programs to specifically address that? We will come to those issues down the track. The media is obviously aware of the fact that it plays a role. So do we need to look at doing more in terms of public education in that area?

**Mr Smyth**—I am sure we could do more, but I would have to take that on notice and go back and talk to colleagues in the department.

**Senator ALLISON**—You said that discussions have taken place. Could you elaborate on that?

**Mr Smyth**—I do not have the exact details of what occurred. Are you referring to SANE StigmaWatch and the discussions with media outlets?

**Senator ALLISON**—No, I am referring to the discussions you mentioned which I understood to be between the department and the media.

**Mr Smyth**—No, they were not between the department and the media. We are at arm's length from that. That activity takes place through the Hunter Institute and also SANE

StigmaWatch. We do not play any part in that, so we were not contacting media outlets directly.

**Senator ALLISON**—Does the department have a position on the appropriateness of that *60 Minutes* episode?

**Mr Smyth**—That would be a decision of government in many respects as to what the position was, but we did not comment directly.

**Senator ALLISON**—Did you prepare a brief for the minister?

**Prof. Calder**—We have had discussions on the issue, much the same as we are having now. The department's position is that we have been funding the development of resources with the media to ensure that there is an understanding of the responsibilities of the media and the implications of reporting. So in that sense, yes, there is a position but it is providing advice and guidance through resources for the media.

**Senator ALLISON**—You say 'ensure' but nothing was ensured as we saw that go to air.

**Senator Mason**—Senator, you are right but the point is that the government cannot restrict that sort of commentary other than through voluntary efforts. You are right that it was very unhelpful what *60 Minutes* did but it is not for the government to censor the press on the issue.

**Senator ALLISON**—It was a bit more than unhelpful. There was a direct flouting of the media code that governs the coverage of suicide, surely.

**Senator Mason**—That is why the government puts money into organisations like SANE, to ensure that they are monitored and criticised appropriately, but it is not for the government. No-one is committing a criminal offence.

**Prof. Calder**—Our strategy has been to ensure the promotion of understanding, so that is the work that has been going on for some years.

**Senator ALLISON**—What do we know so far about copycat suicides?

**Prof. Calder**—In what sense?

**Senator ALLISON**—Have there been copycat suicides as a result of the coverage?

**Prof. Calder**—We do not monitor direct suicide activity.

**Senator ALLISON**—Who does?

**Prof. Calder**—Statistics are collected on an annual basis through various state jurisdictions.

**Mr Smyth**—Coroners in jurisdictions.

**Senator ALLISON**—So we are none the wiser, effectively, on whether this has been a disaster for young people who might go out and suicide and whether they would have done it or not.

**Prof. Calder**—Not directly through collection of information about other suicides, no.

**Senator ALLISON**—Through the agencies the department funds, was there any correspondence with the major media outlets about this?

**Prof. Calder**—Not that we are aware of. If people have corresponded, they may have done so without advising us. There was a high level of discussion, as you might imagine, amongst the stakeholders with whom we regularly meet about the inappropriateness of this.

**Senator ALLISON**—So you discussed it with those agencies but not what they would do other than—

**Prof. Calder**—Only in the sense that, as you meet with people, various comments were made.

**Senator ALLISON**—So no press releases were released by the minister? I realise the department does not put out press releases. We did not put out a press release about it? There was not a letter written directly by the minister and there were no letters written by the agencies who receive the money for our suicide prevention program. Is that correct?

**Mr Smyth**—I am not sure whether they actually did. We will follow that up with SANE StigmaWatch and find out for you.

**Senator ALLISON**—What about the voluntary code which is expected to guide media outlets? Will there be a high level of review of that code and adherence to it?

**Prof. Calder**—I have not referred to it as a code. It is a set of resources for media that are developed with them. It is called Mindframe resources.

**Senator ALLISON**—Should it be a code?

**Prof. Calder**—That is a matter for the media, I think.

**Senator ALLISON**—Minister, do you think there should be a code which is signed off by media outlets around the country?

**Senator Mason**—I am not sure that would make a difference, Senator Allison. The point is that the media sometimes is irresponsible in its reporting, and I agree with you.

**Senator ALLISON**—There are media codes for advertising, the portrayal of women, the portrayal of children and so on. Why not have a code for suicide?

**Senator Mason**—When you say 'code', do you mean backed up by criminal law? What sort of sanctions would the code be backed up by? What are you suggesting?

**Senator ALLISON**—We have just established the fact that there is no voluntary code. I would have thought that that would at least be the first step in producing a document which was signed off by the media. There is a better chance of them adhering to a set of rules in a code than there is with the current helpful resources that we provide them with.

**Prof. Whiteford**—There are reporting guidelines which have been signed off by print, television and radio. As Senator Mason said, in this case the media outlet concerned did not adhere to those guidelines.

**Senator ALLISON**—That is right. So my question is: are we going to upgrade the guidelines to turn them into a code so that it is obvious that this government takes this issue seriously?

**Senator Mason**—When you say 'code', what do you mean by that?

**Senator ALLISON**—We have codes in a range of areas within the media.

**Senator Mason**—What sort of sanctions are you proposing?

**Senator ALLISON**—I am not proposing any sanctions. We are talking about a voluntary code. We have voluntary codes for a range of subjects within the media which are variously adhered to. I am asking you: are you prepared to take it from the current guidelines, which do not appear to be working, to a slightly more explicit, tougher level, which might be a code?

**Senator Mason**—I do not know, but you are talking here about nomenclature—guidelines and codes. That is not the point. The point is what the sanctions are. That is the key.

**Senator ALLISON**—What do you think the sanctions should be?

**Senator Mason**—It is difficult. You and I both believe in freedom of speech. What the media did was very irresponsible; I agree with you on that entirely. The difficulty is what you do about it, and that is a lot harder.

**Senator ALLISON**—Minister, I am asking you what you are going to do about it.

**Senator Mason**—We fund organisations to monitor the activities of organisations to ensure that the media behave. Generally, to be fair, many do. In a sense this was a bad performance. In general, over the last few years the reporting by the media of suicide has improved in the sense that their sensitivity has improved. That is a good thing. But I agree with you that the performance of *60 Minutes* was undesirable.

**Senator ALLISON**—And probably not through any ignorance on the part of the producers of *60 Minutes*. Would you agree with that?

**Senator Mason**—I cannot comment on that. I do not know.

**Senator MOORE**—Professor Calder, on that point, is this a topic of any of the COAG working groups—that is, the public persona of people with mental illness? I am always amazed at how many working groups there are that come out of COAG. I am wondering whether this particular issue, which is the public face of suicide and how that can be looked at, is an information point on any of those groups?

**Prof. Calder**—Not a specific matter at all, no.

**Senator WEBBER**—We have lots of working groups but we do not seem to have anything that from a national perspective addresses public awareness and health promotion—

**Prof. Calder**—That was not what I was answering.

**Senator MOORE**—I was not talking about that component. I am wondering where it could fit in any of the pre-existing work groups. Could it be a topic?

**Mr Kalisch**—The COAG groups that Senator Moore was referring to are convened by the state premiers' and chief ministers' departments in each jurisdiction. They involve Commonwealth representation. Their primary task is to look at care coordination models in the first instance. So they have a more practical bent in terms of implementation. They also look at coordination and collaboration across jurisdictions in terms of the specific measures. They do not really have a policy development edict. I suppose the other dimension is that they are fairly well occupied in terms of their terms of reference around the implementation of these measures. They are not looking to take on further issues.

**Senator WEBBER**—I do not doubt in any way that their work is of absolute necessity within our community. As I say, it is an initiative that I support. With every other health initiative where we work together and we look at care coordination we actually look at public education as well. With diabetes we have public education. With eradicating smoking we have public education. In my home state we started off the campaign about eating well and the fruit and vegetable campaign. It went national. We do that with every other measure where we try to address a significant issue within our community. We have a campaign around it as well.

**Prof. Calder**—There are various public awareness and education strategies and initiatives within the measures. I was answering what I thought was a particular focus—and that does not.

**Senator MOORE**—My understanding of the National Suicide Prevention Strategy, which has now been caught up with extra funding through COAG, is that there are public awareness elements in that, but there is no working group that feeds out of that and looks at how the image of suicide is actually presented in the public arena. So there is nothing along those lines?

**Prof. Calder**—Not specifically to that extent. There are a range of measures. There is the LIFE Framework which looks at understanding of suicide and alternatives to suicide et cetera. There are a whole range of measures but not—

**Senator MOORE**—Personally focused rather than publicly focused.

**Prof. Calder**—And community and public.

**Prof. Whiteford**—The evaluation of beyondblue showed a significant improvement in the understanding of depression and the risks of depression including suicide. That work showed that those areas which had taken up beyondblue early got a better community education outcome. Groups such as beyondblue and the advocacy of people like Jeff Kennett have done things that the government would find hard to do. I think it has been multipronged, but clearly more needs to be done, as that program evidenced.

**Senator MOORE**—We have some specific questions on Better Access to Psychiatrists, Psychologists and GPs through the MBS. These are quite specific about numbers. I know we have the original funding figures from the early questions, Mr Smyth, but I want to get an idea of patients and how patients have been serviced by these processes. Was it 1 November 1996 that it kicked off in its current life span?

**Mr Smyth**—That is correct.

**Senator MOORE**—How many new patients have accessed a new service?

**Mr Andreatta**—Just one minute and I will get that figure for you. For the period 1 November, when this initiative started, through to 31 March this year, for the GP items—which covers three GP items: the care plan, the review item and the consultation item—we had 226,111 patients. For the psychological therapies, which are covered by the clinical psychologists—three items—there were 22,418.

**Senator MOORE**—They are the ones where people can be referred by a GP to a psychologist?

**Mr Andreatta**—To a clinical psychologist.

**Senator MOORE**—And that is up to 12 visits; is that the one?

**Mr Andreatta**—Correct, six plus six.

**Senator MOORE**—So 22,418—is that people starting it, or does that mean, 'I am popping along 12 times'? I know you have to do it once a month—

**Mr Andreatta**—They are unique patients.

**Senator MOORE**—So 22,418 people have actually received a service?

**Mr Andreatta**—Correct. The final one, the focused psychological strategies, which are those services provided by the allied mental health providers—the psychologists, the occupational therapists and the social workers—was 55,234.

**Senator MOORE**—So just refresh me: what is the difference between that program and the previous one?

**Mr Andreatta**—The clinical psychologists items—they actually provide psychological therapy services; whereas the allied health providers, or the mental health providers, provide the focused psychological strategies.

**Senator MOORE**—The ones that have been approved. There is a list of them.

**Mr Andreatta**—The registered ones, yes.

**Senator MOORE**—And there is an MBS item for those as well.

**Mr Andreatta**—They have their own MBS item.

**Senator MOORE**—So are the 55,234 unique people?

**Mr Andreatta**—Yes.

**Senator MOORE**—Each person being unique. They are global figures. Is there any way we can get that broken down to a smaller unit?

**Mr Andreatta**—Yes.

**Senator MOORE**—We can now start for three hours to describe what those are, but I am not going to do that. What is the building block that you use?

**Mr Andreatta**—I have figures for each of the items by state.

**Senator MOORE**—Great. That is good. Just do not read them out.

**Mr Andreatta**—Would you like me to table this?

**Senator MOORE**—That would be lovely. Is it possible to get it in any smaller building block, or is by state as low as you can go?

**Senator WEBBER**—Can we do it by postcode, say?

**Mr Andreatta**—No, the department does not publish Medicare data by items down to levels less than state and territory.

**Senator MOORE**—If you can table that document, that would be good. Who is doing the most?

**Mr Andreatta**—Who is doing the most?

**Senator MOORE**—In which unique state are the most unique people getting services?

**Mr Andreatta**—Let me see—

**Senator MOORE**—Because this item started on the same date everywhere—there was no roll-in of this one, it started up at the same time—I want to see whether the take-up reflects the population or whether in fact there is any variable there that says that one state is actually providing more services than another.

**Ms Halton**—Do you mean per capita or just the straightforward numbers?

**Senator MOORE**—The straightforward numbers at this stage, because we will be able to see that.

**Mr Kalisch**—That will obviously reflect the lowest—

**Mr Andreatta**—Correct, and the figures reflect that.

**Senator MOORE**—They reflect that. There is nothing that jumps out from that list that looks unusual?

**Mr Andreatta**—No.

**Senator MOORE**—We will have a look to see if there is anything from there.

**Mr Smyth**—The only thing that really jumps out from the list that you have been provided is the amount of clinical psychology item numbers that have been accessed in Western Australia, which is much higher than their population is.

**Senator MOORE**—I am sure that Senator Webber—

**Ms Halton**—This is your home state.

**Mr Kalisch**—Mr Smyth was saying how well Western Australia was doing.

**Senator MOORE**—Or how great their need was. Mr Smyth, would you like to repeat that, because I am sure that the two Western Australian senators will pick up on that.

**Mr Smyth**—Western Australia's population splits around 10 per cent, if you look at it. Under the clinical psychology items, there have been around 100,000 services delivered nationally. So that is almost 20,000 delivered in Western Australia.

**Ms Halton**—So they are sicker, or they are quicker, or they are something.

**Mr Smyth**—They have had a program over a number of years that has worked very well to credential clinical psychologists in Western Australia.

**Senator WEBBER**—Of those statistics—and they are very useful—how can I determine whether, with this new MBS initiative, we are actually providing new services for new clients and so we are broadening the service delivery? Are we actually picking up the people that this was designed to pick up, or is this just people who were able to access the service anyway now availing themselves of the MBS?

**Mr Smyth**—These are all new services.

**Senator WEBBER**—Yes, but they could have been pre-existing clients of the system?

**Mr Smyth**—They could.

**Senator WEBBER**—That is what I am talking about. Is there any way that I can determine the effectiveness of this program in delivering new services to new clients—clients that were not in the system before?

**Senator POLLEY**—Could I ask a question on that as to whether or not, with these statistics, you have any records of those people who cannot access services because they do not have the professionals?

**Prof. Calder**—No.

**Mr Andreatta**—You could look at it one way. There are certainly a lot more GPs included in this initiative than in previous mental health items. So there are more GPs doing mental health care plans. You could draw that conclusion, that there are new patients being seen by those GPs, given the total number of GP management plans. The uptake is very positive.

**Mr Smyth**—Under the Better Outcomes in Mental Health Care program, which is the precursor to this program, around 4,000 GPs or so referred our clients into the Better Outcomes program. There are in excess of 16,000 GPs now engaged in this Better Access initiative to date.

**Senator WEBBER**—But particularly with the MBS numbers for allowing us to access psychological services, is there any way that I can work out that new people—new clients—are accessing these new services?

**Mr Smyth**—No.

**Senator WEBBER**—Has any thought been given to making that happen—getting the psychologists to tick a box on the form that says, 'This is a new client'?

**Mr Smyth**—We have not looked at that, but one of the ways some of those issues will be picked up is when we undertake the second national survey of mental health and wellbeing in October and November of this year. We will look at those figures of service utilisation versus the statistics that we have out of the 1997 survey where we measured unmet need then. We will be able to track against those two groups of statistics.

**Ms Halton**—And that sort of population estimate I think is a much better way to measure this, because any retrofitting of analysis—even if you did say on a Medicare benefits form, 'Have you ever used this service before; yes or no?' you have all sorts of reporting issues. You do not know whether they mean, 'I have never been to this psychologist before.' There are all sorts of issues; whereas, if you just look at macro access to services via that kind of survey methodology, I think you will get a better answer.

**Senator WEBBER**—I accept what you are saying. This is why I wanted to drill it down by postcode, because I have a real concern that we are not necessarily getting out there. It is not new clients accessing the new services in the areas of greatest need because the professionals are not out there, either. The statistics in my home state are just fantastic, but it would be London to a brick, almost, that the people in Kununurra and Rockingham are not accessing it at the level of the people who live near me.

**Ms Halton**—There are two things that I would say about that. Firstly, we know that the dispersion of psychologists is actually pretty good across the country.

**Senator WEBBER**—It is much better than psychiatrists.

**Ms Halton**—Yes, we will agree with that. Certainly, anecdotally—and I know this is a small group of people I went to university with—I am told that they are seeing a far greater number of clients these days so they are actually much, much busier, and they are seeing a lot of people who say when they walk through the door, 'I have never been able to access this service before because I could not afford it,' or whatever. One graduate in a class is not necessarily a good sample of psychologists, but I can tell you that that is what I am being told. I do not know what you are being told.

**Prof. Calder**—Absolutely. In addition, we have a range of measures, pre-existing or new, that are designed to provide for services in areas where there is a shortage of workforce and it is hard to deliver services on an established basis. So we have Divisions of General Practice with fund-holding capacity under Better Outcomes. We will be looking at the interaction of Better Outcomes and Better Access once we have got past the establishment of Better Access to see what the gaps are. We are bringing them together, I think, in June.

**Mr Smyth**—In June we are meeting with the CEOs in all Divisions of General Practice to look at alignment.

**Prof. Calder**—And we are hearing anecdotally that they are targeting Better Outcomes to the people who have greater difficulty accessing Better Access services.

**Senator MOORE**—Are all Divisions of General Practice now engaged?

**Prof. Calder**—I think that is correct.

**Mr Smyth**—As of next week we will have 100 per cent coverage with the Pilbara, as I understand it. That is coming on next week with the signing of the contracts.

**Senator MOORE**—So that means all the current Divisions of General Practice are active participants in—

**Mr Smyth**—In the Better Outcomes program, yes.

**Senator MOORE**—In terms of Senator Webber's questions—and these are things that I know are threshold to the whole of the program—with the crossover of mental health services in rural and remote areas and the specialised education programs that you outlined earlier, one of the things we are struggling with is how that is going to be evaluated. How are we going to establish effective benchmarks to say: 'This is what is happening. This is the input and this is the outcome'? I am wondering how you are going to use statistics of this nature at this stage of the program when you then start looking at the input of those other programs which you described earlier that are determined to provide professionals into the areas that Senator Webber was talking about. How are you going to coordinate the evaluation of these programs to see whether the MBS data is one performance indicator of whether the other programs are being effective or not?

**Prof. Calder**—The short answer to that is that we will do just as you have described. We will coordinate all of the information on the range of measures into an overarching evaluation of input and outcome.

**Senator MOORE**—Will you then be able to publicise that? As you have said, you do not release figures below the state level generally. But, in terms of that kind of evaluation, whilst you may not release particular figures you are going to have to release to the public the impact of the change. Let us use Senator Webber's example of Western Australia. I do not know Western Australia, but in any place in the state you will know somewhere in the system that the MBS item for psychologists has been accessed by X number of people as of April this year. Twelve months down the track, when you have had 12 months of trying to encourage professionals into those regional areas, you will be able to know how many times that MBS figure has been accessed in that area.

**Mr Smyth**—That is right. As Professor Calder said, you then need to overlay all of the fund-holding arrangement programs to get a complete picture of that, because the fee-for-service MBS model gives you only one part of the picture, particularly in rural and regional Australia.

**Senator MOORE**—But at least it gives you a figure of who has been able to see somebody.

**Mr Smyth**—Yes. In the evaluation of all of the Australian government measures, we are asking the questions: what services were delivered; by whom; to whom; at what cost; and with what effect?

**Senator MOORE**—I have got up on this wonderful machine the new mental health MBS items, the fees and rebate table.

**Mr Smyth**—Yes.

**Senator MOORE**—Anecdotally what we have been told—and I am sure you have as well—is that, with the introduction of the psychologists and other allied professional item, which was widely welcomed and everybody wanted it, almost the first impact was that psychologists put up their fees. I do not want to dump on the whole profession, and it will not be everyone, but when I scroll down—if I can do this; I am courting with danger here—for clinical psychological therapy the item is about $129.40 and you get $110 back. I know that you do not have it in front of you and that is unfair—

**Mr Smyth**—I do have it in front of me, Senator.

**Senator WEBBER**—He has the old-fashioned version.

**Senator MOORE**—That whole line, Mr Smyth, has a proposed cost, as with all medical elements in this area, and the rebate. The rebate looks fine if people are actually charged the schedule fee, but you and I know that they are not. The anecdotal feedback that I have about psychologists is that people who were seeing a psychologist before 1 November last year were paying a certain amount of money to go to a psychologist. Since the input of the new program they are paying almost the same amount under the new process because the fee has gone up. Is that the kind of feedback that you have heard?

**Mr Smyth**—Senator, we hear varying accounts obviously across the country and there is no consistent pattern to this.

**Senator MOORE**—So you have not found that as a consistent pattern—

**Mr Smyth**—Not at all.

**Senator MOORE**—the professionals have put their fees up?

**Mr Smyth**—Not at all.

**Senator MOORE**—Okay. Has anyone done a snapshot? Mr Andreatta, have you done a snapshot of the fees that people are paying?

**Mr Andreatta**—Given that it is only six months into this initiative, we do not have any solid data, but we have had a quick look at it. The out-of-pocket expenses are very comparable to the GP items, the time based items. So we are talking between $20 and $30, on average.

**Senator MOORE**—That is not what we have heard.

**Mr Andreatta**—That is doing a very quick look at the data. In terms of getting anecdotal feedback from different areas, I am not aware of any large out-of-pocket expenses.

**Senator MOORE**—What about the college of psychologists? Have they—

**Senator WEBBER**—The Australian Psychological Society.

**Senator MOORE**—Yes, them. Why don't you ask the question? You know who they are.

**Senator WEBBER**—The Psychological Society.

**Senator MOORE**—Have they given you any feedback on this issue?

**Mr Andreatta**—Not to me, no.

**Prof. Calder**—We have ongoing discussions with them at various meetings. The issue that we have discussed to some degree is the gap payment that still exists but not the quantum or whether it has increased. That has not been raised with us. I cannot speak for their information but it certainly has not been passed on to us.

**Senator MOORE**—Professor Calder, probably the second most often stated thing that we hear about the program—apart from the welcome that there are enhanced services, and no-one questions that—is disappointment from people that their out-of-pocket expenses with the new program are probably as high as original services in the past. If people want to give that feedback to the department, to whom should they give it?

**Prof. Calder**—It can come to us.

**Senator MOORE**—Okay, we will encourage them to—

**Senator Mason**—Senator, what are the ballpark figures?

**Senator MOORE**—$70 to $80.

**Senator WEBBER**—At least $50 out of pocket—$70 to $80.

**Senator MOORE**—And these are people who were paying about $70 to $80 before the program came in where they could find services. There was much jubilation with the

introduction of this particular item, with the maximum of 12 services per year to be subsidised, and to their disappointment they have found—

**Senator Mason**—The out-of-pocket expenses were the same or very similar.

**Senator MOORE**—Well, very similar. Their savings, if any, have been quite small. We will encourage those people to put that to the department.

**Senator WEBBER**—That feeds into my concern about new clients accessing new services, because a lot of these people were cut out of the old system because of the cost. So to access it there was great celebration, but then the fee goes up and it is becoming cost prohibitive again.

**Prof. Calder**—One of the aspects of the Better Access measure is that it provides for bulk-billing for a sector, or a profession, that has not had significant access to that before. We would therefore expect to see that there will be new services developed—this is obviously speculation but it is informed speculation. There is a market out there. There is now the potential to provide services in areas where the community perhaps would not be able to have afforded to pay a gap payment, and there is the potential for competition in areas where there are services that have a gap payment. So we would expect to see over time some of these early implementation issues that you are identifying to us to be addressed by a greater range of service providers.

**Senator MOORE**—In the various committees that you all serve on, when you look at how these things are going, is this one of the areas that has been considered?

**Prof. Calder**—No, it has not been a direct issue. It is fair to say that those committees are still working extremely hard at getting the measures out and established, and all of the services in place. We are starting now to think about post early implementation, the next range of issues.

**Senator MOORE**—Which one of the existing structures that you have set up to monitor this particular program would you suggest that the issue of cost to client and out-of-pocket expenses fits best to be considered?

**Prof. Calder**—We will look at it through the evaluation strategy, but as I have said to you, if there is anecdotal information that people want to provide to us, we are happy to have it.

**Senator MOORE**—Absolutely. I am surprised that you have not got it.

**Mr Kalisch**—We can certainly take up that specific question with the Australian Psychological Society as well. As Professor Calder says, it has not really been directly raised with us. So we can directly ask them the question.

**Mr Andreatta**—We have plans for a post-implementation review of these items in 2008. During that review some of the things we will be looking at are the appropriate use, the cost, the access. It will certainly be looked at during that review.

**Senator MOORE**—Good. Will that also be linking in with that survey you mentioned is happening in October-November 2007?

**Mr Smyth**—That is right. But the data from that will not become available until about October 2008. As you know, there are 11,000 people to be surveyed so it is a huge undertaking.

**Senator MOORE**—And which bucket do the costings for that survey fit into?

**Mr Smyth**—It comes out of the Commonwealth own-purpose outlays funding. It is about $5.6 million.

**Senator MOORE**—And is that in one of those pages?

**Mr Smyth**—It will not be in one of those pages but it is a direct contract with the Australian Bureau of Statistics.

**Senator MOORE**—It is a Bureau of Statistics undertaking?

**Mr Smyth**—That is right. They are undertaking the survey.

**Senator ALLISON**—While we are on this subject, can I ask how many non-college members—that is, the College of Clinical Psychologists—qualify for the Medicare rebate, the so-called Medicare eligibility?

**Mr Smyth**—Which rebate are you referring to? There are two rebates. There is one for state registered psychologists and then there is another one for clinical psychologists.

**Senator ALLISON**—The clinical psychologists.

**Prof. Calder**—The number registered as at 30 April was 1,561.

**Senator ALLISON**—Do you distinguish between college and non-college member psychologists?

**Prof. Calder**—No, we ask for advice on who they have credentialled, not whether they are members or not.

**Mr Smyth**—The Australian Psychological Society is responsible for credentialling clinical psychologists and there are three pathways into that program. We do not have the statistics of those who have come through pathways 2 and 3.

**Senator ALLISON**—What involvement does the department have with the credentialling process?

**Mr Smyth**—We do not have any involvement, apart from providing funds at the outset of the credentialling process for the APS to start registering those psychologists to be eligible for the Medicare rebate. We are not involved.

**Senator ALLISON**—So they were licensed to do this, effectively, by the department?

**Mr Smyth**—That is right.

**Senator ALLISON**—Are you aware of any tensions that currently exist between the APS and the college?

**Mr Smyth**—I am not aware of any. I did have a discussion with Professor Littlefield the other day, who said that certainly some of the members who are not classified as clinical psychologists would like to access the rebate. They are looking at bridging course arrangements to have those people qualify for the clinical psychology rebate. Clearly there are

other psychologists out there who do not meet the credentialling requirements and who are not happy. But that is where the government has set the benchmark.

**Senator ALLISON**—I understand the college turned them down and said they did not want to be involved in any shonky courses or words to that effect.

**Mr Smyth**—I am not aware of any of that.

**Prof. Calder**—I am not aware of it.

**Senator ALLISON**—So will it be of concern to the department if courses are not as rigorous as they might have been in the past for clinical psychologists?

**Mr Smyth**—We would certainly look to ensure that the highest standards are maintained. The Australian Psychological Society accredits all university psychology courses and also does the credentialling for international students. So we look to that peak body to provide that information.

**Mr Kalisch**—It is probably fair also to say that we are not aware of any problem.

**Senator ALLISON**—Well, I am and perhaps I should pass it on to you. One of the criticisms that has been made is that the sorts of hours that are required to be put in for the new eligibility status are nothing like previously.

**Mr Smyth**—I am not aware that the APS has changed its requirements for the College of Clinical Psychologists.

**Senator ALLISON**—I might get you to take this on notice. The figures are around 194 hours for the various subjects within that qualification—and most of them, according to the critique I have received, are described as undergraduate rather than postgraduate—and that compares with 250 in the current college arrangement.

**Prof. Calder**—In the early days, we heard the opposite information—that is, there was concern that the credentialling requirement excluded some people who would like to be included.

**Senator ALLISON**—I am sure it does. The question is whether we are seeing a downgrading of the standards for clinical psychologists or not; that is what I am driving at.

**Prof. Calder**—We will take that on notice.

**Senator WEBBER**—I have a number of other questions which I will place on notice about access to all of those services. Before I turn to the issue of evaluation, I want to have a brief chat about the GP referral for a care plan. We had a conversation last time about what was required. I raised with you some anecdotal feedback that things were perhaps not quite as detailed in terms of referring these people to professionals. It has since been brought to my attention that sometimes letters from GPs will say as little as, 'Can you please look after Mr X. He needs help,' and for that they get paid money. So what kind of evaluation or rigour are we putting in to make sure this meets all of our expectations?

**Prof. Calder**—We have been working with the Mental Health Association. We are about to finalise a project with them that will look at how referral behaviours are encouraged. We will be aiming at a project that will have a substantial impact on understanding what is required in a care plan. It will focus on fostering good working relationships between psychologists and

general practitioners. We are also working with the Australian General Practice Network to ensure they are running information sessions with their members on what is expected in the care plan.

**Ms Halton**—And there is a technical requirement under the MBS which Medicare Australia should be enforcing in relation to compliance, so there is a kind of carrot and stick to this and both will be employed.

**Senator WEBBER**—That is very good. I am pleased to hear that because I do not find that approach—and nor would the person concerned—either satisfactory or helpful.

**Ms Halton**—Indeed, it is not. We agree entirely.

**Senator WEBBER**—I would be really concerned. This is the second time issues like that have been brought to my attention. We had a bit of a chat about it last time and no-one had ever heard of it. Well, it has not gone away.

**Ms Halton**—And we agree with you; it is not appropriate.

**Senator WEBBER**—Because of the time, I want to finish off with a discussion about evaluation and research and I will put the rest of the sections on notice, if that is okay.

**Senator MOORE**—And should the Indigenous issues be discussed with you, Professor Calder, or with the Indigenous mental health people?

**Prof. Calder**—Both, I think. It depends on the question.

**Senator MOORE**—It is generally in terms of the provision of services in that area, the involvement specifically with consumers in the Indigenous area and whether there is any special allocation within any of the programs you worked through earlier to ensure that Indigenous issues are picked up. I know there is in the suicide strategy. That one jumps to mind because there is a particular component, but for the other ones—with rural and remote, with the Better Access to psychiatrists, with the education components in terms of getting professionals into the field, all of those—could you give us a briefing paper on the Indigenous components? Would that be better than taking the time now?

**Prof. Calder**—It would probably be easier, yes.

**Senator MOORE**—We will just put that on notice and if we have questions we will come back to it later.

**Prof. Calder**—That is fine. We are happy to do that.

**Senator WEBBER**—Overall, in terms of the COAG package, what proportion of that funding is going to be spent on evaluation measures?

**Mr Smyth**—It is a bit too early to look at what proportion that will be in some respects, because evaluation components are built into each of our individual measures. The Commonwealth will be evaluating all of its measures as well; as I said, we will be looking at who got the service, to what effect and all of that.

The Prime Minister has written to all health ministers across Australia in the last month to ask health ministers to bring forward to senior officials of COAG in six months a costed evaluation that will be undertaken in the fifth year. So we as part of the Commonwealth will

fund a scoping study—I suppose the scoping of that evaluation, through a tender process—that will engage each of the jurisdictions as to what elements need to be included in that fifth year independent evaluation and what cost that might entail for each of the jurisdictions. So that will then need to go back to the health ministers, or to COAG, to get funding endorsement. For a ballpark figure we are thinking around $3 million to $4 million for the overall evaluation.

**Senator WEBBER**—My main concern in this is the extent to which that evaluation takes place. All of us in this room have been part of the discussion: it's about the amount of money and who is responsible for which amount of money and allegations across jurisdictions of responsibility and who has to put what in where. My concern would be that the evaluation therefore is not a strict accountability, financial evaluation but also involves an actual attempt to measure whether people got better.

**Mr Smyth**—There is a way that we are looking to do that as well. As you know, we are undertaking the second national survey of mental health and wellbeing this year. We may look to do that in five years time, which will be at the end of the COAG cycle, to look again at whether or not there has been a difference there. Funding for that will obviously be dependent on Commonwealth own-purpose outlay funding that may or may not come as part of the healthcare agreement cycle.

**Mr Kalisch**—When the National Action Plan on Mental Health was discussed and progressed through COAG, as part of that process there were also a number of key performance indicators that were agreed that had a greater focus on actual outcomes. It is really outcomes that we want to predominantly evaluate—whether there has been a change in outcomes for individuals and for the population. I suppose, from our perspective, that is going to be a key feature of the evaluation. It will not just be the financial dimensions, it will not just be the inputs; it has to have a predominant focus on the outcomes—whether it has actually delivered a difference.

**Senator WEBBER**—Is there any thought to introducing some of that evaluation now? For instance, with this MBS item, access to psychological services, you can have your six to 12 sessions; are we then going to try to track some of those people after they have had their 12 sessions and work out whether they are any better? At the moment it is an uncapped thing, and that is fine, but there is no point in allowing this to keep going on forever if it is not addressing the concerns in the community.

**Mr Kalisch**—There will certainly be some information available in the interim as we move through, but also, as has been mentioned, a number of these initiatives are only just coming on stream now or are even going to come on a little bit later. In some of these instances it would be premature to be making such a significant call so soon, but there are certainly mechanisms to monitoring.

**Senator WEBBER**—I am not looking for a guarantee; I am just looking for consideration.

**Senator MOORE**—In looking at the Better Outcomes in Mental Health Care program, particularly with the enhanced access to other professionals, the kind of data that some people are talking about is the number of people who access one or two visits and then stop going and then maybe want to go back in two years time—that kind of cyclical approach—and

trying to understand what provides the best support. When we were looking at what was going to be introduced, we were so keen to get anything in there in terms of being able to evaluate exactly what is the best option for a number of people. There will be some people—and we have been told that there are some people—who seek long-term care. So the 12 visits within a 12- month period seemed to be a bit of a balance; we were told that was a balance in terms of introducing it. There could be people who would be seeking to have 12 visits for 12 years if that is available. There could be others who only want to go once. How do we best capture the data as to how many of those 55,000 that we heard of keep going back?

**Mr Smyth**—Each GP mental healthcare plan that is developed requires that the GP utilise an outcomes measurement tool unless it is clinically inappropriate to do so. This program will be evaluated after five years and at that particular point in time we will be looking at aggregating some of those outcome measures as well.

**Senator MOORE**—And the data is being kept all the way through?

**Mr Smyth**—We are currently looking at some of the design parameters around that evaluation and we hope to have that completed by the end of this year.

**Senator MOORE**—And, in terms of standard data collection across all states that are being involved in different processes, do we have an agreement that people are going to be measuring and counting the same stuff?

**Prof. Calder**—There are three national dataset collections that are in place.

**Senator MOORE**—Do the three cover everything?

**Prof. Calder**—Yes, they are across the public and private sector and the acute and community sector and residential sector. I think the question that I heard you ask was: how are we going to track consumer outcomes. As Mr Smyth said, there are outcome measures that general practitioners using the mental health item are expected to keep. We are not tracking individuals who access services but we are expecting to use this second survey as one tool to identify consumer outcomes—client outcomes. We will also be looking, in the development of the five-year evaluation, at ways of perhaps surveying general practice experience and perhaps through the consumer and carer network identifying sampling techniques to identify people's experiences in the group but not at the individual level.

**Senator MOORE**—So when was the first survey?

**Prof. Calder**—1997.

**Senator MOORE**—So that is a five-year sequence?

**Prof. Calder**—The next one is after a 10-year gap—2007. It will go into the field later this year and, as Mr Smyth said, as part of a timely evaluation we are thinking of a five-year rotation to the next.

**Senator MOORE**—Okay.

**Senator WEBBER**—So we are going to see some consistency in priority and service delivery—as much as we can be assured of anything—in those five years? We are measuring the same thing at the end that we are talking about today?

**Prof. Calder**—I think it is fair to say that mental health is now probably the most measured health service in the system. We have a variety of measures of input and output and we have a national strategy to collate and collect that data and use it. So I think we are in good shape.

**Senator WEBBER**—I am not doubting the ability to measure; I am just trying to guarantee that we are still going to be talking about offering the same services—the same access regimes. Otherwise we are not going to be measuring the same thing in five years time as we are measuring now. It is going to make it very difficult to work out whether people got better—whether what we offered them made them better or whether they found another way around it. In terms of other challenges that people face in society, the Commonwealth has played a leadership role in funding significant research in these things like drug and alcohol abuse, not just evaluation but also research. Is there any program, any consideration being given to that leadership role in this area?

**Prof. Calder**—The National Health and Medical Research Council has made mental health an area of focus, and that is where we would expect to see the sort of research that you are talking about.

**Senator MOORE**—We have them coming later this evening, I am aware. In terms of the focus on mental health, was that from the announcement of COAG? Was that when that focus was introduced? I just want to see when we are expecting to see the first grants that have a focus on mental health being granted.

**Mr Kalisch**—It is part of the COAG announcement.

**Prof. Whiteford**—And the National Health Committee of NHMRC have taken that on board and, as Professor Calder said, have made it a priority for the current triennium of NHMRC.

**Senator MOORE**—So at the next round of grants we might see some coming through?

**Prof. Whiteford**—A lot of those grants are investigation driven, but certainly there is an attempt to make mental health a focus. Perhaps the NHMRC could answer just how they are going to do that.

**Senator MOORE**—And making the industry, using the term perhaps incorrectly—

**Prof. Whiteford**—Yes, they could certainly encourage grant applications in that area.

**Senator MOORE**—Good. One of the things that we asked FaCSIA—and we deliberately did not ask questions about how you and FaCSIA work together, because we know it is a cooperative—and the minister and the departmental head yesterday was to perhaps look at giving us briefings along the way so that we have an interchange between estimates, which might be useful.

Minister, what we will do is go through the formal process of asking the minister for that. We have not actually accessed that from your unit yet because we seem to have too many meetings to get through it. We think that would be a useful mechanism. Also with the reforming of a mental health focus around this committee and with another one coming up, it is a good time to do it. I am just putting on notice at the estimates process that we will be going through the access for briefings.

We actually asked FaCSIA as well that, if something comes up that you think we should know about, it would be useful if you could stimulate that that as well, because sometimes we only find out after the event. If there is an issue or something that you think would be useful for us to know about, we would be more than open to have yet another meeting. Mr Smyth, how many meetings do you go to in a month?

**Mr Smyth**—My wife asks the same question, Senator.

**Senator MOORE**—Professor Calder, I should have asked you as well.

**Mr Smyth**—Since August of last year I think I have been to 35 COAG meetings around the country plus numerous subcommittee and—

**Senator MOORE**—And interdepartmental—

**Mr Smyth**—All up, it would be 100 meetings at least, I would say, since August.

**Ms Halton**—He does not win the prize though, Senator.

**Senator MOORE**—I would be interested to know who does, Ms Halton.

**Ms Halton**—I think I can probably guess.

**Senator MOORE**—We will put the rest of our questions on this outcome on notice because we are running into—

**Ms Halton**—Senator Crossin will be having words with you.

**Senator MOORE**—Mr Smyth, if we could get some of those data things as quickly as possible—

**Mr Smyth**—We have just been discussing this.

**Senator MOORE**—I know that is rude but—

**Mr Smyth**—We might try to work this out.

**Senator MOORE**—We might be able then to focus our questions on notice more effectively if we get back those basic things from you instead of asking the same thing, which is a waste of everyone's time.

**Mr Smyth**—Sure, yes.

**CHAIR**—I think we have now finished outcome 11.

**Ms Halton**—Chair, Senator Stott Despoja asked for some copies of the advertising on the Pregnancy Support Helpline—copies of the artwork—which I am happy to table, including the delightfully titled Convenience Advertising. So there is the Convenience Advertising, the poster and the wallet card. I will table that and then you can sort it out.

**CHAIR**—Okay. We will suspend for five minutes while we huddle around and talk about our program.

**Proceedings suspended from 5.09 pm to 5.15 pm**

**CHAIR**—We will resume now. It is proposed that we do approximately half an hour more in mental health. Senator Allison has a question.

**Senator ALLISON**—I hope the officer who understands everything there is to know about alerting the community to links between illicit drugs and mental illness did not escape us.

**Mr Smyth**—Unfortunately, Senator, that is the Drug Strategy Branch—no, sorry, it is Ms Van Veen. It is a $21 million campaign, Senator.

**Senator ALLISON**—Correct—$21.6 million.

**Mr Smyth**—That is correct. She is not here, Senator.

**Senator ALLISON**—Oh, the officer did not come at all?

**Mr Kalisch**—She came earlier for program 1.

**Senator ALLISON**—All right. Does that mean improved services to people with drug and alcohol problems and mental illness, the $74 million over five years, is also not—

**Mr Smyth**—That is outcome 1as well.

**Senator ALLISON**—That is the same thing, even though I thought it was outcome 11. I am sure I was told that earlier today. I might just go back to the expanding suicide prevention program. Is that within this program?

**Prof. Calder**—Yes.

**Senator ALLISON**—It has come to my attention that the reports in the evidence suggest that data on suicide provided by the Bureau of Statistics is not completely accurate. In terms of this strategy, what is the method intended to be used for data collection? You are familiar with the problems associated with suicide reporting?

**Mr Smyth**—I understand, Senator, but it is an issue for the Australian Bureau of Statistics and not for this portfolio as to how that data is reported. I understand the differences in the way that coroners operate in each of the jurisdictions and that that has an impact, but we do not have an input into how that data is collected.

**Senator ALLISON**—So what data will you collect?

**Mr Smyth**—We rely on the data that the ABS provide us.

**Senator ALLISON**—Even though it is problematic?

**Mr Smyth**—We understand it is problematic, Senator, yes.

**Senator ALLISON**—But you are not going to do anything about it?

**Prof. Calder**—It is a compilation of statistics that is held by the jurisdictions.

**Senator ALLISON**—This would have obvious problems in terms of guiding the program, I would have thought, and in setting targets or understanding levels of suicide. Or is the discrepancy not as great as has been suggested?

**Prof. Calder**—We use the statistics to measure over time the reporting of suicide events and behaviours, and we can measure change in those statistics that acknowledges that the statistics themselves are complex and have differences within them.

**Mr Smyth**—We understand that the ABS has formed a task force to look at the accuracy of those statistics and the way that coroners report suicide statistics. In terms of an issue, we would hope to input into that; there is no question.

**Senator ALLISON**—When is the task force expected to complete its work?

**Mr Smyth**—I would have to take that on notice—well, really it is a question for the ABS, not for this department.

**Senator ALLISON**—I understand that but you obviously have an interest in this issue—

**Mr Smyth**—Yes.

**Senator ALLISON**—and in getting it right.

**Mr Smyth**—I do not have that information.

**Senator ALLISON**—Okay. But it will be available in time for the next survey, will it?

**Mr Smyth**—I am not sure.

**Prof. Calder**—We do not know.

**Senator ALLISON**—What accountability framework has the department put in place for this measure so far? How do we know that the methodology which has been relied upon is reliable?

**Prof. Calder**—Are you talking about the LIFE Framework, Senator—the guiding principles for activity by jurisdictions and ourselves?

**Senator ALLISON**—Yes.

**Prof. Calder**—We are undertaking an evaluation and review of the LIFE Framework at the moment. That has been in place for some years and we are reviewing it—the stakeholder group and the jurisdictions.

**Senator ALLISON**—Is that just going to be an internal document or will it be made public?

**Prof. Calder**—No, it will be a public revision of the documents that were the suite of LIFE Framework documents. That is a process in train at the moment. We use the suite of data that we have talked about earlier—I think you might have been out of the room, Senator—to measure progress against the indicators that we have got. So the rates of suicide are used to indicate the extent to which the activities in the LIFE Framework have been effective and there have been changes in those data items.

**Senator ALLISON**—And the workshops to test that framework, are they going ahead next month as planned?

**Prof. Calder**—We have had a number of workshops all through this year on the LIFE Framework. There has been a consultancy that has met extensively and run workshops in various parts of the country and with various parts of the sector groups.

**Senator ALLISON**—Are there any Indigenous-specific programs within this outcome?

**Mr Smyth**—I would have to take it on notice, but there is a national Indigenous program and there are some community based programs that specifically target Indigenous communities as well. Out of the last funding round there were 46 community based projects, and I understand that some of those have an Indigenous focus. We will endeavour to get that information to you.

**Senator ALLISON**—To what extent will they be different from the others? I am thinking in particular of internet based, telephone based or broadband based programs that might apply in city areas. How will those be modified for Indigenous, particularly remote Indigenous, communities?

**Prof. Calder**—The projects are funded on an application by communities, and they identify their needs and their preferred methods of delivery. I could not answer that for you specifically. Some of those contracts are still being negotiated, but they are community driven, so they are defined and delivered by communities according to their assumptions of need. We are having a workshop with the Indigenous community sector next month in Alice Springs to look at methods of delivery issues that have been raised in their experience. We are looking for guidance about the next round of projects.

**Mr Smyth**—Out of the 46 projects, there are 12 Indigenous-specific projects. I have that information here, which we will be more than happy to table.

**Senator ALLISON**—Is it possible to provide the committee with a kind of mud map of the country to show where the applications have come from so far in terms of whether their reach is going to be across the country or not?

**Prof. Calder**—The list of projects identifies where they are located. We do not have a map, as it were, but we can provide you with that list and we will identify the spread.

**Senator ALLISON**—To put out the application invitation process, see who applies and reward those projects according to some criteria set by the department may mean that whole communities and whole populations of people do not get this service. At what point will you be able to evaluate the spread of programs—not just this one but programs that are done in this way? In fact, most of them from what I can see are. When will we know that this is not just a patchy, one-off, here and there approach and that it is more universal?

**Prof. Calder**—It is one of the reasons we have such a range of stakeholder groups that were working with us in committees and workshops to identify areas of need. We also in some instances identify capacity to deliver. So some of the programs are focused on working with areas that have some capacity to deliver them whilst we then move towards identifying how to develop capacity in areas that currently do not have it.

One of the reasons we are having the workshop next month with the Indigenous community sector is to talk about how to develop capacity where it does not exist. That is one of the issues that will be under discussion. So we have a range of strategies to ensure that we get maximum coverage over the life of the program. To some degree, we are identifying where it can be delivered first in order to then move on to where we need to develop capacity to deliver.

**Senator ALLISON**—Again, I come back to the mud map. When are we going to see a document which demonstrates the reach of this program?

**Prof. Calder**—There probably will not be one document until we have the five-year evaluation. There are so many parts to this, as we have identified in the discussion today, that if we concentrated on trying to map what we are doing we would severely limit our time spent on doing it.

**Mr Smyth**—Also, this program has been running for quite a length of time and there have been a number of national and community based Indigenous projects that have been funded over that time. So we would need to go back and take a historical look at each of those programs as well because, as I understand it, around 20-odd per cent of all community based programs have been Indigenous in their focus over the life of the National Suicide Prevention Strategy.

**Senator ALLISON**—Could I turn to mental health services in rural and remote areas, the $72.3 million project. There was an expert forum into how we could deal with this and overcome the current problems for rural Australians. What sorts of solutions were put forward at that forum? Is there any documentation about the suggestions which were made?

**Mr Smyth**—There were some ideas that were put forward at that forum, which was held at the end of November, I think, in Melbourne. We got together a range of experts from rural and remote Australia. There was a document that we would be more than happy to make available to you in relation to some of the ideas and concepts that we should be looking at in relation to the rollout of this particular measure. This measure has a number of phases and now obviously has an additional $20 million allocated to it as well as part of the reallocation of funding from Better Access. We are more than happy to table that document. We have taken into account all of the information that was provided at that forum into the design of this particular program as well.

**Senator ALLISON**—Did the department determine who would be on that expert panel?

**Mr Smyth**—We asked the experts we knew as to who else should be in the room. We took advice from a number of different groups as to who should be at that meeting.

**Senator ALLISON**—Can a list be provided of those invited?

**Mr Smyth**—We would be more than happy to provide you with a list of who was there.

**Senator ALLISON**—Were those organisations invited to submit funding proposals?

**Mr Smyth**—Some of the organisations that were in the room were directly approached in phase 1 of the measure—and we are just in the middle of finalising contracts with that now—to provide proposals to us. So we directly, I suppose, targeted particular organisations. That was done through a long period of consultation with the jurisdictions as to where their areas of greatest need were.

We also looked at the areas where the MBS uptake is in the lowest 30 per cent per capita. It pretty much correlated that the areas of highest need obviously in each of the jurisdictions that we were looking to fund corresponded with our formula as well, as to the lowest 30 per cent. So it was quite an easy task in the end to actually identify particular organisations that had the capacity to take on allied healthcare professionals and mental health nurses to fund the staffing for that measure.

**Senator ALLISON**—So this bypassed a tender process?

**Mr Smyth**—That is correct.

**Senator ALLISON**—What were the contract amounts?

**Mr Smyth**—They vary from about a minimum of $350,000 per annum up to in excess of $1 million per annum. That information and the actual details of those contracts are still under negotiation, so I am not able to give you the exact details at the moment, but they will be made publicly available.

**Senator ALLISON**—Did all of those invited to participate make an application?

**Mr Smyth**—They did, yes.

**Senator ALLISON**—Were they all successful or are you saying—

**Mr Smyth**—There is one group that we are still working with that was not successful because the model they put up to us was more about looking at how they might evaluate what they are currently doing rather than putting actual services on the ground. So we are still working with that particular area to hopefully get some funding. We are not saying that they are not getting any funding, but we are working with them to get another proposal that meets the criteria that have been set by the government.

**Senator ALLISON**—Are there other services outside that series of negotiations that are currently providing services already—that are up and running?

**Mr Smyth**—Not under the rural and remote measure. The first service that is up and running and will be providing services, hopefully soon, is GP North West in north-western Tasmania, and that was launched by the Prime Minister on 2 May I think. Senator Mason is also now looking at the launch of the remaining auspice organisations across the country.

**Senator ALLISON**—So is there a list and a program of launches of these projects around the country?

**Mr Smyth**—We do not have a publicly available list at the moment. As I said, we are still in the stages of finalising a number of those contracts and then Senator Mason will be making some public announcements.

**Senator ALLISON**—Will they all be in marginal electorates?

**Mr Smyth**—No, as I said, they are all in those areas that were identified by state and territory governments in conjunction with us, and those are areas that fell within the formula of the bottom 30 per cent of access to Medicare.

**Senator ALLISON**—If I can go back to the expert forum and their suggestions, what progress has been made in developing plans as a result of those suggestions?

**Mr Smyth**—We took into account issues that were raised there to give a degree of flexibility to the auspice organisations that we are engaging to employ these workers and to look at the issues of how they attract them and how they retain them as well. One of the innovative ideas that came up was that, when assessing candidates for their suitability to be employed under the model, some organisations actually wanted to physically take those allied healthcare professionals into the area where they would be operating. So if it was going to be in the APY Lands or something like that, instead of just interviewing them and having them look at Alice Springs, they were looking to actually physically take them into those locations so people knew exactly what environment they were going to be operating in, who some of the key players were and whether they felt comfortable in their capabilities of being able to

operate in that environment. So we allowed quite a degree of flexibility because we understand the difficult nature of attracting people into some of those rural and remote communities.

**Senator ALLISON**—What about training for people who suddenly find themselves in these remote locations?

**Mr Smyth**—That is an issue that was addressed by each of the proposals as to how to support those workers. Also, through the education and training component of our Better Access to Mental Health Care Initiative we will be specifically targeting rural and remote workers to ensure they are adequately supported in terms of the education and training they receive. We also have recently had some discussions with professional bodies that really focus on rural and remote localities to look at the particular and peculiar needs of those workers.

**Senator ALLISON**—Now that you know more about the problem hopefully and more about some of the solutions, how does the $51.7 million stack up to what looks like a way forward?

**Mr Smyth**—Well, it is now $72 million because we have transferred the additional funding. We have to look at it as a complete picture of all of the other arrangements that the government has—like more allied health services, rural health services, MSOAP arrangements, the Better Outcomes in Mental Health Care program and the Better Access program. We need to be able to complete an entire picture as to what services are out there on the ground, what are the particular requirements of each of those components and what needs they are meeting. But we are certainly confident that we are making some significant inroads into getting services into some of these more difficult locations.

**Senator ALLISON**—That does not quite answer my question. It was quite a specific sum of money when it was allocated—the $51.7 million plus the 20, or whatever it was. What was that based on?

**Mr Smyth**—Really it is a budget consideration and I do not have those details.

**Senator ALLISON**—So it is a case of, 'It's a bit of guesswork. Let's see what we can fit into it,' or is it the case—

**Mr Smyth**—I do not think anything was guesswork. It was all obviously looked at in the context of the budget and what the government decided was a priority and the allocation of funding that was made.

**Mr Kalisch**—It is probably fair to say that it is all considered advice to government.

**Senator ALLISON**—I am sorry?

**Mr Kalisch**—It is all part of considered advice to government. But I think the point that Mr Smyth is making is nonetheless quite pertinent in that this is not the only program that is providing services in rural and remote areas. I think the broad question you are asking in terms of service delivery in rural and remote areas—we cannot just look at this item in isolation.

**Senator ALLISON**—I am not suggesting we do, but we have an expert panel that gives us advice with some terrific ideas, hopefully, on how to achieve this and I am wondering how that stacks up against the $51.7 million that was originally set aside.

**Mr Kalisch**—As Mr Smyth mentioned, those views were taken into account in terms of designing the program that is now around $72 million.

**Senator ALLISON**—Can I turn to nurses. Has the department got any up-to-date data on how many mental health nurses are currently employed in rural and remote areas and how many more mental health nurses are needed?

**Mr Smyth**—I do not have the statistics in terms of the nurses, I am afraid, in rural and remote areas. A lot of those, obviously, are employed in the public sector. Through some of our COAG mapping activity we are hoping to pick up exactly the geographical distribution of that workforce as well as other allied mental healthcare workers as well, but I do not have a number on that at the moment.

**Senator ALLISON**—But there is work being done to establish that number and discover how many are needed. Where are you at with understanding the supply issues for mental health nurses?

**Prof. Calder**—We are working through a number of measures to increase the supply. We are also working with the professional organisations around how to identify where mental health nurses are and, in fact, increase the number, because there is a very low base of membership or identification of mental health as a nursing area of expertise. So we do not—

**Senator ALLISON**—A high turnover as well.

**Prof. Calder**—Yes, that is right.

**Senator ALLISON**—So it is likely that some of those solutions will be advertising for these nurses overseas?

**Prof. Calder**—We have a range of measures that are in place. The government has funded an additional 1,000 nursing undergraduate places which will increase the supply over time. We will start to see that change over four years. These measures are expected to result in a total of 1,412 additional mental health nurse places. In addition to that we have some others. We are also working through—

**Senator ALLISON**—Is that 1,412 an overall figure or is that related to rural and remote areas?

**Prof. Calder**—It is the number of new education places.

**Senator ALLISON**—But they could all end up in Melbourne and Sydney though?

**Mr Smyth**—As you know, as part of the COAG package there was funding for 420 additional mental health nursing places. The government made a decision to fund 431. The cumulative effect by 2011 will be an additional 1,412 mental health nurses. This is clearly an issue for the states and territories. At each of our COAG meetings we talk about workforce related issues. Western Australia, which is where I was last week, is embarking on international marketing campaigns to attract mental health nurses to their jurisdiction. A lot of jurisdictions are engaged in trying to increase the numbers of mental health nurses.

**Senator ALLISON**—Do we have a benchmark in terms of the numbers of specialist and nursing staff per head of population in rural and remote areas?

**Prof. Calder**—No.

**Senator ALLISON**—Why is that?

**Prof. Calder**—Workforce planning is under the COAG umbrella through the Health Workforce Principal Committee. That is doing a range of pieces of work looking at workforce needs and modelling. It is not something we do. It is a shared activity through the COAG structure.

**Mr Kalisch**—Last night at estimates when discussing the health workforce outcome this issue of benchmarks for specialists or GPs came up. It was certainly quite clear from that conversation that there is no real clear-cut benchmark for any profession. Really the key is having good access and good affordability of services. That is really the outcome you are trying to achieve rather than necessarily an input measure.

**Senator ALLISON**—Yes, I understand that argument. If remote area mental health nurses are few and far between, I would have thought one objective would be to set some targets or at least know where it is you are going in terms of recruiting more and getting more into that sector.

**Mr Kalisch**—We certainly do not quibble about the desire to increase the workforce in those areas where it is quite clear there is an undersupply. As to what the target is—

**Senator ALLISON**—Are we trying to increase it to a figure? Are we trying to increase rural and remote mental health nursing numbers expressed as a percentage of the population?

**Mr Kalisch**—If someone can give us the perfect figure as to once we reach a particular benchmark we will have reached nirvana and we will be happy. I have not seen any research or any evidence which actually provides us with that level of precision.

**Prof. Whiteford**—I have never seen any country in the world publish a figure like that.

**Senator ALLISON**—Countries publish figures about numbers of GPs per capita and numbers of teachers per capita.

**Prof. Whiteford**—But not targets.

**Senator ALLISON**—I did talk about benchmarks not targets. Maybe it is the same or maybe it is not, I do not know. Benchmarks would suggest it is something you are working towards, I would have thought.

**Prof. Whiteford**—I have never seen them publish a benchmark either.

**Mr Kalisch**—There are comparison documents provided.

**Senator ALLISON**—It might be secret, sacred stuff! If you do not know where you are going, you do not know when you have got there. That becomes a question. When do you know you have been successful in attracting sufficient mental health nurses in rural and remote areas?

**Prof. Whiteford**—What happens in rural and remote areas is that services often advertise for a mental health worker. They say in the ad that this could be a nurse, a social worker, a

psychologist or an occupational therapists. Often it is the clinician you can get with mental health experience that is more important than whether they are a nurse or a social worker. My view would be that the way to go is to look at the prevalence of mental disorders, where they are distributed and how many of those people are getting treatment rather than trying to count the number of nurses or GPs or psychologists in a geographic area, given it is very hard to get a handle on what those clinicians do, even if they are lodged in that area.

**Senator ALLISON**—But, Professor Whiteford, we all know that if a service is not available then the demand for it often is not clear.

**Prof. Whiteford**—Going back to the population survey, if someone has a diagnosis under, say, the new survey that is going out in October-November this year and is not accessing services then for me that is untreated prevalence and that is a problem. One of the things that Better Access is doing is increasing the treated prevalence of mental illness in Australia quite significantly. We will know that when we run the new survey.

**Prof. Calder**—The range of measures under all of the programs that we have talked about are aiming to provide a range of skilled workforce individuals across the country and to facilitate particularly the Divisions of General Practice but other providers as well to provide the mix and balance of staff and skills that are appropriate to their local area.

**Senator ALLISON**—Yes, but the fact of the matter is that it is not so much the appropriate mix as what can possibly be scratched together to provide, I would have thought. We are not going to see very many psychiatrists heading off into remote communities, for instance. Isn't this mix more about how you cobble together something which might assist people rather than—

**Prof. Calder**—No, I think it is a mix of people on the ground and access to skills that are not available locally but can be accessed in other ways. We have such a complexity of initiatives that we have a view that we are going, over time, to see a very consistent pattern of access. It will be a mix and balance relevant to the local community and accessible by the local community. But that is the intention.

**Senator ALLISON**—Chair, I have gone over my 40 minutes.

**CHAIR**—Can I thank you very much for coming back. That does conclude outcome 11.

[5.47 pm]

**CHAIR**—We will move, as agreed, to outcome 9, Private Health, which we will do for 45 minutes or so.

**Senator McLUCAS**—Thank you, Chair. Ms Halton, you are going to provide us with that comprehensive information about advertising.

**Ms Halton**—Yes. I do not know where it has got to. I have already asked that question, because I am hoping that it will all turn up soon.

**Senator McLUCAS**—And that will include the campaign on private health insurance that is currently running?

**Ms Halton**—Yes, they are working on it.

**Senator McLUCAS**—That is great. Thank you.

**Ms Halton**—Just so I can be clear, they are doing whatever they can to get you something today and then whatever else we are going to follow up with.

**Senator McLUCAS**—Thank you. I understand that the government has sent a letter to the health funds telling them that a letter will be sent to all uninsured people under 31 in Australia. Is that correct?

**Ms Flanagan**—I am not aware that we have sent the health funds a letter advising them of it. We possibly mentioned it in a bulletin, but we have not sent a separate letter to them on the issue.

**Senator McLUCAS**—But that is the intention—that there will be a letter sent. When is that proposed to occur or has it occurred?

**Ms Flanagan**—It is I think almost occurring as we speak, so arrangements have been put in place. The text has been cleared and we are working with Medicare Australia to get that mail-out out very soon.

**Ms Shakespeare**—The timing is with Medicare Australia, but it should be very soon.

**Senator McLUCAS**—Can we have a copy of the letter, please?

**Ms Flanagan**—Yes. I think that is fine.

**Senator McLUCAS**—Thank you. Who is the letter being sent from?

**Ms Flanagan**—The letter will be signed by a departmental officer. I think that Ms Shakespeare, sitting to my right, will be the signatory.

**Senator McLUCAS**—We will get a copy of the letter, but was the minister mentioned in the letter?

**Ms Flanagan**—Certainly my recollection is that he is not mentioned in the letter per se. The government is mentioned, but not the minister.

**Senator McLUCAS**—Is it just a letter or has it got additional information in the envelope?

**Ms Flanagan**—No, it is just a standard letter.

**Senator McLUCAS**—Okay. How did the department obtain the names of all those people who are not insured under the age of 31?

**Ms Shakespeare**—The department does not have that information. Medicare Australia is arranging the mail-out, so Medicare Australia has the information.

**Senator McLUCAS**—Medicare Australia has information about all people who have a Medicare card and can cross-reference that with all of the people who are not insured.

**Ms Shakespeare**—I understand that is the case, but I think the details about how that occurs will need to be taken up with Medicare Australia.

**Senator McLUCAS**—What is the propriety issue between the Department of Health and Ageing getting Medicare Australia to use their database—a database that they are allowed to have but clearly DOHA is not allowed to have to do the mail-out for them?

**Ms Shakespeare**—The decision to send out the letters was a government decision and it involves both our department and also Medicare Australia.

**Senator McLUCAS**—I am not sure of the legislation around what information the Department of Health and Ageing can collect legally and what information Medicare can collect and whether or not there can be a transferring of that. I know they are not transferring that data to you, but you are accessing their data.

**Ms Halton**—We should be quite clear about that. We are not accessing their data; they are accessing their data in respect of giving effect to a decision of government. But there is a decision-making process under the legislation in order to enable any such use, and that matter has to be managed within the Human Services portfolio. So whilst the content of any such letter needs to be managed in our portfolio because it is a policy issue relevant to our portfolio, the sending out of the letter has to be managed through Human Services. So we give them the product and then they have processes, including an appropriate authority, to so do.

**Senator McLUCAS**—They have an authority?

**Mr Kalisch**—And we understand the authority was issued by their minister to Medicare Australia to undertake this activity.

**Ms Halton**—So their minister would authorise this under the legislation. It used to be the case when it was in our portfolio our minister would authorise it, and there are precedents for this. But now it is in that portfolio their minister would authorise and it is on that basis it can occur.

**Senator McLUCAS**—Where did the request for the letter—for the mail-out—come from?

**Ms Flanagan**—It was a government decision that it would be appropriate to write to all of those reaching the age of 31 to let them know the consequences—that, in effect, there would be a loading applied to their premium. The decision was taken I think when a range of decisions were taken on changing private health insurance arrangements the budget before last I think it was.

**Senator McLUCAS**—Who is paying for this mail-out?

**Ms Flanagan**—I think that the money has been appropriated to Medicare Australia to actually pay for the mail-out itself.

**Senator McLUCAS**—So DOHA is not paying Medicare Australia to send it out?

**Mr Kalisch**—The government is paying Medicare.

**Senator McLUCAS**—Yes, but I am just trying to ascertain whether there is a transfer of funds between the Department of Health and Ageing.

**Ms Flanagan**—They were directly appropriated to Medicare for that part of the process. I think you were asking questions earlier on about the campaign and there were certain amounts of money given to our department to do things, but the mail-out has actually been appropriated direct to Medicare.

**Senator McLUCAS**—How many people did the letter go to?

**Ms Flanagan**—The letter has not yet been sent. Do we have an estimate of how many we think it will go to?

**Ms Shakespeare**—The letter is to people turning 31. I think it is just a bit below 300,000.

**Senator McLUCAS**—I might have this wrong, Ms Shakespeare, but is it people turning 31 or is it people under 31?

**Ms Shakespeare**—It is people who will be turning 31 this year.

**Senator McLUCAS**—Thank you. Did the department seek legal advice before proceeding down this road of commissioning Medicare Australia to use the database and send out their letter?

**Ms Flanagan**—Yes, legal advice was commissioned and received.

**Senator McLUCAS**—To the effect that this was legal?

**Ms Flanagan**—To the effect that, yes, the Minister for Human Services had the authority to make a determination that it was appropriate to do this.

**Mr Kalisch**—Both our department and Medicare Australia have discussed this matter, and came to an agreement that this was the best course of action.

**Senator McLUCAS**—A letter is sent to everyone who is turning 31 this year irrespective of income; is that right?

**Ms Flanagan**—Yes, it is just by age.

**Mr Kalisch**—Medicare Australia would not have income details.

**Senator McLUCAS**—Medicare Australia knows that this cohort of people do not have private health insurance. Let me ask the question the other way: they know who has private health insurance because they are not paying—no? How does Medicare Australia know that someone does not have private health insurance?

**Ms Halton**—It is the people who are registered for the rebates.

**Ms Flanagan**—That pay the rebate.

**Senator McLUCAS**—Okay. We will ask Medicare Australia some more questions. You may be able to help me with this issue, but it may be in the wrong outcome. Fourteen months ago the health minister said that doctors would have less than 12 months to ensure higher rates of informed financial consent or he would regulate that. Is this in this outcome?

**Ms Flanagan**—It is, Senator. You have the right outcome.

**Senator McLUCAS**—I take no credit.

**Mr Kalisch**—You win the jackpot; you get to ask questions.

**Senator McLUCAS**—Has there been any discussion with the department about designing legislation that would force doctors, particularly specialists, to ensure higher rates of informed financial consent?

**Ms Flanagan**—That is an internal process that we are going through, and we do not discuss policy in the Senate estimate committees.

**Senator McLUCAS**—I do not want to know what might be being discussed. I do not want to know what the advice to the minister may or may not have been. Essentially, I want to know if the department is doing any work around designing legislation that would force medical practitioners to comply with the minister's expressed views.

**Mr Kalisch**—Senator, with respect, if we were to answer that question we would be providing you with advice on the advice that we were providing to government.

**Senator McLUCAS**—I have actually had this argument with a few people and I have taken advice from the Clerk. The Clerk's advice is that for you to tell me whether or not something is happening is reasonable, but it is not reasonable for you to tell me what the nature of advice to the minister is. But the fact that that advice might be being prepared is reasonable to us.

**Ms Halton**—And it is reasonable to us, Senator—whether or not we are working on informed financial consent, which we are working on. But it is not reasonable to ask what the nature of the advice is, and in respect of this case what you have asked about is legislation.

**Senator McLUCAS**—Well, not necessarily advice. I am talking about whether or not departmental officials are using appropriated money to design legislation that would enact an increased level of informed financial consent from patients.

**Ms Halton**—But that goes to the nature of the policy discussion internally. As I said, I am very happy to say we are working on informed financial consent, which we are.

**Mr Kalisch**—Which we are.

**Ms Halton**—But the nature of that work is something we cannot talk about.

**Senator McLUCAS**—Okay. Can you tell me what work is happening in the department around the area of informed financial consent?

**Ms Flanagan**—Senator, I think you may be aware that we have just recently finished conducting a survey and the results of that were released publicly on 22 April. What that actually showed was that there has been an increase in the rate of informed financial consent. The minister has also publicly committed to hold a further survey. The AMA is currently working with clinicians, doctors et cetera to try to increase the rate of informed financial consent. So a second survey has been contemplated for around the middle of this year, and that is where we are focusing our effort at the moment.

**Senator McLUCAS**—And that survey will be targeting patients?

**Ms Flanagan**—Yes.

**Mr Kalisch**—What we are looking to do is do a further survey from which we can compare the results of the survey at that point in time to past surveys to see whether there has been, again, a commensurate increase.

**Senator McLUCAS**—Was that survey, the results of which were published on 22 April, the first of its kind? Is that the benchmark?

**Mr Kalisch**—No.

**Ms Flanagan**—No. There was a survey done in 2004. That is why we can do the comparison in terms of the change between what has happened more recently. But because the AMA's campaign had only just started, we were not necessarily seeing the full impact of that in the survey that was conducted, I think, in November-December of 2006.

**Senator McLUCAS**—Is there any further work other than the survey?

**Ms Flanagan**—That is what we are concentrating our efforts on at the moment.

**Senator McLUCAS**—The Lifetime Health Cover loading issue is not one that I think we have canvassed here a lot. Do we have the numbers of people who have and people who do not have private health insurance?

**Ms Flanagan**—Sorry, of the people who pay a loading or generally?

**Senator McLUCAS**—No, just as a general opening question, because we have not got this on the record.

**Ms Flanagan**—The proportion of the Australian population covered by private health insurance is currently 43.6 per cent.

**Senator McLUCAS**—In terms of reasonable questions that you have data on, what sorts of age cohorts do you have on which you keep data?

**Ms Flanagan**—I think we did discuss this last time. We do have some data in terms of 65 to 70 and 70-plus, because there are different rebate levels for those particular age groups. I am not sure that we would be able to get a breakdown of ages below those because, as you would appreciate, Medicare Australia pays the rebate so that data is available to us and we have provided it in the past. But I do not think we can provide breakdowns below that.

**Ms Shakespeare**—We can get some age based data from the Private Health Insurance Administration Council. PHIAC data includes age based data.

**Senator McLUCAS**—And how do they collect it, Ms Shakespeare? Is it by five-year cohorts or is it decades or—

**Ms Shakespeare**—By five-year cohorts.

**Senator McLUCAS**—Can you then provide us with—I do not think we have asked for this before—age cohorts?

**Ms Shakespeare**—It is published quarterly, I think, so we can certainly get you the most recent quarter—the March 2007 data.

**Senator McLUCAS**—Where is it published?

**Ms Shakespeare**—On the PHIAC website.

**Senator McLUCAS**—Coming back to 43.6 per cent of people with private health insurance, how many people is that?

**Ms Flanagan**—I think it is 9.3 million or 8.9 million. We have the exact figure down to the last person.

**Senator McLUCAS**—It is probably on the PHIAC web site!

**Ms Shakespeare**—It is 9,068,000. That is with hospital insurance. There are different figures for ancillary.

**Senator McLUCAS**—That is the number with hospital—

**Ms Shakespeare**—Hospital cover.

**Senator McLUCAS**—And they may have hospital and ancillary—

**Ms Shakespeare**—Yes.

**Senator McLUCAS**—But that does not capture people who have ancillary only?

**Ms Shakespeare**—No.

**Ms Flanagan**—Most people have both, as you would appreciate, so we have figures on those who have ancillary and those who have hospital and they are different figures. But of course you would appreciate that the large majority of that is an overlap.

**Senator McLUCAS**—That is right. So what is the number who just have ancillary?

**Ms Flanagan**—It is 8.9 million I think. It is a slightly smaller proportion. I will give it to you. Do you want numbers or proportion?

**Senator McLUCAS**—Both if possible, please. Do we know how many people are paying the Lifetime Health Cover loading—the two per cent on premiums?

**Ms Flanagan**—We have that figure, too. Once we find our facts sheet, we will be in business.

**Ms Shakespeare**—I can give you that number right now: 465,015 people have a Lifetime Health Cover loading that they are paying at the moment. The ancillary benefits figure is 8.97 million people. That is 43.1 per cent of the population.

**Senator McLUCAS**—The question that I am actually trying to get to, Ms Shakespeare, is the number of people who have ancillary only.

**Ms Shakespeare**—Yes. Sorry, the overlap. I think I will have to get that figure to you on notice.

**Senator McLUCAS**—Okay. Is that something that is on the PHIAC website—the ancillary-only numbers?

**Mr Maskell-Knight**—My memory is that it is there, Senator, yes.

**Ms Halton**—I think it is there, too.

**Senator McLUCAS**—If we cannot find it, do you mind if we ring up and get advice?

**Ms Flanagan**—No.

**Senator McLUCAS**—What I am trying to find is if there is a trend occurring with that ancillary-only cohort. What data do we keep on the income levels of people with or without private health insurance?

**Ms Flanagan**—We don't.

**Senator McLUCAS**—It is quite an important piece of information. Is there any way that you can?

**Ms Flanagan**—I think we have been asked questions before. We do not have any records by income level of people who take out private health insurance.

**Ms Halton**—The Household Expenditure Survey is the one place where you would get it, because the Household Expenditure Survey actually breaks it down by income level and expenditure on items. They definitely include private health insurance—the ABS every five years, yes.

**Senator McLUCAS**—Thank you. We have heard reports—and we should have called the Private Health Insurance Ombudsman, but this issue came to us after we had said no, so you may not be able to answer question—that there are an increasing number of complaints going to the ombudsman from people who are required to pay the Lifetime Health Cover loading. Is that your understanding as well?

**Ms Flanagan**—Again, I think the ombudsman has recently published figures which suggested that the level of complaints was going down. But I am not quite sure whether, as you say, within that—it might be easier if we take that on notice and get them to provide the data through us. Is that okay if we do it that way? What do you have?

**Ms Shakespeare**—I do not have any information on that particular issue.

**Senator McLUCAS**—Okay, if you could come back to us as to whether or not that is happening. Does the legislation allow a private health insurer to make an exception for someone being insured to be able to not pay the Lifetime Health Cover loading?

**Mr Maskell-Knight**—Not that I know of. I think it would be a very creative interpretation of the legislation. I have the number of people with ancillary-only cover as of 30 June last year. It is 1,344,000.

**Senator McLUCAS**—Do you know if that is trending up or down?

**Mr Maskell-Knight**—I do not know.

**Senator McLUCAS**—We can check that with the website. Regarding the way the Private Health Insurance Ombudsman collects the data on complaints, and particularly these complaints about having to pay the Lifetime Health Cover loading, does the ombudsman collect any data on the age and income of the complainant in that circumstance?

**Ms Flanagan**—I would need to ask them. I am not sure.

**Senator McLUCAS**—Good. Thank you. I now have some questions about the Lifetime Health Cover calculator. To begin this, I wonder if you could give me an explanation of it. I am no expert.

**Mr Maskell-Knight**—While we are talking about Lifetime Health Cover, the secretary and I have just had a conversation about the answer I gave earlier. What I meant to say was that there was no discretion for a health fund to say, 'You don't have to pay the Lifetime Health Cover loading.' However, the act does provide exemptions for people in particular circumstances—so if you were overseas on 30 June 2000, if you have been covered by the defence forces, if you have been living in the Antarctic and had your health care provided for by the Australian Antarctic Division and so on, but the general principle is that there is no discretion.

**Ms Halton**—No, so I have not lost my grip. But there are circumstances—

**Senator McLUCAS**—The series of exemptions are available on the PHIAC website, too, are they?

**Mr Maskell-Knight**—They are in the legislation.

**Senator McLUCAS**—They are in the legislation. It may be around those individuals who should be allowed to claim an exemption from the levy that this issue has arisen. I wonder if

you could ask the ombudsman whether it is around the people who are entitled to an exemption or try to make a case with the private health insurer and then having that rejected.

**Ms Halton**—Yes.

**Senator McLUCAS**—Thank you. Now, to the Lifetime Health Cover calculator. Who is going to educate me on that?

**Senator Mason**—I might throw this one as a hospital pass.

**Ms Flanagan**—We are going to get our copy of the act and read you the relevant bits.

**Senator McLUCAS**—I want an explanation.

**Mr Maskell-Knight**—I am sorry, I missed what exactly the question was.

**Senator McLUCAS**—I understand that there is a Lifetime Health Cover calculator provided by government on the PrivateHealth.gov.au website. Can you explain to me how that works?

**Mr Maskell-Knight**—Essentially what it does is replicates the diagram at section 34-25 of the new Private Health Insurance Act, which looks like that, and which is essentially a flow chart for working out what a person's Lifetime Health Cover base day is. Then it builds onto that a calculation that says what is their Lifetime Health Cover base day—did they have health insurance on that day and, if they did not, then they are subject to the Lifetime Health Cover loading; how old are they now and take 30 away from that age and multiply it by two.

**Ms Flanagan**—We can give you a photocopy of the relevant page of the legislation.

**Senator McLUCAS**—That is very kind, but no thank you.

**Mr Maskell-Knight**—And then there are also provisions that say that if you had had health insurance at some time since you turned 30 and before now, you get sort of a credit for the years for which you have had health insurance coverage.

**Senator McLUCAS**—I understand that if there are people who had hospital cover on 31 March 2007 and that hospital cover is continued they are to contact their health insurer for details of the Lifetime Health Cover payable. Why is that?

**Ms Shakespeare**—That caveat has been put on to the calculator on the website because there are quite complex rules about prior loadings, depending on the legislation that applied. This is legislation that was in place before the Private Health Insurance Act. The calculator cannot take account of every circumstance. That is why that advice is provided on the website.

**Senator McLUCAS**—We will leave that one, thank you. I want to ask about the impact on Lifetime Health Cover loading of the legislative changes that took effect on 1 April 2007. What did they do?

**Mr Maskell-Knight**—They did not do anything in a substantive policy sense. The changes in the legislation between the old schedule 2 of the National Health Act and the new act essentially simplified the Lifetime Health Cover base day calculation. Because the old legislation had been changed several times, there were, I think, 17 possible circumstances a person could fall into. We now think there are about five, so we got rid of all the ones that said

something like, 'If you were in the country before 23 May 2003, then this is the rule,' and 'If you were on a temporary visa at that time, then this is the rule,' and so on. So we have tried to simplify the calculation. But the basic principle of two per cent per year for every year after you have turned 31 has not been changed.

**Senator McLUCAS**—Okay.

**Mr Maskell-Knight**—There was one more thing—and if you have paid the loading after 10 years, then you no longer have to.

**Senator McLUCAS**—And that was a significant element of it.

**Mr Maskell-Knight**—Yes.

**Senator McLUCAS**—What would be the Lifetime Health Cover loading payable by a 50-year-old person who had never had private hospital cover but took it up on 31 March 2007?

**Mr Maskell-Knight**—It would be 40 per cent, other things being equal.

**Senator McLUCAS**—And what about the same person who took it up on 1 April 2007?

**Mr Maskell-Knight**—It would be 40 per cent.

**Senator McLUCAS**—Is there a need for a transitional arrangement to the calculator to accommodate the 10 years? Not yet, I suppose.

**Mr Maskell-Knight**—Not yet, no.

**Senator McLUCAS**—Maybe in 10 years time it might be relevant.

**Mr Kalisch**—a cap on it.

**Mr Maskell-Knight**—It is not actually in 10 years time; it is four years.

**Senator McLUCAS**—So 10 years after the individual has had private health insurance.

**Mr Kalisch**—And paying the loading.

**Senator McLUCAS**—I am glad you have made it less complex, Mr Maskell-Knight.

**Mr Maskell-Knight**—Me too, Senator.

**Senator McLUCAS**—Chair, they are all the questions I have on private health insurance.

**CHAIR**—I have a couple of my own so we might close off the time available with that.

**Ms Halton**—You do not have to, Senator.

**CHAIR**—I know that. Thank you for the kind offer, but I might pass on it on this occasion. We do not have the Private Health Insurance Administration Council here today, do we?

**Ms Halton**—No.

**CHAIR**—I just wanted to explore a bit about where we are going with the regulation of players in the private health market, particularly brokers and people like that. I understand that a corporate product review is being conducted which is leading to legislation. Can you tell me where that stands at the moment?

**Ms Shakespeare**—The draft report of the review is still being considered by the government so there has certainly been no decision on legislation.

**CHAIR**—And that is not publicly available yet?

**Ms Shakespeare**—No.

**CHAIR**—There is an expectation, I take it, that recommendations arising from that review will lead to legislation. Is that fair?

**Ms Shakespeare**—It is still being considered by the government, so I do not think it is really fair to say that at this point.

**CHAIR**—Okay. Is that review intended to cover things like how health insurance products are marketed, how they are made available, how people compare products in the marketplace—things like that?

**Ms Shakespeare**—The review covers corporate products and how they are marketed—and obviously they are marketed to a specific part of the community—and also more generally how discounting arrangements apply, because they are tied in with corporate products. Yes, it includes things like brokers and arrangements for brokers to market products.

**CHAIR**—You cannot tell me anything about what the position will be on the practice of discounting or offering commissions by health insurance brokers under these arrangements?

**Ms Shakespeare**—It is still being considered by the government.

**CHAIR**—I just thought I would try. Do we have a time frame for when this is likely to be available—either the review or the legislation arising out of that?

**Ms Shakespeare**—I do not think it will be very long. I would say the review will be completed and made publicly available in the next couple of months at the latest.

**CHAIR**—I might put some questions on notice to PHIAC about those matters. That does exhaust me after all.

**Senator McLUCAS**—Someone think of something.

**CHAIR**—I am sure we can.

**Ms Halton**—We could just have an extended dinner break—a whole eight minutes.

**CHAIR**—That is a very good idea; I like your thinking. I think that is what we will do. Thank you very much to those involved in this outcome. We will now suspend for dinner and resume on Indigenous health.

**Proceedings suspended from 6.21 pm to 7.33 pm**

**CHAIR**—I call to order the Community Affairs Committee in budget estimates. We will now resume. As agreed before the break, we decided that we would proceed now to spend an hour or so on outcome 8, Indigenous Health. Are there any matters that have been taken on notice that need to be reported on at this point? No-one seems to be aware of any, so we will proceed.

**Office of Aboriginal and Torres Strait Islander Health**

**Senator CROSSIN**—Can I get a breakdown of the programs under the Indigenous health expenditure. Is the Aboriginal and Torres Strait Islander health services still a program and what is the amount for this year?

**Mr Thomann**—You are talking about the appropriation for 2007-08, I presume.

**Senator CROSSIN**—Yes, I have the 2006-07 in front of me.

**Mr Thomann**—With the budget reporting elements, we have a one-line appropriation. Within that one-line appropriation Aboriginal and Torres Strait Islander health services will be $287.977 million.

**Senator CROSSIN**—And the Primary Health Care Access Program?

**Mr Thomann**—That will be $99.262 million.

**Senator CROSSIN**—The Bringing Them Home program?

**Mr Thomann**—Bringing Them Home, including Link-Up, will be $14.045 million in 2007-08.

**Senator CROSSIN**—Petrol sniffing?

**Mr Thomann**—The combating petrol sniffing measure will be $10.64 million.

**Senator CROSSIN**—The Healthy for Life program?

**Mr Thomann**—That will be $27.58 million.

**Senator CROSSIN**—And the coordinated care trials?

**Mr Thomann**—The funding for those ceased this year.

**Senator CROSSIN**—COAG mental health?

**Mr Thomann**—That will be $5.098 million.

**Senator CROSSIN**—Are there other programs?

**Mr Thomann**—The remaining program is the Indigenous child health check, which will be expenditure of $2.63 million in 2007-08.

**Senator CROSSIN**—What is the total in Indigenous health expenditure?

**Mr Thomann**—$447.232 million for the 2007-08 financial year.

**Senator CROSSIN**—What is included under ATSI health services? How is that different to the PHCAP?

**Mr Thomann**—There is a historical difference. The health services represents the money that was originally transferred from ATSIC, as it then was. That function was transferred to the department of health. So that is base funding, and it covers funding for primary health care services as well as other costs related to the program. The Primary Health Care Access Program was introduced in the 1999 budget, and that is for primary health care services as well. Both budget reporting elements fund primary health care services and substance use services.

**Senator CROSSIN**—I know what the PHCAP is. I just wanted a bit more of a delineation between that and the ATSI services. Is the PHCAP only delivered to AMSs?

**Mr Thomann**—No, both are part of a one-line appropriation and they both contribute to funding for primary health services. The only difference is the history. The Primary Health Care Access Program has been focusing on the expansion and enhancement of services since

the measure was introduced, whereas the base of the program also funds other elements necessary to run the program.

**Senator CROSSIN**—There is $38.2 million over four years for family-centred primary health care: additional health workers, new or upgraded buildings, six clinics and business management for 100 Indigenous health services managers. How was this costed? How did you get to the $38.2 million? Are each of those broken down in different appropriations? The 45 additional health workers will cost how much?

**Mr Thomann**—I would have to take that on notice. We have agreed the costings with the Department of Finance and Administration through the budget process, and that costing has been agreed on the basis of our experience with managing the program and the department of finance's own experience with negotiating with us over previous budgets as to what they are used to seeing us deliver for the quantum of a certain measure.

**Senator CROSSIN**—You might have misunderstood what I meant. Out of that $38.2 million, do you have an amount that will be discretely attributed to the 45 additional health workers and how much of that would go to the new or upgraded buildings?

**Mr Thomann**—There is no discrete allocation of funding for a specific purpose, except within the measure we have training and skill enhancement for 100 Indigenous health service managers.

**Senator CROSSIN**—So you cannot tell me that is going to cost $8 million of the $38 million?

**Mr Thomann**—We estimate that that particular element of this measure will cost $6.1 million.

**Senator CROSSIN**—Do you have an estimation for the other two measures?

**Mr Thomann**—We do not have an estimation for the other deliverables. We are confident we can deliver the 45 additional health professionals and the necessary upgrading and/or building of new clinics and houses within that price.

**Ms Podesta**—The costings are based on our knowledge and understanding of the historical pattern within the program, but we recognise that this program will be delivered by a process of consultation within our state and territories. There are many factors, including remoteness, capacity of the organisation and other activities and priorities within those organisations. So to some degree they are estimations, but they are based on a well-understood knowledge of what is delivered through the program at this stage.

In all budget measures there is some degree of estimation in relation to the costings based on that experience, but we do not set a particular figure for each one of the inputs. When expressions are sought to be funded, we do not say, for example, 'There is only $50,000 per nurse.' Services apply, they give us a budget and we make an assessment of the proposals based on need and based on their capacity to implement it.

**Senator CROSSIN**—How will the six locations be decided? When will they be decided?

**Mr Thomann**—They will be determined on the basis of the regional planning process that we discussed previously, which highlights those regions across Australia that are underfunded

and underserviced. We will be looking at those underserviced areas to see whether they are organisations that have the capacity to deliver additional primary health care to those areas and, depending on the kinds of proposals that we are able to develop with those organisations, we will be making decisions about the best proposals.

**Senator CROSSIN**—Will the business management training be outsourced?

**Mr Thomann**—We have not made any decisions about how that will be rolled out. It will be done in consultation with the sector and with NACCHO and its state based affiliates.

**Senator CROSSIN**—The $37.4 million over four years for the Health @ Home Plus, a nurse led home visiting program for mothers and babies and ongoing support for Indigenous children aged two to eight years in rural and remote areas—what does that consist of?

**Ms Podesta**—Health @ Home Plus is a new program in Australia.

**Senator CROSSIN**—Is it basically all for nurses? How is this going to work?

**Ms Podesta**—This is a program based on extensive international evidence and research on the most effective intervention around prenatal and antenatal care and early years of parenting to build on the capacity of parents and families to make good decisions about parenting. It builds on a number of the things that primary health care services are delivering through our health system and provides Aboriginal and Torres Strait Islander families with the opportunities to extend their skills and make very good choices for their children and for themselves as families. It is a nurse led program, and that is based on the international evidence that we have examined in great detail around the most effective model of home visiting programs for parents and young children.

**Senator CROSSIN**—So it is particularly or only for Indigenous families?

**Ms Podesta**—This program is an initiative targeted to Indigenous families.

**Senator CROSSIN**—Does it go to birthing on communities or is it just a pre and postnatal support program?

**Ms Podesta**—It is not birthing. It is a program where expectant mothers will be identified through services, through community agencies and through organisations and be encouraged to join the program. Nurses will visit the expectant mother in her home and develop a relationship with her, if she chooses. Then the nurse will continue to visit the mother and family if that is what they decide to choose, for at least the first two years of the child's life and depending on the needs of the mother and the child, up to eight years to encourage milestone development in children and support for the mother.

**Senator CROSSIN**—So they will all have to be nurses or midwives?

**Ms Podesta**—Nurses and midwives have traditionally been the group who have been recruited in this program. We recognise that, to implement the program in Australia successfully, we might need to look at some cultural adaptation around this program. It is based very much on programs by Professor David Olds in the United States. We have looked at being able to identify Aboriginal health workers who may accompany nurses. In some cases, given the labour market, we might look at some highly skilled Aboriginal health workers, but our preference is for nurse led parenting teams.

**Ms Halton**—It is worth acknowledging here that this is a very significant program internationally and the evidence in relation to the effectiveness of this program is significant. We have spent considerable time looking at interventions that have evidence and looking at how we might adapt them and use them in our context. We have had a lot of interaction with the researchers from overseas in relation to this, so this has a solid evidence base. We are pleased with this decision.

**Senator CROSSIN**—So you would funnel this money through AMSs or through state and territory governments?

**Ms Podesta**—Probably not through state and territory governments. We would imagine that Aboriginal medical services will be one of the groups who put their hand up to be one of the partners in this program, but it will not be limited to AMSs. It will need to be organisations that can demonstrate strong linkages and a capacity to develop trust with expectant mothers.

**Senator CROSSIN**—So Good Beginnings might employ a few nurses?

**Ms Podesta**—Potentially, yes. It is important to note that it does not replace antenatal care or primary health care. It is a supplement to those, but it is very much a support service for the mother and the child.

**Senator CROSSIN**—It is for rural areas or urban areas?

**Ms Podesta**—It is for remote and regional areas; outer regional.

**Senator ADAMS**—Is that going to come under the benefit item that we spoke about last night?

**Ms Halton**—No. This will not be done on the basis of benefits. The item we were talking about last night is a care item. This is a program that will be rolled out and the program will fund a number of professionals to work in the program, so it is not on a fee-for-service basis. This will be organised more in what we used to describe as a community service kind of way. The program will fund professionals to deliver these services, but not on a fee-for-service basis. What we were talking about last night was on a fee-for-service arrangement.

**Senator ADAMS**—Just come to 'appropriately trained'. Aboriginal health workers are going to be appropriately trained in antenatal care?

**Ms Halton**—Let us be clear. It is not delivering antenatal care. It is a development based program, so what it is looking at is different from the services provided as part of a confinement. What we talked about last night were the arrangements in respect of care for a pregnant woman as part of the pregnancy. This is actually around child development.

**Senator CROSSIN**—You mentioned this in the last estimates, didn't you?

**Ms Podesta**—I do not believe we mentioned this one.

**Senator CROSSIN**—I am sure you mentioned Professor Olds's work at some time.

**Ms Podesta**—We might have talked about evidence previously.

**Ms Halton**—I think we did have a conversation about the notion of evidence in relation to child development, but I am sure we did not—

**Senator CROSSIN**—No, I am sure you did not say it was coming. It is not the first time I have heard this name, I think.

**Ms Podesta**—No. There have been three longitudinal studies now undertaken on this program. The 20-year longitudinal research has been published. It looked at poor, vulnerable, economically and educationally disadvantaged first time parents in urban areas in the first instance. It compared this intervention with a range of other positive interventions, and has looked at the short-term and now long-term impact of the home visiting program. The evidence is extraordinary in terms of increased school retention, high school graduation, reductions in teenage pregnancy, increases in parents' income, increase in parent stability and reduction in child abuse notifications, which are most of the indicators that we are working towards.

The long-term evidence has shown that this program has been the most effective intervention—and we have looked at evidence of about 40 different home parenting programs. It is important to know that this program has been developed very much around the same principles and with a commitment to the program integrity of the David Olds model, because there have been many home visiting programs where the impact has been much less, and we have worked very closely with Professor Olds on the development of this proposal.

We have also worked very closely with the United Kingdom, who have announced a similar program, so there are three countries now working with Professor Olds. It is important to know this, because he does not agree to most countries adapting his model, but he has allowed Australia to do so. We think that this is going to be one of the best investments that we can make at this time.

**Senator CROSSIN**—For the benefit of the committee, is there some sort of paper or an explanation of this that you can provide?

**Ms Podesta**—We can certainly give you a copy of the random control trial peer reviewed information about the evidence that we have based some of our work on.

**Senator CROSSIN**—Why is it not going into urban areas?

**Ms Podesta**—It is going to go here as a priority.

**Senator CROSSIN**—Into remote and rural areas?

**Ms Podesta**—Into remote and outer regional areas. It would be fair to say that, on most indicators, success in school in the early years has probably not been as high as we would like for children in some of the outer areas and remote areas. A strong performance indicator from this program has been a much higher school starting and school retention rate, and we think that there is a very high need in some of those regions. This program will not go everywhere. The program is for 10 regions over four years. There are more than 10 regions in remote and outer regional Australia where this could be of benefit.

**Senator CROSSIN**—The 10 regions will be based on what?

**Ms Podesta**—We have not finalised the criteria yet.

**Senator CROSSIN**—We will have to find out. I am conscious that we only have an hour and we want to deal with petrol sniffing, but I cannot let the chance go by without asking you

about what is happening with the trachoma initiative. I know I have not been directed to ask about that, so for people who might be watching, it is a bit of self-indulgence here.

**Ms Podesta**—We would be disappointed if you did not.

**Ms Podesta**—Are you going to ask us about what is happening with the Central Australian Eye Health Program, because we would love to tell you about that.

**Senator CROSSIN**—That is on my list. I did have a discussion with congress about it, but tell me about the program; how much you have spent and what is happening.

**Ms Podesta**—Trachoma first?

**Senator CROSSIN**—Trachoma first. Sorry.

**Ms Halton**—Aren't we talking about Central Australia first?

**Senator CROSSIN**—I do not mind.

**Ms Halton**—We are pleased with ourselves about this.

**Ms Podesta**—We will start with Central Australia.

**Senator CROSSIN**—Central Australia Eye Health Clinic, isn't it?

**Ms Podesta**—Okay, we will talk about the Central Australian Eye Health Program.

**Senator CROSSIN**—It is part of the money that you have provided to congress.

**Ms Podesta**—We have. There are a number of initiatives. Some months ago the Australian government held a meeting with the Northern Territory, in particular the Alice Springs Hospital but others as well—the two Aboriginal medical services in Central Australia and the Fred Hollows Foundation—and we devised a plan to work together cooperatively. The plan was that the Hollows Foundation would source and identify specialists to supplement the resources that are available in Central Australia and that, through funding available from our department, an eye health coordinator would be employed to coordinate the patient transport, accommodation and scheduling with Alice Springs Hospital.

**Senator CROSSIN**—Is this for cataract surgery?

**Ms Podesta**—Yes, predominantly cataract surgery. The initiative commenced this week and it is called the 'eye health blitz'. Nearly 40 patients have been operated on this year. They have been brought in from remote regions, operated on, looked after with post-care, and taken back to their communities. The blitz will take place over a number of weeks—this is the first week. There will be a break, and then another team of theatre staff and specialists will be brought in. Together, as a cooperative effort, our objective is to reduce entirely the waiting lists for eye surgery in Central Australia for Aboriginal people.

**Senator CROSSIN**—What is the cost of this?

**Ms Podesta**—The funding that has been provided by OATSIH, by Health and Ageing, is $138,346 towards the program manager and $40,290 towards the costs for patients.

**Senator CROSSIN**—My understanding is that there are about 700 or 800 Indigenous people on the waiting list for eye surgery. Is that right?

**Ms Podesta**—I do not believe it is 700 or 800; 300 to 500, we believe, Senator.

**Senator CROSSIN**—All right. This is one surgeon working for the week or a team of surgeons?

**Ms Podesta**—There is currently a surgeon in Alice Springs. He is part of the team. He is supplemented this week with another surgeon and nursing theatre staff. They have been able to block-book the theatres, and that has been critical. I think you appreciate—I know a lot of people do not because they do not understand how difficult this issue is—that the frustration has been the inability to have an effective coordination mechanism where people are identified, transported, accommodated, turn up for surgery, and surgical staff and theatre staff scheduled and block booked.

One of the problems previously has been getting people there, and this has been a coordinated and concerted effort to get the patients there, make sure that they are operated on at a high standard and looked after afterwards and get back home. There has been a whole plan developed amongst the different levels of government and between the communities and the Aboriginal medical services to reduce what has been in the past a substantial cost for the hospital: people just have not turned up because of cultural obligations, and lots of other reasons.

**Senator CROSSIN**—When you talk about 'Central Australia', this is taking in Warburton down to the Pit lands in South Australia, or just to the Territory borders?

**Ms Podesta**—I cannot tell you the particular geographic. It is Central Australia and the people on the waiting list for Alice Springs Hospital. My guess would be that it would go there but, rather than give you a definitive, we are happy to give you the detail on notice, if that is okay.

**Senator CROSSIN**—Okay. The national trachoma surveillance unit tender has been awarded to Vision 2020. Is that correct?

**Ms Balmanno**—It was the Centre for Eye Health Research.

**Senator CROSSIN**—That is right. This is the unit that will actually set up the database and start to collect the statistics?

**Ms Balmanno**—Yes.

**Senator CROSSIN**—Where is that at? When did they actually start?

**Ms Balmanno**—The unit has been operational since November last year and has been working with us and other members of the reference group, which include state and territory governments and NACCHO, to agree on the details of the data reporting elements that will be collected in the next set of trachoma screening that happens this year. Meanwhile, they have also been working on collating data from the 2006 screening program to produce a report this year. We expect to have the report by the end of July. The report will not cover all of the data elements, because obviously the data was collected before agreement was reached on the future collection strategy. But they will do their best to cover off as many of those elements as possible, based on existing data. Certainly in the next batch of screenings that occur, mostly in the second half of this calendar year, they will be collecting against the agreed data element and be able to report consistently to the unit, so that next year's report will cover off most, if not all, of those elements.

**Senator CROSSIN**—All right. On the training of the health workers under this program, is the Northern Territory still not coming on board until June 2008?

**Ms Balmanno**—No, I do not believe so.

**Ms Podesta**—There is a funding agreement in place now.

**Senator CROSSIN**—Yes. The funding agreement is in place. In my notes I have 'not commencing until June 2008'.

**Ms Balmanno**—No, it continues until June 2008. The funding agreement goes from January 2007 to June 2008. They have employed a public health nurse to improve coordination of staffing and training, screening community treatment and data collection relating to trachoma already.

**Senator CROSSIN**—I am looking through an answer to your question. I have misinterpreted it. I thought they did not start until June 2008. The WA, NT and South Australia funding agreements are in place?

**Ms Balmanno**—The South Australian funding agreement is not in place yet. We expect to have it signed off within the next few weeks.

**Ms Podesta**—They have just had staff turnover in their department. It has been offered to them. They just have not finalised it in South Australia.

**Senator CROSSIN**—You offered it to them way back in November though.

**Ms Podesta**—What can we say, Senator? You say to us sometimes, 'Why haven't you spent your money?' It often is not us, and we do spend it. It will be signed before June.

**Senator CROSSIN**—We will have to start lobbying the South Australian government.

**Ms Podesta**—It is important to note that even though they have not signed the agreement for training they have made the commitment to provide the trachoma data to the surveillance and reporting unit.

**Senator CROSSIN**—I am hoping all of the states will sign on to that pretty quickly, but they are not. Has the training manual happened and being updated.

**Ms Balmanno**—There is not a training manual per se. Each jurisdiction is taking a slightly different approach to training because they are actually rolling it out. Their trachoma screening program is slightly different. For example, in the Northern Territory they traditionally roll it out through a school based screening program, whereas in Western Australia it is rolled out through the clinics. They are training their clinic staff to undertake the screening, whereas in the Northern Territory it is a group of experts who travel around and undertake the screening. It is a different model in each jurisdiction.

**Ms Podesta**—The guidelines have been released and distributed and they were released in April last year.

**Ms Balmanno**—Yes, that is right.

**Ms Podesta**—They are all training to the same guidelines.

**Senator CROSSIN**—Has the training started yet?

**Ms Balmanno**—Yes. Certainly in WA it has started. In the Northern Territory, because they have the different model where it is actually a core group who travel around and do the screening, the need for training is not quite the same. They are not training a whole lot of on-the-ground staff.

**Senator CROSSIN**—South Australia have not signed their agreement yet?

**Ms Podesta**—No, they have not commenced in South Australia.

**Ms Balmanno**—If they have started something, we are not aware of it.

**Ms Podesta**—It has been really positive to see some of the ways that the states have approached it, and it would be useful to see what Western Australia is going to do in a couple of months time. They are going to do an interregional trachoma screening and treatment eye blitz. This will be a coordinated two-week screening and treatment process across a number of regions in WA. It will be the first time that screening and treatment for trachoma has been conducted simultaneously across those regions. We think this is a really important decision by the state, because one of the problems that we have all identified in this room many times has been that, because of mobility, there have been too many people previously who have been missed when it has been a one by one process. This is going to hopefully alleviate that because it will be a blitz around trachoma and we think this, hopefully, will lead to lower transmission rates.

**Senator CROSSIN**—Has the national trachoma surveillance unit developed the methodology yet for monitoring the antibiotic resistance?

**Ms Balmanno**—No.

**Senator CROSSIN**—That is all part of the work still to be done?

**Ms Balmanno**—That is still ongoing, yes.

**Senator SIEWERT**—Can we change to petrol sniffing. First off, I want to know how the rollout in Alice Springs is going.

**Ms Balmanno**—Good. We have full replacement of regular unleaded with Opal, so there is no regular unleaded petrol for sale in Alice Springs. There is still premium unleaded for sale, because we do not have a replacement fuel for premium, and there is obviously still diesel for sale, which is not a sniffable fuel. All 11 service stations have converted. That has been since mid-March, I think, when the last one switched.

**Ms Podesta**—Yes.

**Ms Balmanno**—There have been a number of issues raised about possible problems with car engines. All of those have been investigated by the Automobile Association of the Northern Territory, which is affiliated with the South Australian one, and so far they have found no evidence that any of the problems were caused by Opal. It was old fuel pumps and things like that. At this stage it is looking quite good. There is still a slightly higher consumption of premium than there was prior to the switch, but it seems to be starting to drop back down to normal levels at the moment.

**Ms Podesta**—It spiked for a short time and went up to about 60 per cent but it has dropped down now to about 40 per cent, which is becoming more normal for Alice Springs.

**Senator SIEWERT**—So people started fuel switching?

**Ms Podesta**—Yes.

**Ms Balmanno**—At the moment the AANT, based on the investigations they have done of the claims, are finalising a public statement that they will make to their members that there is no reason not to use Opal. They are quite satisfied with the investigations they have done but they will continue to investigate any other problems that arise.

**Senator SIEWERT**—How are they going for getting the pumps locked up? We discussed previously what the strategy was to ensure that people could not get access to premium.

**Ms Podesta**—We have certainly contacted all of the fuel companies in Alice Springs and they have been very cooperative about increasing surveillance of the premium pumps, limiting the use of jerry cans and monitoring the use by high-performance vehicles. It would be fair to say that there is a high degree of compliance and cooperation from the fuel companies in Alice Springs.

**Senator SIEWERT**—Are there any reports of premium being taken?

**Ms Balmanno**—We have not had any reports from the petrol stations. There have been some reports in the media of people breaking into cars at a used car lot, I understand.

**Senator SIEWERT**—Yes, I understand that.

**Ms Balmanno**—So there are still some petrol sniffers in Alice Springs, but anecdotally the numbers have dropped, based on the youth services and other services in the area; they have seen a significant reduction. But there is still a group of sniffers who are accessing sniffable petrol wherever they can.

**Ms Podesta**—Essentially, whenever it is drawn to anyone's attention that there might well be a source of fuel that kids primarily can access, there is a very strong network in Alice Springs—as you probably know—who make it their business to go and make contact with that source and identify what you can do to make it secure. We have certainly been aware of the used car yard story. The media might have been a little bit more sensational than the actual, but nevertheless there does seem to be potentially a problem there and they are certainly looking at options about securing those cars to make sure that that is not available.

It has not been what people imagined. You know the horror stories about doing this to people's cars that would be broken into in their driveways et cetera. That has not come to fruition.

**Senator SIEWERT**—Are you doing ongoing media monitoring?

**Ms Balmanno**—Yes.

**Senator SIEWERT**—How long is the media monitoring going to go on for?

**Ms Balmanno**—It is being done within the department for the foreseeable future, I think is the only answer there.

**Senator SIEWERT**—Once something comes up, you are responding to it. Obviously you responded to the car yard one, by the sounds of it, because you sound like you are across it.

**Ms Podesta**—We do not have to. We are interested to know, but there is a unit based in Alice Springs and they really take the local responsibility to initiate action through the network they have with the youth services and others.

**Ms Balmanno**—We have staff in Alice Springs.

**Senator SIEWERT**—Yes, sorry. I appreciate what you have just said, but I meant responding to the negative media; that if people are running negative media rather than the actual—

**Ms Balmanno**—It has been very limited compared to September last year, which was quite vocal and public. There has been very limited media since the switchover in March and most of it has been quite fair and balanced.

**Senator SIEWERT**—I want to move on to the diversionary programs, if that is okay.

**Senator MOORE**—There was media coverage last week about international interest in the Opal program. There were a couple of stories—not too many, but just enough that piqued my interest. Was the department involved at all in talking with the international delegation? I would just like any information we can get about that.

**Ms Balmanno**—Yes. We had a delegation from Canada come across. They have small amounts of petrol sniffing in the region that visited us, but obviously they have other substance use problems and they are very interested in the multipronged approach with diversionary programs as well as the fuel substitution. Like many parts of remote Australia, they are geographically quite isolated and have the opportunity to cut off fuel supply into a region. BP Australia hosted the visit, but they did include meetings with us in the department of health, and also with the Office of Indigenous Policy Coordination, about some of the other elements of the strategy. It was all very positive and they are very interested, so we will continue to follow up that relationship with them.

**Ms Podesta**—And we have between governments an exchange of information. We are part of an intersectoral forum next month which will be communicating information to people in Canada around the program that we have run concerning petrol sniffing.

**Senator MOORE**—Did they get a chance to meet with the CAYLUS people?

**Ms Balmanno**—A group did go to Alice Springs, but I am not sure who they met with. The delegation split. Some came to Canberra and others went to Alice Springs.

**Senator MOORE**—I can actually see affirmation in the area behind you.

**Ms Balmanno**—Have they met with CAYLUS? Yes.

**Senator MOORE**—Just for the sake of *Hansard*, could we get that on the record.

**Ms Podesta**—You are not supposed to nod. They know they are not supposed to nod so much.

**Senator MOORE**—Fine. Thank you very much.

**Senator SIEWERT**—Can you tell me how much money is available for diversionary programs in this financial year?

**Ms Podesta**—The diversionary programs funded by family and community services?

**Ms Balmanno**—And Attorney-General's Department and the Department of Education, Science and Training.

**Senator SIEWERT**—Who is coordinating it?

**Ms Balmanno**—The Office of Indigenous Policy Coordination in FaCSIA.

**Ms Podesta**—And family and community services. We certainly put in ideas, but we are not one of the funding bodies for the diversionary program.

**Ms Balmanno**—We do provide small amounts for CAYLUS, for example. The Department of Health and Ageing is one of the primary funders of CAYLUS, but that existed prior to this strategy. The major investment in diversion which was announced in the 2006-07 budget was to those other three agencies.

**Senator SIEWERT**—Okay. Do you know where they are located? If you cannot tell me about funding, I appreciate that.

**Ms Balmanno**—The most recent decision was the Central Australian announcement of, I believe, $12 million. I think Mission Australia got the contract for that. It is across four communities in the Northern Territory. Do you have the names?

**Ms Podesta**—I do have them now, yes. Eight million dollars to conduct youth services and $4 million for recreation facilities. It is Finke, Docker River, Mutitjulu and Imanpa. Workers will commence in June 2007.

**Senator SIEWERT**—So they are Central Australia. Can you also give us an update on how much is being rolled out in Northern and Western Australia.

**Ms Balmanno**—At this stage there are no specific commitments that have been made. Are you talking about the East Kimberley region that was announced?

**Senator SIEWERT**—Yes.

**Ms Balmanno**—No specific funding commitments have been made there yet. We have three locations that are receiving Opal fuel and have been for some time in that region. We have done some site visits to get a feel for how many other communities there are that would be interested in making the switch to Opal as well as how many roadhouses and public service stations there are in the region. We have started to talk to those communities, in particular about their willingness to make the switch to Opal. They have expressed a very strong desire to do that in the context of the other services—the diversionary activities and other things—coming on line at more or less the same time. So we are now working with our colleagues obviously in those other agencies about the nature and rollout of those programs into that region. It will probably involve quite a bit more discussion with the communities involved before we agree to exactly what should be put in place.

**Senator SIEWERT**—I have a couple more questions, following on from that. Does that mean that when the replacement with Opal happens there will be diversionary programs at the same time? Is that the aim?

**Ms Balmanno**—That is the aim. That is what the communities have requested. If any community, or if any roadhouse, requests Opal in the meanwhile we certainly will not hold it

back. We would not deliberately delay the Opal, but they have requested in most cases that it be done as a consolidated package.

**Senator SIEWERT**—I appreciate it is not your department. Do you expect there will be funding available to enable that to happen?

**Ms Balmanno**—Yes. The 2006-07 budget measure did include rollout to additional regions, and the East Kimberley is one of those.

**Senator SIEWERT**—When do you anticipate that it will happen?

**Ms Podesta**—For diversionary?

**Senator SIEWERT**—Yes. I know that is hard for you to answer it because it is across portfolios.

**Ms Podesta**—It is.

**Senator SIEWERT**—It is hard for us to find out as well.

**Ms Podesta**—I think, Senator, just to be fair, we could not answer that and we would have to take that on notice. We are happy to find out information from our colleagues.

**Senator SIEWERT**—If you could take that on notice, that would be appreciated. Many thanks. So it has not gone beyond the three communities that you have been supplying in the recent past?

**Ms Balmanno**—No, not yet.

**Senator SIEWERT**—Can you remind me which those communities are.

**Ms Balmanno**—I can tell you. Billiluna, Mulan and Balgo.

**Ms Podesta**—There are 14 roadhouses and service stations in that region, there are four feeder locations outside that region and there are six communities.

**Senator SIEWERT**—Yes. Sorry, can we take that one step back. That is the region in which it is already, you mean?

**Ms Podesta**—This is in East Kimberley—the footprint for the East Kimberley region.

**Senator SIEWERT**—Where you are planning to. So can you say that again. Thirteen communities?

**Ms Podesta**—There are six communities.

**Senator SIEWERT**—Six communities, yes.

**Ms Balmanno**—Three of those already have Opal.

**Ms Podesta**—There are three already. It is the same as we have anywhere in Australia with an Aboriginal and Torres Strait Islander community. If they request Opal, it is a given.

**Ms Balmanno**—These are communities which have petrol bowsers, obviously, rather than other communities that do not.

**Senator SIEWERT**—Yes. So we have six communities and 13—

**Ms Podesta**—There are 13 service stations or roadhouses—fourteen, I beg your pardon. One of them has two, and there are some additional feeder locations just outside the region.

Our strategy is always to try to encourage feeder roadhouses to switch as well. We do not pretend that that is an easy or a fast process, because it is voluntary. Realistically what happens is that you get some momentum going and the others come on board. That is what we anticipate happening.

To some degree the communities take on the leadership role then. As the communities make a decision to switch to Opal, they put significant pressure on those around them to do the same thing and that has been the way we have rolled it out in Central Australia. We anticipate East Kimberley will probably take the same sort of process.

**Senator SIEWERT**—Can I ask about Halls Creek.

**Senator JOYCE**—Are people still peddling it in? Is there any illicit movement of old petrol into the communities?

**Ms Podesta**—Into Central Australia? Where we have replaced with Opal—

**Ms Balmanno**—The Substance Abuse Intelligence Desk is operating out of Alice Springs, and it is looking at the trafficking of a whole range of substances, including petrol. We have not had any recent reports of them picking anyone up for petrol-trafficking, but it is certainly part of their core business to look out for that and stop it.

**Ms Podesta**—The most important evidence for us that it is really rare has been from the Nganampa health service in Central Australia, which has just conducted their most recent survey. They have been doing petrol-sniffing population health surveys for many years—for about 20 years, we think. They said in their last survey that no-one under the age of 25 is now identified as a heavy sniffer.

**Ms Halton**—That is a huge turnaround in that region—an enormous turnaround.

**Ms Podesta**—Yes. The Nganampa survey is a very scientifically based survey.

**Ms Halton**—Yes, solid.

**Ms Podesta**—They say that there has been more than a 60 per cent reduction in petrol sniffing in the region in which they have a footprint, which is very extensive in Central Australia. CAYLUS—which, as we all know, is a youth service we respect very greatly—report to us a 90 to 95 per cent reduction in petrol sniffing. So our feeling is that, with that data combined with no reported arrests for trafficking, there is not a big issue at the moment.

**Senator JOYCE**—No, it sounds like a very good result.

**Ms Podesta**—But we would never say it is wiped out; never.

**Senator JOYCE**—That is a very good result.

**Senator SIEWERT**—Can we go back to Halls Creek.

**Ms Balmanno**—Yes. What specifically about it?

**Senator SIEWERT**—Are there discussions going on about Halls Creek? Has the community approached you?

**Ms Balmanno**—I do not believe so, no, but some of the service stations we mentioned earlier are in Halls Creek, so we do intend to have coverage of Halls Creek.

**Ms Halton**—And certainly, given what we know about the issues in Halls Creek and some of the surrounding communities, if they have an interest we would be delighted.

**Senator SIEWERT**—Yes.

**Ms Podesta**—They are a major centre.

**Ms Halton**—They are a major centre.

**Senator SIEWERT**—Yes. You can tell that Senator Adams and I are both interested—

**Ms Balmanno**—Part of the strategy for East Kimberley is definitely to have blanket coverage of Halls Creek.

**Ms Podesta**—Absolutely. So if you can do anything to encourage them, we would be very grateful.

**Senator SIEWERT**—I do not know if either Senator Adams or Senator Moore have more questions on petrol sniffing, but I have one on Bringing Them Home which I would like to put on notice. Could you give us a list of the new counsellors? There was an announcement made on Sorry Day the other day.

**Ms Halton**—Yes, we can do it now.

**Ms Podesta**—We can answer that now. The 22 new counsellors? There will be a male and a female counsellor attached to each of the 11 Link-Up services.

**Senator SIEWERT**—Thank you.

**Ms Podesta**—That is not quite right, I apologise.

**Mr de Carvalho**—The original thinking around the new counsellors was that we would have a male and a female in each of the 11 services, but in the end what we have done is allocate counsellors on the basis of the very heavy case loads. We looked at case loads around the country—New South Wales and Queensland in particular—and have decided to weight more of the 22 into those states. If you bear with me, I will be able to find exactly where it is proposed to locate them. At this stage we have written to the services and we are waiting to hear back from them in terms of their response.

**Senator SIEWERT**—In view of the time, I will be happy if you just table the list. I know other people want to ask questions, and we have a short time for Aboriginal health.

**Mr de Carvalho**—It will take a little while to get through that list.

**Senator SIEWERT**—If you could table it, that would be appreciated.

**Senator CROSSIN**—Can I ask some questions on that same topic. Was there a press release about this, or just a speech?

**Mr de Carvalho**—No, there was a press release, I believe, on the 24th.

**Senator CROSSIN**—I cannot seem to find it under the minister's website.

**Mr de Carvalho**—I will look into that.

**Ms Podesta**—We will make a copy available to you, Senator.

**Ms Halton**—We have a bunch of stuff which we hope will appear before the end of the evening, which I will table. If we can get that, we will put it in as part of the material tabled tonight.

**Senator CROSSIN**—How much will this announcement cost per annum?

**Mr de Carvalho**—Approximately $2 million a year.

**Senator CROSSIN**—When will it come into effect?

**Mr de Carvalho**—It starts in 2007-08. We anticipate that the first of the workers will be in place about three months into the new financial year. It will take some time to develop the guidelines and to do recruitment.

**Senator CROSSIN**—Is there any extra funding for Link-Up services in this budget for these 22 counsellors?

**Mr de Carvalho**—No, this is on top of the existing budget for Link-Up.

**Senator CROSSIN**—So there is no additional money in the Link-Up services in this budget?

**Mr de Carvalho**—Not that I am aware, no.

**Senator CROSSIN**—Apart from the counsellors, do they get any more money to pay their normal bills with?

**Mr de Carvalho**—No.

**Senator CROSSIN**—Is their funding CPI indexed?

**Mr de Carvalho**—There is indexation, yes.

**Senator CROSSIN**—It is just a CPI indexation, and that is all? Okay.

**Ms Podesta**—Link-Up services, in the same way as Bringing Them Home services, can apply for enhancement and expansion funding, as we offer each year in the program. If a service wishes to expand or undertake new activities or is having particular cost pressures, they are eligible to apply through the enhancement and expansion program.

**Mr de Carvalho**—Can I clarify that the indexation is not by CPI. WCI 5 is the index.

**Senator CROSSIN**—How much will you be spending on the Bringing Them Home counsellors and on Link-Up services per annum?

**Ms Podesta**—In 2006-07, the current financial year? We can give you the figures for this year.

**Senator CROSSIN**—Yes, please.

**Ms Podesta**—The Bringing Them Home program is $10.721 million this financial year and the Link-Up program is $4.49 million.

**Senator CROSSIN**—And the coming year, or has that not been finalised?

**Ms Podesta**—That is not yet finalised. We have not applied the indexation to those figures yet.

**Senator CROSSIN**—Who is the official Link-Up service in Darwin? Is it Karu?

**Mr de Carvalho**—Yes.

**Senator CROSSIN**—I will not go there. Ms Podesta knows what I was going to ask.

**Ms Podesta**—Senator, we know that managing all Indigenous programs brings joy and challenge!

**Senator CROSSIN**—If that is the official service, then no other service can apply for this enhancement funding you are talking about. Is that right?

**Ms Podesta**—No, enhancement and expansion funding can be applied for by all services that wish to support Aboriginal and Torres Strait Islander people across Australia. It is not a closed shop. If a service wishes to seek funding to provide particular activities, it can be considered.

**Senator CROSSIN**—There are certain criteria you would have to meet, though, are there?

**Ms Podesta**—As you know, we have the strategic framework agreement and we have our partnerships that exist within each state and territory—our state and territory governments—and the Aboriginal community controlled health sector. They consider the priorities around planning in their region and make recommendations around allocation of resources. The department will always consider sensible, well-targeted and well-developed proposals.

**Senator CROSSIN**—Thank you.

**Ms Halton**—We brought with us the resource kits for the Medicare health checks, which we thought you might like to see. They are fairly hot off the press and they are beautiful. We thought we might table copies for each of the senators.

**Senator CROSSIN**—Thank you.

**Ms Podesta**—It is original artwork that we commissioned by a local artist in Central Australia. The artwork is part of our reconciliation action plan.

**Senator CROSSIN**—Is your reconciliation action plan on your website?

**Ms Podesta**—It is, indeed, and Reconciliation Australia's website.

**Senator JOYCE**—Have we moved off petrol sniffing?

**Senator CROSSIN**—We are just about to move off this program, I think.

**Ms Halton**—Only temporarily, Senator, by the sounds of it.

**Senator JOYCE**—In regards to your program, what is the program like now in regard to the rehabilitation of petrol sniffers and any ongoing problems they are having? Are there any ongoing remedial actions that have to be dealt with in relation to these people into the future?

**Ms Balmanno**—Treatment and rehabilitation services are a shared Commonwealth-state responsibility. There are a number of services in the various regions that are experiencing petrol sniffing that are state government funded and delivered services, but the Commonwealth also funds a range of services. The investment by the Commonwealth into drug and alcohol treatment and rehabilitation services in remote Australia was increased by, I think, $49.3 million over four years as part of the COAG violence summit outcomes. There was a substantial increase in investment there.

We are in the process of finalising where that additional investment should be placed in Western Australia, the Northern Territory and South Australia. Obviously increasing the investment in some of the more remote communities that have poor access to those services at the moment has been a priority, and there has been a strong focus on similar regions to those that have been targeted with the petrol sniffing. It will certainly be part of that.

We are also working with the National Health and Medical Research Council to develop petrol-sniffing treatment guidelines, which up until now have not existed. It is a unique substance, and there do not seem to be any treatment guidelines either domestically or internationally about how you rehabilitate someone from petrol sniffing, so we are working with them to develop the evidence base around that, which will obviously feed into what happens in the services.

**Dr Williams**—The rehabilitation processes follow the common substance misuse rehabilitation programs that we currently have. As Ms Balmanno was saying, we are commissioning some research into volatile substance use rehabilitation. The NHMRC is working with us on that, and that will commence fairly shortly.

**Senator JOYCE**—So it is similar to butane lighter fluid, glues and so on?

**Dr Williams**—That is right. The same principles would apply to other volatile substances as to petrol.

**Senator JOYCE**—Is this program going to get extended into north-west New South Wales and far west Queensland?

**Ms Podesta**—The Opal fuel replacement program is available to any Aboriginal and Torres Strait Islander community which identifies that they potentially have or do have a petrol sniffing problem. We have some targeted regions; government made a decision to have the eight-point plan to target those regions. But as well as that, there are well over 100 communities that receive Opal fuel now, and we continue to receive and to approve those applications.

**Ms Balmanno**—And the growth money for treatment and rehabilitation services was specifically earmarked for remote Australia, but that does potentially include western New South Wales and large chunks of Queensland.

**Senator JOYCE**—Have you had any applications from north-west New South Wales?

**Ms Podesta**—We can tell you exactly. There are none currently. There are none in north-west New South Wales receiving Opal, Senator.

**Senator CROSSIN**—Quality health standards is a new initiative under the budget, of $36.9 million over four years. It is not exactly clear to me how these accreditation services will be done and by whom.

**Mr Thomann**—This is a new measure. The intention of the measure is to ensure that the organisations that OATSIH is funding meet the same standards as apply in the Australian healthcare system. There are a number of elements to this measure. The first element is to develop a single accreditation process which will recognise the scope of services that comprehensive primary healthcare services provide to Aboriginal and Torres Strait Islander people, and, once a single accreditation framework is developed, to trial those arrangements

with a view to establishing a process which organisations would be able to go through to accredit their whole organisation, with a view to accrediting every organisation we fund by the fourth year of this measure.

Another element is to focus on those health services which are high performing—there are a number of high-performing Aboriginal medical services—and to resource them to become centres of excellence, to enable them to deliver comprehensive support to smaller, less well performing organisations in the Aboriginal community controlled health sector. Those centres will address three key areas contributing to quality improvement: business and clinical quality assurance, information and communication technology support, and health workforce professional standards.

**Ms Podesta**—We envisage that they will become almost the teaching AMS concept within the program. We see those centres that are able to demonstrate that they have something to teach others as being able to perform a really leading role as we lead into accreditation through, as Mr Thomann has indicated, the accreditation trials and the regional support trials. We see the centres of excellence playing a mentoring and support role and then being able to provide spin-off of those benefits throughout the rest of the program. It is about trying to raise the standards.

**Senator CROSSIN**—I understand that. The accreditation itself—the accreditation procedures or criteria—will be done with some sort of advisory body or reference group made up of whom?

**Mr Thomann**—We see three elements to developing the accreditation framework. The first one is to scope out the types of services that comprehensive primary healthcare services are providing, and we have entered into an arrangement with the Cooperative Research Centre for Aboriginal Health, based upon their pre-eminent experience in this area and upon our current relationship with them as partners in the industry. They are currently developing a process and waiting for, I think, ethics approval at this stage before they engage in consultation with Aboriginal community controlled health organisations across the country.

The second element will be to engage with the various accreditation bodies that are involved in accrediting various parts of delivering primary health care and community health service delivery. We will be engaging with them to look at what parts of their accreditation standards would apply to various elements of comprehensive primary health care and, given that there are a number of different accreditation standard setters and assessment agencies, how we would manage to work across the different standards to combine them into a single framework, a single process, so that organisations are not unduly burdened by the process.

The third element would be to engage NACCHO and its state and territory based affiliates in assessing what level and type of support Aboriginal community controlled health organisations would require in order to meet a certain set of standards by the end of the fourth year of this measure.

**Senator CROSSIN**—So the view is that you would not fund them after the fourth year if they are not accredited?

**Mr Thomann**—We have not taken a view.

**Ms Podesta**—That will be a decision of government, Senator.

**Senator CROSSIN**—Will they need to meet the same accreditation standards, say, as a metropolitan GP's surgery?

**Ms Podesta**—We would anticipate that we will have accreditation standards that will bring them into line with mainstream health services standards.

**Mr Thomann**—I think it is fair to say, just for your information, that already 40 per cent of Aboriginal community controlled health organisations have met the RACGP standards for primary health care. That is a component of the overall comprehensive type of primary healthcare service that organisations provide to the Aboriginal and Torres Strait Islander people in their region.

**Ms Podesta**—But we should be really clear: the four-year timetable is an objective, because we want to say, 'We're serious about this,' but it is not meant to be something that will cut off services from government funding. It is meant to be a way to bring service standards up, and the four-year timetable is based on investment, quality standards, quality managers being provided throughout the industry, identification of where there are gaps in infrastructure—particularly information systems—in our health services, capital works et cetera. We are looking at this being a framework around ongoing investment in those services to bring up the standards.

We think it is a real issue that it is the only part of the Australian health system that is not subject to any formal accreditation process. It is a voluntary process to get AGPAL accreditation and, as Mr Thomann has indicated, more than 40 per cent of our services are AGPAL accredited, but a number of our services are not. It is the only part of the health system where there is nothing that says, 'These standards are met.'

**Ms Halton**—We have had a significant push on quality in the Australian healthcare system. State and territory ministers and the Commonwealth minister have recently established the new Safety and Quality Commission. In the world context, we are seen as leaders on safety and quality, but we know that, across the health system more broadly, we can do a lot more to improve quality, and one of the reasons we were very keen to do this in this budget was that we would be remiss if we did not lift the standard of quality for Indigenous peoples at the same time as we were doing it for white, middle-class Australians living wherever. We have to manage this, and I have to say that, in the couple of sessions we had with stakeholders to discuss this issue before we actually put the budget proposal in, there was a huge amount of enthusiasm and support.

**Ms Podesta**—Unanimous. The sector has made it very clear to us in all of the discussions that they want an accreditation process. They want to be able to demonstrate to everyone that these are high-performing, quality services.

**Ms Halton**—That it is not a second-class service.

**Ms Podesta**—That it is not second-class; it is not some dinky little room with a couple of untrained people running X and Y.

**Ms Halton**—Exactly.

**Ms Podesta**—That this is a genuine part of the health system.

**Senator CROSSIN**—Can I just quickly move on to the CDEP jobs. Out of the 825, it looks as if you have got 120 positions. This will be for people who are predominantly in urban areas? This is the conversion from CDEP to—

**Mr Thomann**—Could I just clarify that you are talking about the announcement in the 2007-08 budget?

**Senator CROSSIN**—Yes, I am.

**Mr Thomann**—Those positions relate to community care, which is in outcome 4.

**Ms Podesta**—Aged care.

**Mr Thomann**—And aged care.

**Senator CROSSIN**—You are not managing those, then?

**Mr Thomann**—No. We did the previous year. We were the forerunners of this.

**Ms Halton**—We started this.

**Mr Thomann**—We started this.

**Ms Halton**—This was our portfolio initially. Everyone else has now got on the bandwagon. We think that is kind of good.

**Senator CROSSIN**—I do not know. You should go back and have a look at some estimates from previous years.

**Ms Podesta**—We had a previous measure.

**Senator CROSSIN**—What did you do previously? You converted how many?

**Ms Podesta**—Last year we converted—

**Senator CROSSIN**—In 2006-07?

**Ms Halton**—Yes.

**Mr Thomann**—In the 2006-07 budget, we—

**Ms Podesta**—We identified 152 full- and part-time CDEP positions.

**Ms Halton**—In the AMSs.

**Senator CROSSIN**—All in AMSs?

**Ms Halton**—Pretty much

**Ms Podesta**—And Bringing Them Home and substance abuse.

**Mr Thomann**—All OATSIH funded organisations, so it could be substitute services.

**Senator CROSSIN**—So what have you done? You took the money from DEWR and that is part of the salary and you topped up the salary and they are now being paid—

**Mr Thomann**—No, we asked organisations to identify where they had long-term CDEP positions and asked them to make submissions to us for full-time funding for those positions. We assessed their applications. We identified that there were 152 full-time and part-time positions which were eligible for funding. We have offered organisations funding for those

positions and have now provided funding for 93 of them. We are hoping that before the end of the financial year we will have completed the contract signing.

**Ms Podesta**—Once again, this is not the department being slow. It just takes some organisations a long time to reply.

**Senator CROSSIN**—Where are you getting the funding for these 93 positions?

**Ms Halton**—Last year's budget. We found the savings to offset the additional costs.

**Senator CROSSIN**—What I want to know is, did DEWR hand you over the equivalent money 93 times—I think it is about $11,000 in CDEP funding—and then you just had to find the difference?

**Mr Thomann**—No.

**Senator CROSSIN**—DEWR kept the CDEP funding, did they?

**Mr Thomann**—I can only answer for us.

**Senator CROSSIN**—Is that a yes, Ms Halton?

**Ms Podesta**—DEWR confirmed cessation of their subsidies for 54 of those positions on 21 May, Senator.

**Senator CROSSIN**—This year?

**Ms Podesta**—Yes.

**Senator CROSSIN**—But they didn't—

**Ms Podesta**—Ours have been progressively implemented this financial year.

**Senator CROSSIN**—But the money you found for 93 positions—

**Ms Podesta**—152.

**Senator CROSSIN**—none of that was cross-subsidised by DEWR?

**Mr Thomann**—The point of this is to end cross-subsidisation.

**Senator CROSSIN**—Yes. I understand that.

**Ms Podesta**—As the position became fully funded by our department, the DEWR subsidy ceased.

**Senator CROSSIN**—Okay. In this year's budget initiative, DEWR are handing over the equivalent of the CDEP money to the departments, and then the departments—

**Ms Halton**—It is a different arrangement.

**Ms Podesta**—Yes. This year's budget measure was coordinated by DEWR. The budget that OATSIH administered was our budget measure.

**Senator CROSSIN**—All right.

**Ms Podesta**—And we were glad that we had the lead time of a year to finalise ours and communicate extensively with our agencies. We found that it took a bit of time and communication with them for people to understand how this was going to work.

**Ms Halton**—The new ones for this portfolio in this budget are in aged care. They are the urban service community care places plus a couple of others.

**Senator CROSSIN**—You still believe you have capacity for about another 60?

**Mr Thomann**—We are well on track to fully funding those 152 positions identified. All I was saying was what the status is at this point in time.

**Ms Podesta**—As of now, 93 of them are there. They have all been offered the money and the contracts.

**Ms Halton**—Yes. The rest will come.

**Ms Podesta**—They just have to sign them and then we can give them the money. We have identified them and they all meet eligibility criteria. What we will have at the end of the financial year is that there will no longer be any positions in Aboriginal health services that are subsidised by CDEP. They will all be fully funded real jobs.

**Ms Halton**—They will be proper jobs. This was our objective last budget and some people were a bit surprised.

**Mr Thomann**—Just to clarify: there will no longer be long-term CDEP positions.

**Ms Halton**—There might be some that are short term, but the long-term positions that have been full-time positions that were underpaid we attended to last budget. It was in the budget before last.

**Ms Podesta**—They have all been normalised.

**Ms Halton**—'Regularised', I prefer.

[8.49 pm]

**CHAIR**—I think we will finish Indigenous health there. Thank you for your time. We will now proceed to outcome 10, Health system capacity and quality.

**Senator MOORE**—I have some general questions about Strengthening Cancer Care and then about Cancer Australia. I want an update on the same kind of question, Ms Halton. I imagine it would be someone from your area that would tell me the expenditure on the Strengthening Cancer Care package and the subprograms. Can you confirm for us what the expenditure on the Strengthening Cancer Care program has been? I know it was an election policy in 2004.

**Ms Halton**—It is probably worth noting at the outset that the measures are scattered across programs.

**Senator MOORE**—They are, I know. That is standard policy, isn't it? In terms of the range of policies that your department handles, a lot of them are in that situation.

**Ms Halton**—That is why Mr Eccles's face has been a constant over the last two days, Senator.

**Ms Bryant**—We provided an outline of the administered funding allocated and the administered funding expensed for each of the 19 items in the Strengthening Cancer Care Initiative for the 2004-05 and 2005-06 years in our response to the question on notice last time, No. 128.

**Senator MOORE**—Yes. Can we have No. 128 updated?

**Ms Bryant**—No. It remains as at that point because in 2006-07 we do not have end of financial year figures available as yet.

**Senator MOORE**—So you cannot tell me anything about what money has been spent in 2006-07?

**Ms Bryant**—No. I do not have with me—

**Senator MOORE**—In a number of other programs, Ms Bryant, for these estimates we have had a year-to-date figure established. Some of them were April; some of them were March. We were able to get expenditure.

**Ms Bryant**—For some of the items in outcome 1—for example, the bowel screening one—

**Senator MOORE**—Which we talked about yesterday, yes.

**Ms Bryant**—we have already given you updates in that context.

**Senator MOORE**—You said that you were going to give me some figures for 2006-07 up to date in that answer. I got that on the bowel cancer screening program.

**Ms Bryant**—I thought we gave you yesterday—and I did not bring it with me again—what we had to date.

**Senator MOORE**—On that program, you did. That was one of the comparisons I made. I cannot remember, but I think it was up until April that you were able to give me the money in that program. Can we do similarly with others?

**Ms Bryant**—I do not have them with me. They are scattered, as Ms Halton said, across a range of outcomes.

**Senator MOORE**—Can you take it on notice?

**Ms Bryant**—Yes, we can.

**Senator MOORE**—Can you let me know in the answer what you can and cannot do. We are interested in knowing. We did get your answer to question No. 128, which was in a format that was very useful. Could we get that updated to the best of your ability, with the snapshots.

**Ms Bryant**—Okay, will do.

**Senator MOORE**—In terms of the programs, are you spending the money this year? We had this discussion with the bowel cancer screening program because of the slow uptake. We went through that in detail yesterday, about the fact that in 2005-06 and 2006-07, early, there was a delay in spending the money and you explained that. In the other programs in front of you, what is the current status of expenditure?

**Ms Bryant**—I will tell you what I can. Out of the 19 initiatives, two have been fully expended and finalised.

**Senator MOORE**—Which ones are they?

**Ms Bryant**—Make-A-Wish, and Camp Quality and the Royal Children's Hospital, Melbourne.

**Senator MOORE**—Right.

**Ms Bryant**—Five initiatives had been expended as per the allocation to 2005-06. There was no underspending. They are the Breast Cancer Network, the palliative care grants program, the Breast Cancer Centre, the Sydney Children's Hospital and the infrastructure support for cancer care trials.

**Senator MOORE**—Their money has all been spent?

**Ms Bryant**—They were up to date as of the 2005-06 year. Those that we can perhaps comment on from our knowledge—the Local Palliative Care Grants Program in 2006-07—would be basically fully expended in terms of our expectations for where we would be at at this time of year.

**Senator MOORE**—These are the grants that are given out for local initiatives and palliative care across the community. Is that right?

**Ms Bryant**—Yes.

**Senator MOORE**—Are there any tender processes going on with that one at the moment?

**Ms Bryant**—We do run grants rounds. We will go through those.

**Senator MOORE**—I just wanted to get a snapshot of the latest one.

**Ms Bryant**—If you can bear with us while we turn to that.

**Senator MOORE**—Is it under 'L'.

**Ms McLaughlin**—The Local Palliative Care Grants Program has had a call for applications out recently.

**Senator MOORE**—I remember seeing that, yes.

**Ms McLaughlin**—They closed in April and the applications are currently being assessed.

**Senator MOORE**—What was the sum of the total allocation of money in that last round of grants?

**Ms McLaughlin**—My memory is that it is of the order of $5 million. Sorry, Senator, I cannot find that number.

**Senator MOORE**—You can give that to me on notice. How many times a year are those grants given out?

**Ms Bryant**—They are not so much given out—

**Senator MOORE**—As called for tender.

**Ms Bryant**—This was the third or fourth round and they tend to have been in the preceding years rather than all in this year.

**Senator MOORE**—You can tell me, when you tell me what the money was, over what period of time those grants are going. You can give me a snapshot of that program. You just called for them in April. They will be assessed. Will they be in this financial year? Will the decision be made and the money expended in 2006-07?

**Ms McLaughlin**—No. The funding will not be expended in 2006-07. It is 2007-08 funding.

**Senator MOORE**—It is 2007-08 funding we are talking about?

**Ms McLaughlin**—Yes.

**Senator MOORE**—It is not a rollover. You are calling for the grants for 2007-08 funding?

**Ms McLaughlin**—Yes.

**Senator MOORE**—Okay, that is the palliative care. Next one?

**Ms Bryant**—The Breast Cancer Network Australia again would be expended in terms of our normal expectation for this stage of—

**Senator MOORE**—I thought you told me that was fully spent. It could just be my appalling handwriting.

**Ms Bryant**—No. They have been fully expended as per the allocation to the end of 2005-06.

**Senator MOORE**—Okay. That was one of the five?

**Ms Bryant**—That was one of the five, and for 2006-07 its initiative for the expenditure is consistent with our current expectations at this stage of the financial year.

**Senator MOORE**—You are expecting that, when you close the books for 2006-07, the full expenditure will have been made?

**Ms Bryant**—Yes.

**Senator MOORE**—Okay. Next one?

**Ms Bryant**—The National Breast Cancer Centre is also up to date and consistent with our expectation at this time of the financial year.

**Senator MOORE**—That is the one that has been refunded?

**Ms Bryant**—That is right. The announcement was made in January.

**Senator MOORE**—Yes. What was the nature of that refunding? For what period of time?

**Ms Bryant**—It was over a further four years.

**Senator MOORE**—The same amount? I remember seeing the media announcement of the refunding.

**Ms Bryant**—Yes, it was. It was broadly the same amount.

**Senator MOORE**—It is on track?

**Ms Bryant**—It is on track.

**Senator MOORE**—I would not be surprised if it were not.

**Ms Bryant**—Yes, it is on track. In fact, it was $4 million over five years, according to the advice I have here. It might be four point something; it was of that order of magnitude. The Sydney Children's Hospital is in outcome 3, so I do not have information on that.

**Senator MOORE**—I am getting the heading of outcome 3. Tell me exactly why it is in outcome 3 and not under cancer programs.

**Ms Bryant**—Because it is Medicare benefits eligibility for the magnetic resonance imaging, so it falls under—

**Senator MOORE**—I had to write myself a note as to why that belonged in another one. It still comes under the heading of a cancer focused program.

**Ms Bryant**—It was one of the initiatives. That is correct.

**Senator MOORE**—That goes in another program because it has got that focus.

**Ms Bryant**—The fifth one was 'Infrastructure support for cancer clinical trials'.

**Senator MOORE**—Yes. I thought that got more money as well. There is a commitment to clinical trials.

**Ms Bryant**—It is under Cancer Australia currently. In the 2006-07 financial year, Professor Currow may be able to comment.

**Senator MOORE**—That is your program, Professor Currow?

**Prof. Currow**—It is, Senator. The cancer clinical trials do sit within Cancer Australia. As the agency started, we inherited six corporate oncology groups nationally that had funding agreements that went through until 31 December 2007. Two of the other four existing national oncology groups had funding agreements to 31 December 2006 but sought variations to take them through to the end of this year, and the last two are groups with whom we are currently negotiating. The variation is in place to bring them in line—31 December 2007—but we will be topping up their grants in order to ensure that they can have continuity of staff within that.

**Senator MOORE**—Now you have 10 programs and the goal will be to have them all aligned to have the process through until December 2007 for all of them?

**Prof. Currow**—That is correct.

**Senator MOORE**—And the expectation, Professor, is that they will be continuing, or can't you make that statement?

**Prof. Currow**—The expectation is very much that we will have a round of applications out in July, with a view to finalising contracts in October so that they can have continuity from there. In addition to that, we are seeking applications for two new cooperative groups in the 2007 year and another two in the 2008 year.

**Senator MOORE**—So that would bring you up to 14.

**Prof. Currow**—A total of 14.

**Senator MOORE**—That is part of your ongoing growth plan, in terms of that particular program.

**Prof. Currow**—That is correct.

**Senator MOORE**—Was there a budget decision on the extension of clinical trials? I thought I read that, but I may have got it wrong. I cannot find it, so I must have read the wrong book. Of the programs so far, that is the first one that is yours?

**Prof. Currow**—Yes, that is correct.

**Senator MOORE**—Ms Bryant?

**Ms Bryant**—Going back to my list, I should correct a piece of information I gave you before. The NBCC funding allocation announced in January was $8.8 million over four years. The Local Palliative Care Grants Program is $4 million in the current round, and we have 123 compliant applications on hand.

**Senator MOORE**—That is a lot of applications, and I know the nature of those grants is that it is very localised and small. How much per grant is normal? $4 million, with 123 compliant applications, so they meet the guidelines that you had in your tender. Is it likely that they will all get money?

**Ms McLaughlin**—They may not all get money. It will depend on the size of the individual applications. They will be ranked on the strength and need of the applications, and they vary. They could be quite small or they could be a couple of hundred thousand.

**Senator MOORE**—Who makes that decision? Who assesses those grants?

**Ms McLaughlin**—A group of people in the department are assessing the applications, and a delegate within the department will make the decision.

**Senator MOORE**—At what level is that, Ms McLaughlin? Let me know later. That is fine. The next program?

**Ms Bryant**—The next one on my list is the evaluation of the Strengthening Cancer Care Initiative. Funding for that does not begin until 2007-08, so there is no expenditure to date.

**Senator MOORE**—How many years is that over?

**Ms Bryant**—Two. Of the remaining 11 initiatives, we spoke about the bowel cancer screening initiative yesterday. 'Quitting smoking when pregnant' has an allocation of $4.3 million over three years. The expenditure on this in the 2005-06 year was delayed and the money was rephased to 2006-07. In October 2006 the advisory group that was set up to make recommendations to the minister on project funding recommended a number of projects, and the minister approved the funding. The administrative funding under this measure has now been allocated, and the advisory group is no longer active.

**Senator MOORE**—It was a three-year funding program?

**Ms Bryant**—Yes.

**Senator MOORE**—Can you tell me why it was not expended in the first 12 months.

**Ms Bryant**—The funding was allocated in July 2005. The government formed an advisory group on smoking and pregnancy to make recommendations to the minister on project funding. The advisory group had its first meeting in September 2005 and recommended that a scoping study on smoking cessation, interventions and current smoking policies at that time be undertaken, which was done using departmental rather than administrative funds. The advisory group considered the scoping study when it received it and decided that further work and analysis was required.

A firm, Ipsos Australia Ltd, was selected in February 2006 to carry out some qualitative research for the advisory group. The advisory group was hopeful that that again would inform them regarding the priority areas to be funded under the measure, but again the information in the qualitative research did not sufficiently point to areas for development, in their view. The advisory group held a number of further meetings and in 2005-06, I think, recommended one project for funding, although it was not expended in 2005-06, and then finally in October 2006, as I mentioned, it recommended three additional projects, which have been approved by the minister.

**Senator MOORE**—The 2005-06 funding was rolled over to the 2006-07 year?

**Ms Bryant**—The 2005-06 funding was rephased to 2006-07, yes.

**Senator MOORE**—Can you tell me how much has been spent in 2006-07?

**Ms Bryant**—I cannot tell you precisely how much has been spent in the financial year to date, but the money has all been allocated and my expectation is that it is current for this stage of the year.

**Senator MOORE**—Then we roll into 2006-07?

**Ms Bryant**—Yes, there would be more money in 2007-08.

**Senator MOORE**—The advisory group will meet again?

**Ms Bryant**—No, the advisory group is no longer operating because all the available money has been allocated. I would need to double-check for you that a number of those were multiyear projects.

**Senator MOORE**—So 2006-07 is happening, but the allocation has not come through yet for 2007-08. Is that right?

**Ms Bryant**—Well, 2007-08, I believe, will largely be a continuation of the existing projects, but I would need to check that for you.

**Senator MOORE**—There does not seem to be any further need for assessment and decision.

**Ms Bryant**—No.

**Senator MOORE**—The money just gets spent. Could you clarify that for me.

**Ms Bryant**—Yes, that is right.

**Senator MOORE**—I think that is one that we had earmarked to find out what was happening with it, because of the significant original delay. That is good that it is now happening. The next one?

**Ms Bryant**—Skin Cancer Awareness Campaign.

**Senator MOORE**—Yes.

**Ms Bryant**—The budget for the Skin Cancer Awareness Campaign was restructured to reflect the planning and development phase of the program in 2005-06, and then implementation and evaluation in 2006-07.

**Senator MOORE**—Yes.

**Ms Bryant**—The planning and development phase was delayed by several weeks, resulting in some activities—$200,000 worth—moving into the 2006-07 financial year, and that was rephased. That initiative has been added to in the context of the most recent budget. This one is in fact being managed by the Communications Branch and I have their advice here about—

**Senator MOORE**—So it is purely a promotion campaign? There is no policy?

**Ms Bryant**—That is right. It is a social marketing campaign.

**Senator WEBBER**—Perhaps you can take that on notice and they can get back to me.

**Ms Bryant**—Yes.

**Senator MOORE**—But it is your program, isn't it? It is definitely 10.

**Ms Bryant**—It is funded in outcome 1, in fact.

**Senator MOORE**—Why? I am sorry. I thought I had this one down. I thought this was definitely outcome 10. Why is it outcome 1?

**Ms Bryant**—Because it is a health promotion activity.

**Senator MOORE**—And always has been?

**Ms Bryant**—And always carries the word 'cancer' in it.

**Senator MOORE**—But all the money has been spent.

**Ms Bryant**—Yes, that money has been spent. I will need to get the other folder. I do probably have some more on skin cancer here, but I have left the folder behind.

**Senator MOORE**—Ms Bryant, take it on notice: just give us an update on that one.

**Ms Bryant**—Phase 1 of the Skin Cancer Awareness Campaign was funded for a total of $7 million over two years from 2005-06, including $5.5 million in total from the Strengthening Cancer Care Initiative.

**Senator MOORE**—Can you explain that to me, Ms Bryant. It is total funding in the program now of $7 million, but $5 million of that has come out of the budget initiative from last year?

**Ms Bryant**—Yes; $5.1 million administered came from the Strengthening Cancer Care Initiative.

**Senator MOORE**—And that was dated when?

**Ms Bryant**—It was an allocation initially in 2005-06 and 2006-07. Then in the most recent federal budget, the 2007-08 budget, phase 2 is allocated $11.486 million over two years from 2007-08 so that phase 2 will build on the phase 1 messages and address deliberate tanning. The target audience for the phases is teenagers aged 13 to 17 and young adults aged 18 to 24. It is basically a social marketing campaign that is being extended in the current budget.

**Senator WEBBER**—Now I am completely confused. I am not in any way trying to belittle the campaign, but how is that a Strengthening Cancer Care Initiative? 'Cancer care' implies to me that you have got cancer, not that you are trying to prevent it. It is late at night and it is week two, but I am confused.

**Senator MOORE**—Is it just because the word 'cancer' is there, so it is actually included in the cancer funding?

**Senator WEBBER**—If you decided to take the money from there and put it into another initiative, I would cope.

**Ms Bryant**—The Strengthening Cancer Care Initiative was always a mixture of mechanisms to invest in better coordination of cancer services, the establishment of Cancer Australia, enhanced prevention programs, support for people living with cancer, support for health professionals, research and preventive measures.

**Senator MOORE**—What Ms Bryant just read out sounds a lot like going to the website of Cancer Australia, Professor. That means that the providing information element is covered?

**Ms Bryant**—Yes.

**Senator WEBBER**—Okay.

**Senator MOORE**—So the two years, 2005-06, 2006-07, flood over from 2005-06. It is going to all be expended in 2006-07, and the new budget initiative of $11.486 million will be spent over the 2007-08, 2008-09 period.

**Ms Bryant**—That is correct, and the messages will build on the first phase.

**Senator MOORE**—It is being coordinated by the in-house communications section.

**Ms Bryant**—It is being managed in the Communications Branch.

**Senator MOORE**—But I would expect that this will be an outsourced activity, in terms of the process.

**Ms Bryant**—That is correct.

**Senator MOORE**—Good.

**Ms Bryant**—The next one on my list is the Research Centre for Asbestos Related Disease. This was $5.5 million over four years. The allocated unspent 2005-06 funds will be available for allocation in future years.

**Senator MOORE**—So it kicked off in 2005-06?

**Ms Bryant**—The initial allocation was $100,000—$0.1 million, in 2005-06—of which the funding expensed was $0.03 million, which was primarily for meetings of a research working committee, and the balance of the funds was reallocated in the medical research endowment account to 2006-07.

**Senator MOORE**—So it rolled over to 2006-07?

**Ms Bryant**—That is correct.

**Senator MOORE**—What was the allocation for 2006-07?

**Ms Bryant**—I am sorry, I do not have that with me. I have got that it was $5.5 million over four years.

**Senator MOORE**—Sure. Could you update us on that as well. This is purely a research program, Ms Bryant?

**Ms Bryant**—That is my understanding, although it is not one that falls in my world, so I am again going from collated information.

**Senator MOORE**—Where does it belong?

**Ms McLaughlin**—Outcome 14.

**Senator MOORE**—Of course it is. Okay, the next one?

**Ms Bryant**—Cancer research. This is one that, again, my colleague in Cancer Australia is responsible for. This was money that was $17.6 million over four years. No money was expensed in 2005-06 due to delays with the establishment of Cancer Australia and, from 1 July 2006, Cancer Australia has been responsible for the initiative.

**Senator MOORE**—Professor Currow, that is on track now?

**Prof. Currow**—Cancer research is going to be a series of project grants administered in a facility provided by the National Health and Medical Research Council. As such, we are adopting, to avoid duplication, at least their timetable process and their application form, with an additional three pages that relate to the specific priorities and the specific weightings that Cancer Australia is bringing to those processes. A s such, money has not been expended in 2006-07. The applications closed in mid-March. The normal NHMRC panel process will be assessing those applications over the next six to 10 weeks. The scores will then be brought to Cancer Australia and its funding partners. Our $5 million has been bolstered by money from the Prostate Cancer Foundation of Australia, the National Breast Cancer Foundation and the Diagnostics and Technology Branch of the Department of Health and Ageing, and we would hope to have those moneys available early in the new financial year for the successful applicants.

**Senator MOORE**—The total allocation against this particular program was $17.6 million over four years. Nothing was actually allocated in 2005-06 and in 2006-07. I know you have a partnership arrangement, but how much of the $17.6 million are you expecting to have for research in 2007-08?

**Prof. Currow**—We expect that approximately $2.8 million will be committed in 2007-08 as we will have several out years for new grant rounds and, as such, we expect this entire program to be expended by the end of the Strengthening Cancer Care program.

**Senator MOORE**—2008-09?

**Prof. Currow**—2009-10.

**Senator MOORE**—That means you are actually going to be requesting a rollover for one year outside the original allocation.

**Prof. Currow**—That is correct.

**Senator MOORE**—And it has been delayed due to getting Cancer Australia ready. It was always the intent that Cancer Australia would pick up this particular process, wasn't it?

**Prof. Currow**—That is correct.

**Senator MOORE**—From the time it started, this research funding was going to be Cancer Australia's. Cancer Australia has now been formed—I am just making sure I have this right—

and now you have aligned the process with the NHMRC process, which Senator Patterson knows all about.

**Senator PATTERSON**—What do I know all about!

**Senator MOORE**—The decision process is not in NHMRC; it comes back to Cancer Australia and the panel you determine to do the assessment?

**Prof. Currow**—It is a two-stage process. The first of those is an NHMRC evaluation against their normal criteria of innovation, science and track record.

**Senator MOORE**—So they rule over it according to their scientific expectations?

**Prof. Currow**—That is correct. But we will be getting scores for each of those areas, rather than just a consolidated score, because our program is badged differently and our weightings are different. We are putting weight on the involvement of consumers from initiation through to execution and, in fact, the implementation of any research findings. We are also looking to reward, if you will, in the weightings, collaboration between cancer researchers as part of that process. It is distinct from the National Health and Medical Research Council in that regard.

**Senator MOORE**—The applicants are fully aware of that when they are claiming?

**Prof. Currow**—Absolutely. That was very clearly articulated both on the NHMRC website and in the information that went to the research officers at the universities.

**Senator MOORE**—So we can find on the NHMRC website the kinds of weightings that you will be using?

**Prof. Currow**—That is correct.

**Senator MOORE**—And you are hoping that the decision on the first round of research grants will be in 2007-08?

**Prof. Currow**—That is correct. Those applications are already in and they are in process at the moment.

**Senator MOORE**—There is $2.8 million in 2007-08, but then you are expecting to spend the other $15-odd million over 2008-09 and the anticipated 2009-10 rollover.

**Prof. Currow**—Yes.

**Senator MOORE**—We will now go to the next one.

**Ms Bryant**—The next one is 'Developing training courses for cancer nurses'.

**Senator MOORE**—It is Workforce, isn't it? Is this your outcome?

**Ms Bryant**—This one is Cancer Australia. David, I will let you comment, if you like.

**Prof. Currow**—Thank you.

**Senator MOORE**—What is the time frame and the money for this one?

**Prof. Currow**—The total allocation for this program is approximately $4 million over four years.

**Senator MOORE**—Was the anticipated figure $1 million a year?

**Prof. Currow**—It is $4.1 million over four years. That is running at $1 million a year and it is on time.

**Senator MOORE**—Was that kicking off in 2005-06?

**Prof. Currow**—Yes.

**Senator MOORE**—And did it start in 2005-06?

**Prof. Currow**—Yes.

**Senator MOORE**—So 2005-06 was spent. Do you anticipate that 2006-07 will be spent?

**Ms Bryant**—For 2005-06, only $0.7 million of the $2 million was expended, and that was when it was with the department. The reason for the slippage at that point was the need to undertake consultations with stakeholders to develop an agreed curriculum. That initial curriculum development phase took longer than we had initially anticipated.

**Senator MOORE**—And the stakeholders were—or are?

**Ms Bryant**—Are.

**Senator MOORE**—So they would still be the same stakeholders?

**Ms Bryant**—They would be the same stakeholders.

**Prof. Currow**—The stakeholders for this project are nurses across the country. This is a program for curriculum development in oncology for undergraduate and postgraduate nurses. It is a workforce development issue, as you have indicated.

**Senator MOORE**—Yes. You look after it, but it actually fits in the other program. Is that right?

**Prof. Currow**—We are happy to look after it as a Workforce initiative.

**Senator MOORE**—Is the College of Nursing involved in this? Is it one of the stakeholders?

**Prof. Currow**—The principal stakeholder is Peter MacCallum Cancer Institute, and the school of nursing there, in collaboration with several nursing schools across the country. Their brief is to have contact with all nursing schools and to look at curriculum content, as well as developing ideal curriculum and, indeed, curriculum resources for oncology inclusion.

**Senator MOORE**—For special oncology nurses?

**Prof. Currow**—Both at an undergraduate level, so that nurses who are graduating have some experience in oncology, and then, you are quite right, for—

**Senator MOORE**—Encouraging people to do postgraduate work specialising in that. It is $4.1 million over four years. Will 2006-07 be on track?

**Prof. Currow**—Yes, that is correct.

**Senator MOORE**—And then, for the out years, is it vaguely $1 million a year that you are working to?

**Prof. Currow**—Yes.

**Senator MOORE**—We would hate to get that out year on record, because we are not allowed to. And now to the next one.

**Ms Bryant**—The next one is 'Radiation therapy internships and undergraduate places'.

**Senator MOORE**—Another Workforce one?

**Ms Bryant**—It is outcome 3.

**Senator MOORE**—What is the money? I am sure you have got that.

**Ms Bryant**—It is $14.9 million over five years.

**Senator MOORE**—Starting in 2005-06?

**Ms Bryant**—There was money available in 2004-05 and 2005-06, so it has three years beyond that: 2006-07, 2007-08, 2008-09.

**Senator MOORE**—It started off in 2004-05.

**Ms Bryant**—Yes, that is correct.

**Senator MOORE**—Did it spend all its money in 2004-05?

**Ms Bryant**—No, it did not. There was zero expended in 2004-05.

**Senator MOORE**—So we rolled over without losing any?

**Ms Bryant**—In 2005-06 it had an allocation of $1.7 million, with $0.5 million expended. The initiative, I am advised, given that this is outcome 3, was to provide 100 additional radiation therapist training places.

**Senator MOORE**—I remember that.

**Ms Bryant**—Part of the initiative, $6 million, is in fact managed by the Department of Education, Science and Training and the remainder of the money is managed through the department of health.

**Senator MOORE**—So you still are the senior partner?

**Ms Bryant**—If dollars count, I guess we are.

**Senator MOORE**—I think it is the only thing that does count!

**Ms Bryant**—$8.9 million is managed through the department of health.

**Senator MOORE**—Is that across the whole country, or is it similar to the one Professor Currow spoke about with nurses—that is, centred in one place of excellence? Actually, can I put that question on notice. It is in another program and you are going to have to look across stuff. I am interested in that one because it is a radiography project which we have heard a bit about. So it would be good if we could get some information about that.

**Ms Bryant**—That is fine. The next one is 'Establishment of Cancer Australia'.

**Senator MOORE**—Is that Professor Currow's?

**Ms Bryant**—This was $13.7 million over five years. Expenditure on the measure was delayed as a result of the timing of the 2004-05 mini-budget, the need for broad consultation about the establishment of the new agency and the complexity of establishing the governance structure for the new body. The funds, I think, have been rephased for this across several

years, but I would have to get a bit more detail about that. Cancer Australia, as we know, is alive and well.

**Senator MOORE**—It has been established. Could I get you to, on notice, make sure of the money flow there. I am trying to get a sense of the allocation, when it was done, the rephasing and the expenditure to date. We had previous discussion about the delay for 2004-05, and even 2005-06, but in 2006-07 the money began flowing. I just want to get a sense that it is all secure and in the system.

**Ms Bryant**—Yes. I am happy to take my bits of that on notice.

**Senator MOORE**—Professor Currow, I know that Cancer Australia is up and running, but can you refresh my memory: does Cancer Australia, under your leadership, do the administration for Cancer Australia, or is that done by the department?

**Prof. Currow**—This is a statutory authority.

**Senator MOORE**—You are totally self—

**Prof. Currow**—We will be in the next few weeks.

**Senator MOORE**—Can you give me a snapshot of exactly how your implementation is going?

**Prof. Currow**—Cancer Australia has been charged with a number of key initiatives nationally—particularly in consumers of cancer services better supporting each other; secondly, in the research issues that we have touched on already in budget; and, thirdly, in professional development and quality, under which sits the education program that we have touched on, but there are other initiatives there. In addition to that, Cancer Australia was charged with an audit of national cancer control. That audit is underway. A consortium won that tender and will be reporting in the second half of this year.

**Senator MOORE**—Who won that tender?

**Prof. Currow**—It is a consortium led by the Cancer Council Australia, but it was an open tender process. Within that broad aegis, everything in Cancer Australia is up and running in terms of our housekeeping. We have secured premises and we have the team on board.

**Senator MOORE**—Are you fully staffed now?

**Prof. Currow**—We are fully staffed.

**Senator MOORE**—How many staff do you have?

**Prof. Currow**—We have 24.4 full-time equivalents, and that will expand by one FTE as we take on a project person for the national gynaecological cancer centre.

**Senator MOORE**—That question is sneaking up.

**Prof. Currow**—We have premises and we have most of our processes in place. We are just waiting for the transfer of our information technology, which we hope will happen in the next six to eight weeks.

**Senator MOORE**—Is all of that funded under the $13.7 million in the original allocation?

**Prof. Currow**—Yes, that is correct. That is funded under the departmental costs of Cancer Australia. The other initiative that is labelled 'Cancer Australia' is the rollover of the National Cancer Control Initiative moneys, which is the other part of that pot of money.

**Senator MOORE**—I may as well ask about the gynaecological cancer centre. In the budget papers it says that the $1 million is there but that it is not new money; it has been rephased. From where has it been rephased?

**Prof. Currow**—Certainly not from within Cancer Australia.

**Senator MOORE**—Ms Bryant, can you help me as to where the money has been rephased from?

**Ms Bryant**—Yes.

**Senator MOORE**—I always love reading those budget lines where there are no figures at all!

**Ms Bryant**—The government agreed to provide $1 million in seed funding to support the establishment and initial operation of the Centre for Gynaecological Cancers. The source of funding in 2006-07 is a 2006-07 underspend on the National Bowel Cancer Screening Program. In the 2005-06 budget, the government announced it would invest $43.4 million over three years to phase in the bowel screening program. The delayed start to the program in a number of jurisdictions has resulted in a $1 million actual saving across the life of the program, which is manifested in 2006-07. It is due to a reduction in the scale of communication activities in 2006-07, as many of the planned national activities could not commence until jurisdictions were on board. The $1 million saving has been redirected to the gynaecological cancer institute and it will not compromise our ability to achieve the objectives of the bowel screening program.

**Senator MOORE**—We went through the bowel cancer process pretty closely yesterday, and that information about the rephasing did not come up in that discussion.

**Ms Bryant**—My recollection is that it was not triggered by a question or a topic that we were discussing particularly.

**Senator MOORE**—I was interested to find out where the money came from. I thought I went through almost lineball yesterday about the bowel cancer screening program, the delay and what happened.

**Ms Bryant**—We were primarily discussing the take-up rates, participation rates and positivity rates—the progress of the program to date. I thought that was the primary focus of our discussion.

**Senator MOORE**—One million dollars is being saved and rephased into another very worthy cause; I think that was the time that we could have found it. I am just wondering if I had not asked this specific question, 'Where did the money come from?'—which somebody else may have asked—we still would not have found out, because the budget papers do not say where that money came from. I am not trying to be negative towards you, Ms Bryant. Please accept that. I am just trying to find out where the money is.

**Ms Bryant**—I am just responding to questions and did so yesterday as they came up.

**Senator MOORE**—Because of the slow take-up of the bowel cancer screening process involving the partner agencies—the state governments,—money that had been allocated to be spent in that time was not spent, so the funds were harvested and reinvested in the gynaecological council. So at this stage we have a one-off payment of $1 million for seed funding. Professor Currow, has that come to you?

**Prof. Currow**—That is correct.

**Senator MOORE**—There has been significant interest in what is going to happen with that. When are we going to get some public statement about what is going to happen with the seed funding and what is going to happen next? I do not know about your emails, but a few of us here have been getting regular ones on that. Can you tell us what the program plan is for that $1 million?

**Prof. Currow**—Certainly. As you would be aware from the announcement itself, the charge for Cancer Australia was to look at scoping the concept of the national gynaecological cancer centre and to look at education and increased awareness, particularly for medical practitioners and allied health practitioners. To that end, the money is now available to us. We have appointed a project officer, who starts with us in two weeks time.

**Senator MOORE**—At your Canberra office?

**Prof. Currow**—Yes.

**Senator MOORE**—We have discussed once before that the way Cancer Australia is going to operate is not necessarily that your 24.4 bodies are all going to be in Canberra. This person is going to be in Canberra in two weeks time?

**Prof. Currow**—That is correct.

**Senator MOORE**—And we will be expecting information by media release?

**Prof. Currow**—We will certainly be making stakeholders aware of what is happening.

**Senator MOORE**—There has been a program plan established for what they are going to do?

**Prof. Currow**—Absolutely. We will have the first meeting of the working group next week

**Senator MOORE**—Who is on that? Is it anywhere that I should have read?

**Prof. Currow**—Not that you should have read, no. We are just finalising it. But I want to assure you of the process that we have gone through in order to put the working group together.

**Senator MOORE**—Please do.

**Prof. Currow**—We have gone directly, as we discussed in February, to consumers nationally—to consumer organisations. We have sought to span cancer—from prevention through to survivorship, to living with cancer and, indeed, to premature death because of cancer. We have engaged the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, the Australian Society of Gynaecological Oncologists, the gynaecological oncology group within the Royal Australian and New Zealand College of Obstetricians and

Gynaecologists, radiation oncologists, medical oncologists, psycho-oncology, palliative care, primary care, the Department of Health and Ageing and the National Breast Cancer Centre.

**Senator MOORE**—Okay. And consumers?

**Prof. Currow**—I started with consumers, Senator. They were the first people I mentioned.

**Senator MOORE**—When will we be able to get their names?

**Prof. Currow**—That can be something of public record now, if you would like.

**Senator MOORE**—Put it on notice rather than read through them all.

**Senator ADAMS**—I think we should—

**Senator MOORE**—Certainly, Senator Adams. Go ahead, Professor.

**Prof. Currow**—Thank you. The consumers are: Stephanie Alveraz and Lesley McQuire; from the Cancer Australia Advisory Council, Professor Sanchia Aranda, who will chair the advisory group; laboratory research, Dr Penny Webb, Professor Michael Quinn and Professor David Bowtell; from clinical trials, Professor Michael Friedlander; from epidemiology and prevention, Dr Marion Carey; from the screening section of the Department of Health and Ageing, Ms Andriana Koukari; by way of a gynaecological oncologist, Professor Ian Hammond and Associate Professor Margaret Davy; radiation oncology, Dr Robyn Cheuk; from nursing, Ms Tish Lancaster and Ms Helen Green; psycho-oncology, Dr Monica Janda; from palliative care, Dr Katie Clark; from primary care, Dr Katharine Salmon; from the Department of Health and Ageing cancer control branch, Ms Joy McLaughlin; and from the National Breast Cancer Centre, their CEO, Dr Helen Zorbas.

**Senator MOORE**—You have covered a fairly good geography there.

**Senator PATTERSON**—Would you be able to table that document so that we do not have to try to decipher it all.

**Prof. Currow**—Certainly.

**Senator PATTERSON**—Thank you.

**Senator MOORE**—And you are meeting—

**Prof. Currow**—Next Tuesday.

**Senator MOORE**—Have you met before?

**Prof. Currow**—No.

**Senator MOORE**—This is the first one. Good. I know, Professor Currow, that there is so much on, but there is interest in that particular group. I think there would be major interest in getting some public statements out there about that.

**Prof. Currow**—I accept that.

**Senator MOORE**—That is the gynae cancer line. Ms Bryant, do we have any more of those programs?

**Ms Bryant**—I think by my count we have two or three left to go. 'Building cancer support networks'.

**Senator MOORE**—Yes, we have seen that one.

**Ms Bryant**—Which is, again, Cancer Australia.

**Senator MOORE**—A Cancer Australia initiative. Is it for 2005-06, 2006-07?

**Ms Bryant**—From my understanding it was $3.1 million over five years, commencing in 2004-05.

**Senator MOORE**—I imagine there would have been a delay in 2004-05 in the expenditure?

**Ms Bryant**—That is correct. Funds were partly expended in 2004-05 and 2005-06, due to the 2004-05 minibudget shortened time frame. The shortened time frame resulted in a smaller number of applications being received, I think, for the initial funding round.

**Senator MOORE**—So it is $3.1 million over five years.

**Ms Bryant**—Yes.

**Senator MOORE**—And you have inherited that, Professor?

**Prof. Currow**—That is correct.

**Senator MOORE**—We are now in 2006-07. How much money have you spent?

**Prof. Currow**—In total sum, $1.9 million has been committed.

**Senator MOORE**—Which is about halfway through.

**Prof. Currow**—It is more than halfway through, so we are planning to bring together the 27 groups that have been funded under this initiative.

**Senator MOORE**—They were individual grant options, weren't they?

**Prof. Currow**—That is correct, before we put out the next round of grants, to wean what we can that can be generalised to other groups and ensure that the next round is going to build on the learning and the strength that has been developed in those 27 grant holders.

**Senator MOORE**—Regarding the decision-making body for Cancer Australia on assessing grants: do you create a special assessment group?

**Prof. Currow**—There will be an assessment panel for this which will, again, include consumers as key stakeholders within that process.

**Senator MOORE**—Have you actually assessed any of the grants under the umbrella of Cancer Australia, or did you inherit grants that the department had previously expended?

**Prof. Currow**—We have not assessed any of these to date.

**Senator MOORE**—When the next round comes, you will have inherited 27 grants that were allocated under the department before your group became operational, so the next round will be the first six months Australia operates in its own right?

**Prof. Currow**—That is correct.

**Senator MOORE**—That will be in 2007-08?

**Prof. Currow**—Yes.

**Senator MOORE**—Right. Back to the list.

**Ms Bryant**—The 'Professional development packages for cancer professionals' initiative was $3.3 million over three years.

**Senator MOORE**—Yes.

**Ms Bryant**—Again, this is one that is now with Cancer Australia. At the point in 2005-06 when it was with the department there was an open tender process.

**Senator MOORE**—Yes.

**Ms Bryant**—Contract negotiations were the preferred tenderer, so it did delay commencement of the first phase of the project to February 2006. There was a bit of slippage there. From July 2006 it was with Cancer Australia.

**Senator MOORE**—Has Cancer Australia spent any money?

**Prof. Currow**—That program is continuing. It is on time and we expect the moneys for 2006-07 to be fully expended as projected in the budget.

**Senator MOORE**—Have you made any decisions as Cancer Australia on that one, or have you inherited the departmental ones?

**Prof. Currow**—We inherited.

**Senator MOORE**—So, in the same way, you are about to implement in your own right an ongoing program?

**Prof. Currow**—We are managing phase 2, which is the extent of this project at the moment.

**Senator MOORE**—Fantastic. The next one? This must be getting very close, Ms Bryant.

**Ms Bryant**—This is my last one.

**Senator MOORE**—Are you absolutely sure of that!

**Ms Bryant**—'Mentors for regional hospitals and cancer professionals'. This was $14.1 million over four years, $12 million of which was administered funds. At the time the department managed this I think 21 joint funding agreements were signed, in 2005-06. From July 2006 this initiative, again, is with Cancer Australia.

**Senator MOORE**—Right. How is it going?

**Prof. Currow**—It is going well. We have worked to move from a small grants project base to working with the states and territories on this, as we outlined in February this year.

**Senator MOORE**—Yes.

**Prof. Currow**—I think we outlined to you at that time that we have had discussions with each of the states and the Northern Territory about looking at a regional program and linking that directly with the metropolitan program. Since that time we have met with the states and territories as a group at the end of February. We have funded project people in each of those offices to put together the applications which closed on 18 May, and are currently being assessed for that program.

**Senator MOORE**—At $3.3 million it is a relatively small program. Is it a grant based program for the mentors?

**Prof. Currow**—This is grant based. It has been to date and it will be grant based on a larger scale across—

**Senator MOORE**—Yes, it has been augmented. Once again, you will be setting up your own grant assessment team.

**Prof. Currow**—Yes, we will.

**Senator MOORE**—Ms Bryant, we may have more questions—not tonight but when we have a look at all this. Would you be able to give us the figures that you can, as quickly as you can. I know that is a big ask, but it is just to get our heads around the whole program.

**Ms Bryant**—But there are so many. I might need the transcript to assist me.

**Senator MOORE**—I am particularly interested in the radiology one, because that does cross a couple of departments and also places. It may well have to be looked into. I did not ask questions of DEST on this one because I thought it was a cancer program, and so I was concentrating on Health and Ageing. But there were public announcements about radiography places that were there, and we want to see how it is tracking, because the radiography area was identified as one of the core workplace shortages. I want to get some figures on that. I will end on cancer there. Senator Adams may have some more on cancer.

**Senator ADAMS**—Professor Currow, the last time we spoke to you here, I think the Cancer Australia board was about to meet. How many meetings has the Cancer Australia board had to date?

**Prof. Currow**—The advisory council has met three times: at the end of August and the beginning of September last year, at the beginning of December last year and again in March this year.

**Senator ADAMS**—How many meetings has your consumer advisory committee had?

**Prof. Currow**—That committee has met once. The next meeting is in October.

**Senator ADAMS**—You were speaking about clinical trials and weighting. Has any provision been made for rural participants to take part in these trials?

**Prof. Currow**—We are asking each of the clinical trials groups to look at their current coverage and to look at ways that we can increase access to clinical trials right across Australia. To that end, we are working with the cooperative groups and ensuring that they are aware that that is a priority for Cancer Australia.

**Senator ADAMS**—Unfortunately, as a rural cancer survivor, I have found that participating in clinical trials is just impossible. There is no funding and it just does not happen. There is nothing more frustrating. I am a cancer survivor and I have a number of friends who would love to be involved. From a rural perspective, you are probably missing out on an awful lot. So, with that weighting, perhaps that could be considered.

**Prof. Currow**—Thank you, Senator.

**Senator ADAMS**—This committee has a Patient Assisted Travel Scheme inquiry. This is a very important thing for cancer. Is Cancer Australia putting in a submission?

**Prof. Currow**—Our submission was combined with that of the Department of Health and Ageing.

**Senator ADAMS**—How involved has your consumer advisory committee been in putting this submission in?

**Prof. Currow**—It was not one of the issues that the consumer advisory committee discussed in detail at its first meeting. As such, our advice and participation is from our wide-ranging consultation from a number of consumers across the country.

**Senator ADAMS**—A number of your Cancer Australia people attended a conference in Perth that I spoke at several weeks ago, and this was the biggest complaint. I spoke about PATS, and they said that, unfortunately, Cancer Australia had not actually asked their consumer advisory committee for information or for any support with it. The reason why I asked you that question is that I am very disappointed. It is very important. As far as rural patients go, most of them have to travel to a capital city or a large city for cancer treatment and there are huge issues associated with that. I would ask that that be drawn to the attention of your advisory committee.

**Prof. Currow**—Thank you, Senator.

**Senator POLLEY**—My questions relate to heart, stroke and vascular disease. As we all know, these are expected to increase, and I would like to know what funds are being provided for those services, both from a hospitalisation and a pharmaceutical point of view.

**Ms Bryant**—Your question is on how we fund cardiovascular and heart and stroke initiatives?

**Senator POLLEY**—And on how much money is allocated.

**Ms Bryant**—We fund cardiovascular and a number of chronic disease initiatives from what is called our BRE base funding. That is No. 36 in our base funding. I think it comes under the heading of the National Diabetes Strategy. Because of the common risk factors across cardiovascular disease, diabetes, kidney disease and a range of other things, they are funded through this initiative. They have the same risk factors and the intervention pathways are the same for a number of these conditions, so our money comes through that source.

**Senator POLLEY**—What is the allocation of funds?

**Ms Bryant**—It was initially committed in 1999 at $2.1 million per annum, I believe, and it is indexed annually. I think it remains at $2.1 million per annum indexed from 1999. I would have to check the current figure for you. We can get those figures for you.

**Senator POLLEY**—How much of that money goes into early detention and prevention programs?

**Ms Bryant**—I think I would need to take that on notice.

**Senator POLLEY**—That would be great. What outcome do these funds fall in?

**Ms Bryant**—Outcome 10.

**Senator POLLEY**—Can you outline any of the programs that identify and prevent these diseases? It is an increasing area that we should be alarmed about.

**Ms Bryant**—We have a number of current initiatives. The centre for monitoring heart, stroke and vascular disease, which is run through AIHW, the monitoring centre, is funded from here. The Public Access Defibrillation Demonstration Project is funded from here, as is the chronic kidney disease pilot study for early detection of chronic kidney disease in high-risk groups. There is a project called 'Production of clinical guidelines for acute stroke management and stroke support'. There is the National Heart Foundation walking initiative. There is a promotional product called *Kokoda with Heart*, which is a DVD for use in hospitals to inspire cardiac patients.

There are a number of diabetes initiatives as well: the Diabetes Register, the National Centre for Monitoring Diabetes—again through AIHW—and the production of diabetes guidelines. There is funding to Diabetes Australia for renal disease and patient education and case detection, diagnosis and primary prevention. There are some guidelines being produced on diabetic retinopathy. There is the Australian National Diabetes Information Audit and Benchmarking project, the diabetes in pregnancy data collection, the Diabetes Prevention Pilot Initiative, a Juvenile Diabetes Research Foundation grant and so on. So there are a significant number of initiatives being funded.

**Senator POLLEY**—When you provide that information about the allocation of funds, would it be possible to get that broken down by state?

**Prof. Horvath**—Cardiovascular disease is in fact a decreasing problem, thank goodness—and, in Australia, stroke and heart disease mortality has dropped dramatically in the last 20 years—but it goes almost across all our outcomes. A lot of the material we covered in outcome 1, around the Australian better health initiatives, is around cardiovascular disease. We can give you the PBS figures but, from memory, either four or six of the top 10 drugs in terms of cost and prescriptions are in fact cardiovascular drugs—prevention drugs, all the statins and all the antihypertensive agents. Again, across the Medical Benefits Schedule, there is that very large group of things around stents, defibrillators and prosthetics. So the prevention of death from cardiovascular disease goes across the entire spectrum. I am not quite sure how much information you want.

**Mr Learmonth**—As Ms Bryant said earlier, there are a lot of high-risk factors for chronic disease—in particular, things like obesity, overweight, nutrition and inactivity. A lot of the programs within outcome 1 that go towards reducing lifestyle risk are significant contributors as well to things like cardiovascular disease and kidney disease. Attribution of things that go to this objective across all our outcomes is, I think, something of a challenge.

**Prof. Horvath**—Just to add the icing to the cake—and I do not dare look at Senator McLucas; I am going to close my eyes—our success with smoking has been, without a doubt—

**Senator McLUCAS**—You were not going to let a whole estimates go through without having a go!

**Prof. Horvath**—Our success on smoking in Australia is the world's best—and there has been a dramatic improvement in cardiovascular death rates.

**Senator POLLEY**—The information I have is that, on the 2004 figures, 36 per cent of all deaths in Australia were attributed to heart, stroke and vascular disease. That is still a significant number.

**Prof. Horvath**—Cancer has overtaken us now.

**Ms Bryant**—A number of these initiatives do not in fact break down to state level because they are national projects, like the production of guidelines or funding through AIHW for monitoring work et cetera. So I would just foreshadow that many of them are not of that nature, but we will do what we can.

**Senator POLLEY**—Thank you. Turning now to the National Service Improvement Framework, can somebody explain to me what that is about?

**Mr Morris**—The National Service Improvement Framework is derived from the National Chronic Disease Strategy, which is the very top-level principal document setting out the broad approach agreed amongst the nine jurisdictions of Australia to the prevention and management of chronic disease. The service improvement frameworks take those principles and articulate them into specific clinical contexts relating to five of the national health priorities. They provide guidance on approaches to prevention, early detection, management, self-management, right through to palliative care, in the context of those five national health priorities.

**Senator POLLEY**—What was the cost for the development of that framework and the national health priority areas? Can you give me a figure on that?

**Mr Morris**—To my knowledge, the cost was borne administratively within the Commonwealth and the state governments that participated in the development of those frameworks.

**Senator POLLEY**—What is the contribution from the federal government?

**Ms Bryant**—As Mr Morris says, at the level of the strategy, the frameworks, the health priorities—that framework within which initiatives are conducted and so on—it is a departmental cost and consequently we do not have a breakdown available of how much of our outcome 10 departmental resourcing would go to this initiative. The strategy, frameworks and blueprints share a number of common themes, including an emphasis on health promotion, prevention, monitoring population trends for chronic disease and so on, supporting integrated service provision and multidisciplinary care, promoting and supporting self-management within the health system, progressing mechanisms to improve the quality of care and improving access to chronic disease prevention and care services by Indigenous and other underserviced population groups. And, of course, the department has a wide range of funded initiatives or administered programs that go to each of those things and contribute to activities under the umbrella of the strategy, framework and blueprints.

**Senator POLLEY**—You cannot break it down into a cost to the priority areas of those programs?

**Mr Learmonth**—While there would have been some direct cost, time was actually the principal component of the development cost for the relevant Commonwealth and state departments, and I am not sure that we would be able to calculate and attribute that.

**Senator POLLEY**—What role do the NSIFs have in determining which programs and policies are taken up?

**Mr Morris**—The frameworks only guide implementation activities at both a Commonwealth and state level and in clinical practice as well as in the administration of programs. In that sense, they are receptacles to be filled by the activities of the Commonwealth, the states, the hospital system, specialists et cetera. If you take the preventive element of the frameworks, you can see major activity through investment in the Australian Better Health Initiative, in the more recent COAG diabetes initiative, in the Building a Healthy and Active Australia initiative and in the range of anti-obesity measures that were announced in the current budget. If you go to matters of clinical treatment and care and management, the recent enhanced primary care reforms have dramatically advanced the ability of general practitioners to manage chronic conditions in the primary care setting and so on. In that sense, the frameworks are best understood as frameworks and not as programs.

**Ms Bryant**—When you look at the particular health priorities—asthma, osteoarthritis, osteoporosis, diabetes et cetera—each of those, as we have discussed over the last couple of days, has a number of initiatives specifically targeted at it. We have talked about the Asthma Awareness Campaign. That is one preventive strategy in the asthma area, but there is an Asthma Management Program with multiple components, and there are funds allocated similarly for osteoporosis, arthritis, diabetes and so on. Each of those types of areas has specific funding allocated to a number of initiatives.

[10.10 pm]

**National Health and Medical Research Council**

**CHAIR**—We will now move onto the NHMRC.

**Senator PATTERSON**—I put about nine questions on notice, or gave you advanced notice of them. The first one was about public submissions being called for response to the copy of the draft *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research 2004* as they were updated in April 2007. Could you advise the date of the call for submissions and the newspapers in which they appeared?

**Prof. Anderson**—Thank you for giving us advance notice. It is much appreciated. We opened public consultation on 11 April 2007 with an advertisement in the *Australian*. That was a Wednesday. On Saturday, 14 April the advertisement appeared in 19 newspapers around the country. The closing date for submissions was 5 pm on 11 May. We can provide a copy of the advertisement if you care. This time frame complied with the relevant act, the NHMRC Act. Again, we can give you details of the requirements of the acts.

**Senator PATTERSON**—I know the requirements of the act, thank you. So it met the 30-day or more rule. Some people were contacted individually. How was the decision as to who was contacted made? And who was contacted?

**Prof. Anderson**—Eight hundred and twenty-seven individuals or organisations were personally contacted to make a submission. The list was developed by our staff and included some of our normal distribution for all requests for consultation: peak bodies, government departments and so on. In addition, it included witnesses called to give evidence to the

Lockhart committee and, indeed, organisations that had previously been involved in consultation on earlier ART guidelines.

**Senator PATTERSON**—Were any members of parliament advised?

**Prof. Anderson**—I would have to take that question on notice. I am not sure, specifically.

**Senator PATTERSON**—I did not get an invitation and, having initiated the bill and since I was away on parliamentary duty and I did not actually scour the newspapers except the headlines, I did not know until I was informed by somebody else. In future it would be appropriate at least for an email to go out to members of parliament when there is something like this, in which obviously many members of parliament take an interest. I would suggest to the NHMRC that there will be other occasions when it happens and that it may be appropriate to send the same message to those of us who may take an interest.

**Prof. Anderson**—Senator, I accept your comment and no discourtesy was intended.

**Senator PATTERSON**—I understand that.

**Prof. Anderson**—I take your point entirely.

**Senator PATTERSON**—I understand that. We try and keep up with everything but we do not read every skerrick of the paper and we had as much input as many of the people who made submissions to the Lockhart review.

**Senator MOORE**—It surprised me that we were not advised of this. As the committee was involved in an extensive committee inquiry on this particular issue, I thought that on this one, if not on anything else, during the process which I know you follow of sending out those personal advices, this committee through the chair—through Senator Humphries—or through the secretariat would have been advised of the process. I want to put on record that I was disappointed that we were not.

**Prof. Anderson**—Again, I accept the criticism. Thank you.

**Senator PATTERSON**—It is not a criticism. It is just another way of looking at it, but we actually do have an interest in these things and sometimes are kept out of the loop accidentally. How many submissions were received from both methods of advertising?

**Prof. Anderson**—We had 93 submissions that were received and considered as part of the process advising the guidelines, so they went through the full consideration process. We had one submission that arrived on Monday, 28 May. That was well after the deadline, when the submissions had already been considered, and it was not included; so that is not in the 93.

**Senator PATTERSON**—Are those submissions public documents?

**Prof. Anderson**—We would make them public anyhow, as part of the routine process of our NHMRC consultation process—except where people who have submitted indicate that they do not want them to be. We can certainly make them available if you would like.

**Senator PATTERSON**—I did ask in question No. 4 could you provide a copy of the submissions to the committee?

**Prof. Anderson**—Yes. We are processing that and they have not quite finished it tonight, but we can certainly have them here tomorrow.

**Senator PATTERSON**—I would be grateful if that could happen. Were the submissions considered by a subcommittee of AHEC or was it the whole of AHEC?

**Prof. Anderson**—Both, which is pretty much the standard NHMRC process for considering public submissions. First of all, all the submissions were provided to all members of AHEC, and then they were considered initially by a subgroup—again, that is our standard process—and then by the whole committee.

**Senator PATTERSON**—Who were the members of the subgroup?

**Prof. Anderson**—The chair was Dr Greg Pike and the members were Professor Colin Thomson, the Reverend Dr Gerry Gleeson, Dr Nicholas Tonti-Filippini, Mr Chris Coyne, Mr Barry Maley, Dr Marian Scarrabelotti and Dr Nikolajs Zeps. That is about half, I think.

**Senator PATTERSON**—Are people asked to indicate their particular position on an issue so that the committee understands where they are coming from, or is that not required?

**Prof. Anderson**—It is not required as a routine thing for our processes. Because of the wide make-up of NHMRC principal committees and expert committees, people come to us with a wide range of views, and, if they have a conflict of interest that is defined by financial benefit or something from it, they are required to disclose those to the NHMRC. Nearly all our committees do have a wide range of views.

**Senator PATTERSON**—Dr Tonti-Filippini, who said my bill was 'Patterson's curse' and who ridiculed former Judge Lockhart on an *AM* program. Is that the sort of conflict of interest we might be looking at?

**Prof. Anderson**—That is not the conflict of interest that I was talking about, which would be a direct financial conflict of interest. I was going to use the example of the NHMRC's renowned dealing with the issue of animal rights, where we do have a wide range of people and our committees that look at the guidelines, when people are completely opposed to medical research that will often have criticised individuals within the medical research facility. What we find is that when they are on our committee, because of our processes they understand the role they play there. We seek to have a wide church, I suppose; not to exclude people because on a particular issue they may hold strong views.

**Senator PATTERSON**—The role is to have guidelines, not to legislate. That must be difficult sometimes. When I read the first lot of guidelines it seemed to me that people had a slight misunderstanding that they were actually implementing the law, not making the law. There was some serious anxiety in the research community expressed to me from a number of sources about that first lot of guidelines. It would seem to me that the first lot of guidelines that went out were, in some ways, prejudiced and, in some ways, reflected views rather than implementing the legislation. My view would be that a first cut in trying to reduce that so that people were not as anxious about it, and as antagonistic as they were, would have made the process a little smoother.

**Prof. Anderson**—May I take a moment to explain the NHMRC's processes. Under our act the Australian Health Ethics Committee prepares a draft for consultation where it is research guidelines involving humans. They issue those for comments, but there are several more steps before that draft becomes known.

**Senator PATTERSON**—I understand that.

**Prof. Anderson**—I am happy to take you through those. I think the feedback we had was very robust—from people with a very wide range of views. All of those 93 submissions were considered by the working group and then the full AHEC and then council on Monday, and every single one of them has been taken into account.

**Senator PATTERSON**—So the final draft will go to the AHEC. Is that completed now?

**Prof. Anderson**—The Australian Health Ethics Committee met yesterday and finalised a draft. That was sent to council late this afternoon. The staff of the NHMRC are also looking at that draft. Our act insists that neither council nor the staff nor the CEO can change any of the wording in a health ethics document, but council will look at that document as it stands on Monday.

**Senator PATTERSON**—Is it the case that, if one council member requires it to go back to the AHEC, it will go back? Is that a requirement?

**Prof. Anderson**—No. The NHMRC Act was changed, effective 1 July 2006, so that the council did not have to issue to me, as CEO, guidelines as prepared by the Australian Health Ethics Committee. They cannot change them, and they do not have to refer them on to me. What I would do is ask for them to be referred back to the Australian Health Ethics Committee. How council wishes to exert that process is up to council.

**Senator PATTERSON**—Is it a vote? What is involved in a set of guidelines not going to you to be approved?

**Prof. Anderson**—There will be a recommendation with the document that they be considered and, if approved, referred on to the CEO.

**Senator PATTERSON**—But is it a major vote?

**Prof. Anderson**—One of the great things about all NHMRC committees, including AHEC, I should say, is that issues are arrived at as a consensus. There certainly has not been a vote in my time as CEO on any of the principal committees of council.

**Senator PATTERSON**—When they go to council on Monday, are you saying that the council arrives at a consensus that they should be made public and become the guidelines, or make a recommendation to you that they become the guidelines? Or are you saying there could be a consensus that they go back? If they cannot agree, do they vote? What is the process if they do not agree? How many people have to say, 'This is not on, we want these to go back'? I just want to understand the process.

**Prof. Anderson**—The act says, of course, a majority plus one. If it came to that, which I am sure the council would not wish to get to, the council could vote and decide what to do. My strong expectation is that they will wish to form a consensus.

**Senator PATTERSON**—When would those guidelines be available to the public?

**Prof. Anderson**—It depends on what council's decision is. If they are forwarded on to me without change, then I would send them to the minister seeking for them to be tabled in parliament as soon as it became possible.

**Senator PATTERSON**—Do you have to be satisfied with the guidelines as well?

**Prof. Anderson**—Yes.

**Senator PATTERSON**—Can you reject the guidelines and ask for them to be reviewed?

**Prof. Anderson**—I have a number of options under the act.

**Senator PATTERSON**—What are those options?

**Prof. Anderson**—I can decide not to pass them on. I can issue interim guidelines. We already have guidelines in place—the 2007 ones that are mentioned in the act itself. There is a range of options.

**Senator PATTERSON**—Have there been many changes to the draft guidelines that were issued?

**Prof. Anderson**—Yes. The working committee of AHEC met for two full days and went over every submission and made a substantial number of changes. Further changes were made yesterday and the day before at the meeting of the full committee.

**Senator PATTERSON**—What is the aim of the guidelines? Is it to change the guidelines to deal with the changes in the 2006 act?

**Prof. Anderson**—Yes. In fact, if I remember correctly, the title is now *Ethical guidelines on the use of assisted reproductive technology in clinical practice and research 2004*, as amended in 2007 in accord with the amendment act. That was the intent of the changes, and that is what the committee has striven to do—to make the changes to the existing guidelines necessary to meet the requirements of the act.

**Senator PATTERSON**—So I would expect to see significant changes from those original guidelines.

**Prof. Anderson**—I cannot speculate on what you would expect, Senator, but I think you will see considerable changes.

**Senator PATTERSON**—I would be hoping to see considerable changes, Professor, because I have had a number of very concerned people who felt that people had overstepped the mark in trying to if not subvert the law—I will not use that term—put people's own stamp on what they think ought to happen and what they think is ethical. There were some quite value-laden statements, and I have a strong feeling about the role of parliament. Parliament makes the law. We do not talk about members of parliament being law makers as much as they do in America, but we are legislators and if people want to make legislation they need to get elected rather than trying to do it through other processes. But that is another matter.

**Prof. Anderson**—I share your view on that, of course.

**Senator PATTERSON**—I presumed you would, but it would have been better had the original draft been a little bit more circumspect. Presuming the guidelines are acceptable and go out, as of 12 June researchers will be able to go to their ethics committees with proposals and proceed towards a licensing process. Is that correct?

**Prof. Anderson**—Researchers will be able to do that on 12 June. There is no question about that. We have all the other things in place that we need to—all administrative changes, the enhanced compliance documents. We have held information sessions in the major eastern state capitals, and we are still rolling that out. We have issued a national statement, and this

must not be forgotten when we are thinking about the amendment act because this is the base line document that was tabled in parliament in March that really underpins such crucial issues as consent and so on.

We are very close to agreement with the vice-chancellor's commission and the Australian Research Council on the Australian Code for the Responsible Conduct of Research, which again will bind researchers to ethical conduct in terms of research misconduct. We have finalised our developing objective criteria for defining when embryos are unsuitable for implantation for research purposes as required in the act. All those things are in place. There are current guidelines. We are very close, I believe, to having the amended ART guidelines in place and, as I indicated earlier, I am able to issue interim guidelines in any case. So, yes, researchers will be able to submit applications to us from 12 June, ready for our licensing committee to look at.

**Senator PATTERSON**—I am not going to ask you for a copy of the guidelines that are going in on Monday, because I do not think that is necessarily appropriate. I would love to have a look at them, but I think that we should let the process go ahead in an appropriate way. But the committee members would appreciate a copy of those guidelines as soon as the decision is made that that is appropriate. Not everyone on this committee has a view, but probably the majority of us have a view that they will be subjected to further scrutiny, so hopefully they will meet our expectations. Thank you.

**CHAIR**—Any further questions of NHMRC?

**Senator WEBBER**—I have a series of them but, given the time, I will put them on notice. I have questions on the ADHD reference group and mental health research.

**Senator PATTERSON**—I know it has not been easy for any of us, but the law is the law.

**CHAIR**—Are there any further questions in outcome 10? No? Thank you.

[10.30 pm]

**CHAIR**—We will move to outcome 13, Acute care. Are you it, Ms Flanagan?

**Ms Flanagan**—It depends on what sorts of questions you are going to ask. The backup team is here as well.

**CHAIR**—You will always have backup.

**Ms Flanagan**—I know.

**CHAIR**—The intrepid Ms Flanagan is facing us by herself.

**Ms Flanagan**—At the moment.

**CHAIR**—So, questions? Senator McLucas?

**Senator McLUCAS**—Thank you. I want to ask you about the process for negotiating the Australian health care agreements. That is your area?

**Ms Flanagan**—That is me, yes.

**Senator McLUCAS**—When do the current agreements expire? The middle of next year?

**Ms Flanagan**—Yes.

**Senator McLUCAS**—The end of June.

**Ms Flanagan**—Yes, the current agreements expire at the end of June 2008.

**Senator Mason**—Will you excuse me for one second. I need to ask the senator a question, Chairman. Does any service require the Office of Health Protection, Senator? Otherwise we could perhaps let them go.

**Senator McLUCAS**—No, but we called them. Is that outcome 14?

**CHAIR**—Yes, the last one.

**Senator McLUCAS**—We were hoping to.

**Senator Mason**—In that case, that is fine.

**Senator McLUCAS**—Sorry.

**Senator Mason**—Thank you.

**Senator McLUCAS**—That is the plan.

**Senator Mason**—Thanks, Chair.

**CHAIR**—Please proceed.

**Senator McLUCAS**—The timetable for the last Australian health care agreements: are we mimicking that timetable now?

**Ms Flanagan**—What do you mean by a 'timetable', Senator?

**Senator McLUCAS**—I dare say there are a series of meetings between departmental officials from the Commonwealth and from the states. They are bilateral rather than multilateral, though.

**Ms Flanagan**—I suspect that every process is different, depending on what needs to be negotiated. Certainly in this process we have not started any bilateral discussions with the states.

**Senator McLUCAS**—Thinking back to the negotiation of the last agreement, would we have begun any preliminary discussions by this stage?

**Mr Kalisch**—Thinking about how SPPs are generally negotiated, that would not be the case.

**Senator McLUCAS**—Perhaps then I should ask the question differently. What is the normal process for negotiating the Australian health care agreements?

**Mr Kalisch**—Probably Ms Flanagan's answer was right in that there is really no normal process in the way of a standard process.

**Senator McLUCAS**—This troubles me, Mr Kalisch.

**Mr Kalisch**—The processes are put in place to seek to come to an agreement by the time the previous one expires.

**Senator McLUCAS**—There would be no formal discussions at the bureaucratic level between state health departments and the Commonwealth?

**Mr Kalisch**—I expect there are discussions happening between state health departments at this stage, just as we are also looking at some of the issues within the Commonwealth. But it is more than 12 months out from the expiry of the current agreement, so it would be very unusual for negotiations or discussions to take place at this stage.

**Senator McLUCAS**—My experience is with the CSTDA, the disability agreement. That is multilateral and a quite different structure, and that has been a bit fraught as well, partly because, I think, the time frame for the negotiations has been extremely truncated.

**Mr Kalisch**—But that one is also due to expire, as I think I recall, at the middle of this year; so they are right in the middle of the process.

**Senator McLUCAS**—At the end of the month, as of tomorrow.

**Ms Halton**—I have done three health care negotiations in my time—far too many, I can tell you.

**Senator McLUCAS**—Do you usually start the formal liaison between the departments a year out?

**Ms Halton**—It depends on the circumstances, to be quite honest. Not necessarily. It depends on the budget cycle. It depends on the predilection of the ministers. In my experience, certainly the last three that I have done—I missed one; that was well timed—probably eight months.

**Senator McLUCAS**—Eight months. So we would expect that in November you would be starting to gear up?

**Ms Halton**—Yes, that would be my expectation.

**Senator McLUCAS**—A bit tricky.

**Ms Halton**—I can assure you some of us are thinking about it, Senator.

**Senator McLUCAS**—I certainly hope so.

**Ms Halton**—It is not a blank canvas in certain people's heads.

**Senator McLUCAS**—Do you go through a scoping process to identify what issues need to be canvassed in the agreement, or are they fairly constant?

**Ms Halton**—The truth of the matter is they are constant, but they evolve. It is a reality that the system does not change in seismic ways between one agreement and the next. Yes, you can have clever ideas about how things can be done better. I think if you look at the evolution of the agreements over the last 20 years, what you can see is a range of themes developing, coming to maturity and then becoming mainstreamed in the agreements.

There is a kind of evolution of an issue from being a niche issue on the agreements to eventually being just something you expect the system to do. There are some things that the system historically has not done terribly well, or we have had several tries at. Step-down care would be the example I would point to.

But if you think about it, in 1988 or whatever the year was that we had that agreement—1988, 1987, about then—one of the things we did was to bring in the notion of incentive for the treatment of people with HIV. It was a new issue at that point. The whole question of

antiretroviral therapy was brand-new. We built an additional component into the agreement to fund that. It is now mainstream, so it is not something we even talk about in the agreements. Similarly, with the methodologies around financing, in that particular agreement we put incentives in place for diagnosis related groups. Again, those systems of funding are now much more common across the country.

**Senator McLUCAS**—How does the fact that we have an election this year in the Commonwealth impact on the time line for negotiation to the framework?

**Ms Flanagan**—The minister has stated publicly that it might be that we do not engage in a robust manner with the states until after the election. He has put that on the public record as a possibility.

**Senator McLUCAS**—But that does not preclude the officer-to-officer negotiations and discussions continuing.

**Mr Kalisch**—We continue to talk about health issues. But in terms of formal negotiations, I think it is quite clear that that will not start—

**Ms Halton**—Until there is a government framework for this.

**Senator McLUCAS**—That is the point I was getting to.

**Ms Halton**—Yes.

**Senator McLUCAS**—There has to be the political framework for officers to move forward.

**Ms Halton**—That is exactly right.

**Senator McLUCAS**—That political framework will not appear until after the election?

**Ms Halton**—No, the political framework will not appear until later in the year. It would not in any event. The fact that this year there happens to be an election—okay. This has happened before with these agreements. In my experience it is very rare to be in heavy negotiations, then stop for an election and then keep going. Do you know what I mean?

**Senator McLUCAS**—That is what I am trying to understand. Are we going to get to 26 December and convene meetings between—

**Mr Kalisch**—I hope not.

**Ms Halton**—It would not be the first time. In truth, as I said, people are thinking about it. As Mr Kalisch says, we are talking to our state colleagues all the time about any manner of things.

**Senator McLUCAS**—Yes, but you have pointed out that there has to be the political paradigm before you can move forward.

**Ms Halton**—Yes, there does.

**Senator McLUCAS**—Given that we do face an election this year, whatever will happen, if that were to be, say, in October or November, the question I am asking is: how does that truncate the time frame that you then have in order to do quite a lot of work to meet the June deadline?

**Ms Halton**—In my view, it does not pose a particular difficulty which is any different to any other agreement. There is a body of work that needs to be done. However, there is a vast body of expertise, knowledge and work which is day-to-day work in any event, all of which then gets channelled for a particular purpose into the process of government considering its views about framework, its views about finance, its views about a whole series of things. There has to be an internal process within the Commonwealth to decide, and everyone has to have a say: Treasury, Finance and PM&C.

**Senator McLUCAS**—Are those meetings occurring now?

**Ms Halton**—No. That is the whole point. I do not expect that that will happen until towards the end of the year.

**Senator McLUCAS**—That is all I need to know about that. I am going to put some questions on notice about dental policy development. We will then move to outcome 14, but while there is the changing of the guard can I go to the answer that you have given us on lapsing programs. The question on notice from the last round of estimates asked for the list of the programs and the year in which the program was originally funded. It also asked for information on expenditure to date by financial year, any rephased or redirected expenditure and for the out years for which any program expenditure has been published. Is it possible to expand that answer to include the financial data that was asked in our original question from February estimates?

**Mr Clout**—Could you repeat the actual information that you are after? I know the piece of paper you have.

**Senator McLUCAS**—We asked for a list of all lapsing programs and the year in which the program was originally funded, which you have provided, but I will go to the definition of 'lapsing' in a minute. For each program we did ask for information on the expenditure to date by financial year, any program expenditure which had been rephased or redirected and, for the out years for which program expenditure has been published, could you provide an update on any expected variations to expenditure. We are talking about lapsing programs, but programs that will lapse a year ahead, for example—so any predicted decrease in expenditure for programs that were indicated as lapsing but not yet lapsed.

**Mr Clout**—Senator, I think that the information is there. If there is no indication that there has been any other rephasing then the expected expenditure is as originally announced.

**Senator McLUCAS**—Absolutely?

**Ms Halton**—Yes, so it is by exception.

**Senator McLUCAS**—There is no—

**Mr Clout**—What you have in that table that you are looking at now—

**Senator McLUCAS**—So programs that have been rephased are in appendix A?

**Mr Clout**—That is right.

**Senator McLUCAS**—Every other lapsed program spent every last cent? Is that what you are telling me?

**Mr Clout**—It is anticipated at this stage that it will be spending all of its money. That is correct.

**Senator McLUCAS**—Every other program?

**Mr Clout**—All of those on the first page of the information, because those are the remaining lapsing programs in the portfolio. The ones in the table are those which have had rephasings.

**Ms Halton**—Because they were not anticipated to spend—

**Senator McLUCAS**—Are these all of the programs in the whole of the Department of Health and Ageing that are finishing? I am using the word 'lapsing' because that tends to be the language of the Finance people.

**Ms Halton**—There are two. There are terminating and lapsing.

**Senator McLUCAS**—Thank you. I was sure I was missing something.

**Ms Halton**—Plus ongoing, as Mr Clout rightly points out.

**Senator McLUCAS**—Are there terminating programs that are not on this list?

**Mr Clout**—There are terminating programs. Those are always indicated in the measure description when they are announced. It says 'terminating in', so, in the budget paper, under 'measure description', it indicates that the measure is a terminating measure.

**Senator McLUCAS**—I am trying to capture all the information that I need. Is there a list of terminating programs that terminate this current year, 2006-07, that you could provide us?

**Mr Clout**—I could do a search of the measures and come up with what we believe to be those measures which are terminating. I would have to take that on notice and provide that to you.

**Senator McLUCAS**—Could you also provide for those programs any unexpended funds or any redirected or rephased—or whatever word—that captures any money that was not spent.

**Mr Clout**—I can provide to you those terminating programs with any rephased funding and the years into which that funding has been reallocated.

**Senator McLUCAS**—Is that what happens to all money? Is it always rephased, which means rolled into another program?

**Mr Clout**—That is correct.

**Senator McLUCAS**—It is not given back to—

**Mr Clout**—There are times when funding lapses, where it is not used, so it just ceases and it is returned to CRF.

**Senator McLUCAS**—Could you identify any programs where that has occurred as well?

**Mr Clout**—I am not sure if it has occurred with any, but I will have a look.

**Senator McLUCAS**—If I ask the question and the answer is no, then the answer is no and that is fine. Thanks for that. On the final series of questions, do you want to give us some answers before we close, Ms Halton?

**Ms Halton**—I hope so. I am still waiting for a couple of bits of paper.

**Senator McLUCAS**—On 'Biosecurity and emergency response', I understand there has been a series of state surveys of the health system's preparedness for terrorist attacks. Could you briefly give the committee an understanding of that process, please.

**Ms Halbert**—You are referring to the capability audits, I believe?

**Senator McLUCAS**—In my brief they are called the 'health system's preparedness for terrorist attacks'.

**Ms Murnane**—They are actually called 'capability audits'.

**Ms Halton**—You probably have the *Daily Telegraph* title.

**Ms Halbert**—There have been two such audits done to date. The data from those have not been made publicly available.

**Senator McLUCAS**—Could you explain to us the two audits, please.

**Ms Halbert**—I will check the exact dates.

**Ms Murnane**—I think I can remember. There was one done in 2004 and one at the end of 2005. When we embarked on this exercise we used as a proxy the survey done by ANZICS, the Australian and New Zealand Intensive Care Society, and applied that to preparedness. We still work closely with the people who do that survey, but we have twice undertaken a survey with the states and territories that we have run and we plan to undertake further surveys.

**Senator McLUCAS**—The audits that were done in 2004 and 2005—

**Ms Halbert**—Sorry, can I just clarify: it was 2003 and 2005.

**Senator McLUCAS**—in 2003 and 2005: were they the same and what was the purpose of them?

**Ms Murnane**—They were predominantly the same. They asked the same questions. This is embarking on something entirely new. What we want to be able to do is to set up a baseline so that we can compare changes. There will, of course, be changes to the surveys as it becomes apparent that we should be measuring things that we were not measuring earlier. In the survey, essentially what we are measuring is the static phenomenon of what is available in terms of the usual theatres and so on. But we also try to measure what the surge capacity is, which is the real measure of what preparedness would be to meet an emergency.

**Senator McLUCAS**—The results of the surveys done in 2003 and 2005 have not been released. Is that correct?

**Ms Murnane**—That is correct.

**Senator McLUCAS**—Is there a reason for that?

**Ms Murnane**—Yes. In looking at the balance between making this information public and making vulnerabilities public, we have taken the decision—and this was also a decision of the National Counter-Terrorism Committee—that the information made publicly available could be used to the detriment of infrastructure and other security considerations in Australia.

**CHAIR**—Senator McLucas, a small thought: we have had Biosecurity and emergency response here for some time. Are we going to ask them any questions at all?

**Senator McLUCAS**—I am, right now.

**CHAIR**—Sorry, I thought we were still on 13.

**Senator McLUCAS**—Someone get him a coffee!

**CHAIR**—Carry on.

**Senator McLUCAS**—I hope that goes on the record! You are basically comparing preparedness in each of these surveys, as I understand it.

**Ms Murnane**—Yes, and we are looking to focus on deficits, and that is really what is the sensitive information. You want to know what those deficits are so that you can take moves to abate them.

**Senator McLUCAS**—In identifying those weaknesses that exist in systems—there may be surge capacity weaknesses at a certain hospital, for example—what do you then do to respond to the weakness that you have identified?

**Ms Murnane**—We ask the states concerned. But there are some things that are of national significance and some of those are in the public arena. For example, we did observe through the very first work we did that there were deficits in the number of ventilators available. Through the national medical stockpile, we purchased ventilators with money from the budget, which we then deployed to the states and territories on the grounds that they would not be kept in mothballs, because then we would not know that they were able to be used. They could be used but they would always have to have a supply so that an identified number of ventilators would be available for an emergency, and we have a memorandum of understanding with the jurisdictions about that. There are some other things that are not in the public arena, but that is an example.

**Senator McLUCAS**—You can assure the committee that remedying failings in our system is happening in a cooperative manner between the Commonwealth and the states?

**Ms Murnane**—Yes, indeed.

**Senator McLUCAS**—Going specifically to a terrorist attack rather than a broader biosecurity attack—being a northern Australian, I tend to think more about biosecurity than terrorism—does the auditing process pick up our preparedness for such an event?

**Ms Murnane**—Yes, it does. It picks up our preparedness to respond to trauma, to explosions, to communicable disease, which most likely would not be the result of the terrorist attack, and to radiological incidents.

**Senator McLUCAS**—Could we say that the health system in Australia would be able to deal with a terrorist attack? Are we at that point yet?

**Ms Murnane**—We have modelled attacks that have taken place in other parts of the world and have concluded that, dealing with the response as a national problem, coordinating it through the Australian Health Protection Committee, we would be able to deal with casualties along the lines of attacks that have occurred and, indeed, casualties beyond that.

**Senator McLUCAS**—Even the London train bombings, for example?

**Ms Murnane**—Yes, but I stress this is a national response. That means that there is a coordination of resources, possibly a movement of patients and possibly a movement of equipment and expert personnel from one jurisdiction to another.

**Senator McLUCAS**—The planning has all of that in place?

**Ms Murnane**—Each state and territory has a plan, yes.

**Senator McLUCAS**—And they are coordinated centrally?

**Ms Murnane**—They are not in the sense that there is an overall national trauma plan, although there is a national burns plan. What the states and territories do is develop plans that are then measured through our surveys, that have been exercised in jurisdictions and, to some extent, in connection with national exercises such as the Mercury exercise that was conducted last year.

**Senator McLUCAS**—When you say there is no national plan, there must be national coordination.

**Ms Murnane**—There is a national coordination protocol, yes.

**Senator McLUCAS**—Are the elements of each of the state and territory plans fairly consistent?

**Ms Murnane**—All of the national, state and territory plans, which are linked to the state emergency plans, deal with mass casualty incidents and how they would respond to mass casualty incidents. They inform us and, during an incident and during exercises, have informed the Australian Health Protection Committee as their capacity is reaching saturation or when their capacity will reach saturation, so we can prepare to either bring expert personnel and equipment to them or transfer patients to other jurisdictions. It is not exactly the same as a terrorist attack in Australia, I know, but this is the sort of thing we have done during evacuations after the two Bali bombings and when we thought we were preparing for a large number of evacuations after the plane crash in Jogjakarta.

**CHAIR**—Senator McLucas, we have reached the appointed hour for the conclusion of our proceedings.

**Ms Halton**—Sorry, I was waiting for something else to come, which I promised, but it has not turned up yet. They have been down there editing it. But I do have two things done. We said we would give you a catalogue of the Medicare statistics, where we publish them.

**Senator McLUCAS**—This is the website?

**Ms Halton**—Yes, just so that you can see what we publish. I thought that might be helpful.

**Senator McLUCAS**—Thank you very much.

**Ms Halton**—The other thing was the question you anticipated about the different programs. I said to you that at least one of them was not ours in terms of the expenditure. This is from 2004. I have the answer to that, which I will table. On the campaigns, they have been down there trying to sort it out. They said it was a couple of minutes away, but they tried.

**Senator McLUCAS**—If it does not arrive, we will talk a little longer. They might run up the stairs but, if they do not, rather than wait till the 30 days, could that come on notice tomorrow or Monday?

**Ms Halton**—Yes, that is fine. I am sorry about that. That is why I ran off to check before, because they were down there. The trouble is, because there is so much information, they have tried to do it all.

**Senator McLUCAS**—I appreciate that.

**CHAIR**—We will have other information supplied to the committee in the usual way.

**Ms Halton**—Yes, we will.

**CHAIR**—That is okay. Can I thank you, Minister, for the time you spent with us and assisting. Ms Halton, I thank you and all the officers of your department for the efficient and cooperative way in which you have assisted the committee. I want to thank also members of the committee for having been so helpful in getting through our work in the last four days. As well I need to congratulate, as usual, our standing staff of the senate committee and the staff of Hansard for their assistance. Thank you. The committee is now adjourned.

**Committee adjourned at 11.02 pm**