COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

STANDING COMMITTEE ON COMMUNITY AFFAIRS

ESTIMATES

(Additional Budget Estimates)

FRIDAY, 22 FEBRUARY 2008

C A N B E R R A

BY AUTHORITY OF THE SENATE

INTERNET

Hansard transcripts of public hearings are made available on the Internet when authorised by the committee.

The Internet address is:

http://www.aph.gov.au/hansard

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

SENATE STANDING COMMITTEE ON

COMMUNITY AFFAIRS

Friday, 22 February 2008

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

Senators in attendance: Senators Adams, Allison, Boyce, Carol Brown, Colbeck, Humphries, Hutchins, Lundy, Moore, Patterson, Siewert and Webber

Committee met at 9.01 am

HEALTH AND AGEING PORTFOLIO

Consideration resumed from 20 February 2008

In Attendance

Senator McLucas, 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
Mr David Kalisch, Deputy Secretary
Mr David Learmonth, Deputy Secretary

Outcome 4—Aged care and population ageing
Ageing and Aged Care Division

Mr Andrew Stuart, First Assistant Secretary
Ms Allison Rosevear, Assistant Secretary, Residential Program Management Branch
Ms Mary McDonald, Assistant Secretary, Community Care Branch
Ms Melinda Bromley, Assistant Secretary, Office for an Ageing Australia
Mr Peter Broadhead, Assistant Secretary, Policy and Evaluation Branch
Ms Carolyn Smith, First Assistant Secretary, Office of Aged Care Quality and Compliance
Ms Carolyn Scheetz, Assistant Secretary, Compliance Branch
Mr Iain Scott, Assistant Secretary, Prudential Regulation Branch
Ms Fiona Nicholls, Assistant Secretary Quality, Policy and Programs Branch

Aged Care Standards and Accreditation Agency

Mr Chris Falvey, Corporate Affairs, Aged Care Standards and Accreditation Agency
Mr Ross Bushrod, General Manager, Aged Care Standards and Accreditation Agency
Mr Mark Brandon, Chief Executive Officer, Aged Care Standards and Accreditation Agency

Outcome 8—Indigenous health
Office of Aboriginal and Torres Strait Islander Health

Ms Lesley Podesta, First Assistant Secretary

Mr Mark Thomann, Assistant Secretary, Budget and Planning Branch
Mr David de Carvalho, Assistant Secretary, Policy and Analysis Branch
Dr John Walker, Acting Assistant Secretary, Health Strategies Branch
Dr Tim Williams, Senior Medical Advisor
Mr Sanjeev Commar, Assistant Secretary, Family Health and Wellbeing Branch
Ms Joy Savage, Assistant Secretary, Northern Territory Emergency Coordination Centre
Mr Gary Fisk, Acting Assistant Secretary, Performance Management Branch
Ms Alice Creelman, Assistant Secretary, Remote Health Reform Branch

Outcome 10—Health system capacity and quality

Regulatory Policy and Governance Division

Ms Linda Addison, First Assistant Secretary
Ms Teressa Ward, Assistant Secretary, Governance and Agency Relationships Branch
Ms Jenny Hefford, Assistant Secretary, Regulatory Policy Branch
Ms Kylie Jonasson, Assistant Secretary, Research Policy and Biotechnology Branch

National Health and Medical Research Council

Professor Warwick Anderson, Chief Executive Officer, National Health and Medical Research Council
Dr Clive Morris, Chief Knowledge and Development Officer, National Health and Medical Research Council
Ms Hilary Russell, Chief Operating Office, National Health and Medical Research Council
Mr Graeme Holt, Chief Financial Officer, National Health and Medical Research Council

Outcome 11—Mental health

Mental Health and Workforce Division

Professor Rosemary Calder, First Assistant Secretary
Professor Rick Mclean, Principal Medical Adviser, Medical Education and Workforce
Professor Harvey Whiteford, Principal Medical Adviser, Mental Health and Workforce
Ms Dianne Knight, Nursing Advisor, Mental Health and Workforce
Dr Jennifer Thomson, Principal Medical Advisor General Practice, Mental Health and Workforce
Mr David Dennis, Assistant Secretary, Workforce Distribution Branch
Ms Juleen Browning, Acting Assistant Secretary, Workforce Infrastructure Branch
Ms Maria Jolly, Acting Assistant Secretary, Workforce Education and Training Branch
Dr Wafa El-Adhami, Assistant Secretary, Nursing Allied and Indigenous Workforce Branch
Mr Nathan Smyth, Assistant Secretary, Mental Health Reform Branch
Ms Colleen Krestensen, Assistant Secretary, Mental Health and Suicide Prevention Programs Branch
Ms Natasha Cole, Senior Director, Policy Coordination Group

Outcome 13—Acute care

Acute Care Division

Ms Kerry Flanagan, First Assistant Secretary
Dr Bernie Towler, Medical Officer
Mr Paul Currall, Acting Assistant Secretary, Medical Indemnity Branch
Ms Gail Yapp, Assistant Secretary, Acute Care Strategies Branch
Ms Georgie Harman, Assistant Secretary, Acute Care Development Branch

Ms Veronica Hancock, Assistant Secretary, Private Health Insurance Branch
Mr Brenton Alexander, Director, Healthcare Services and Financing Branch

Outcome 14—Biosecurity and emergency response

Office of Health Protection

Ms Cath Halbert, First Assistant Secretary
Dr Gary Lum, Assistant Secretary, Health Emergency Management and Biosecurity Branch
Mr Simon Cotterell, Assistant Secretary, Health Protection and Policy Branch
Ms Raelene Thompson, Assistant Secretary, Surveillance Branch
Dr Margaret Hartley, Principal Scientific Advisor, Office of Chemical Safety
Dr Julie Hall, Medical Officer, Health Protection Policy Branch
Dr Andrew Pengilley, Medical Officer, Health Emergency Management and Biosecurity Branch
Dr Leslee Roberts, Medical Officer, Surveillance Branch

National Industrial Chemicals Notification and Assessment Scheme

Dr Marion Healy, Director

CHAIR (Senator Moore)—I declare open this hearing of the Senate Standing Committee on Community Affairs continuing the additional estimates for the Health and Ageing portfolio. Welcome back, Senator the Hon. Jan McLucas, Parliamentary Secretary to the Minister for Health and Ageing; the departmental secretary, Ms Jane Halton; and officers of her team at the Department of Health and Ageing. You all have a copy of today's agenda. We are anticipating finishing at 1.00 pm The only limitation on the agenda is that Indigenous health cannot start before 10.00 am but, apart from that, we will flow through our program. At the conclusion of the hearing on Wednesday the committee had concluded outcomes 1 to 3, 5 to 7, 9, 12 and 15. The committee will now continue with the program as circulated, commencing with Outcome 13—Acute Care. Senator Colbeck.

Senator COLBECK—I will start with some questions on the Mersey hospital. I direct my first question to the parliamentary secretary. Has Minister Roxon met with representatives of the current community committee at the Mersey hospital that you are aware of?

Ms Flanagan—My understanding is that Minister Roxon met with them before the election.

Senator COLBECK—So she has not met with them since the election?

Ms Flanagan—She has not met with them since then, no.

Senator COLBECK—Have any representatives from the agency met with the committee since the election?

Ms Flanagan—Yes, we have.

Senator COLBECK—Can you tell me on how many occasions that that has occurred?

Ms Flanagan—I would need to look at my diary but we have been down there a couple of times. They also held a meeting where we joined them by teleconference from Canberra to brief them on what was going on and to give them an update. So I imagine that we have certainly been in communication with them two or three times.

Mr Kalisch—We have had phone conversations with the chair at different times. So, while it has not been the full committee, we certainly have had contact with some of the key members of the committee on different occasions.

Ms Flanagan—Yes.

Senator COLBECK—My understanding is that the committee was going to provide a report to the government with respect to its views on what should happen at the hospital. Has that report been received?

Ms Flanagan—Yes, it has. The government has also asked for reports from others as well in considering what it might do with the hospital. For example, the CEO has provided a report on the mix of services that can be provided at the hospital.

Senator COLBECK—How many other reports are coming to you? I will come to the tender that you have let or called for in a minute. You have one from the board and you have one from the CEO?

Ms Flanagan—Yes.

Senator COLBECK— Have any other reports come through?

Ms Flanagan—We are also in discussions with Dr Heather Wellington, who is doing a report for the Tasmanian government about the mix of services that would be provided in Tasmania. She is not formally reporting to us, but I just want to let you know that that report is also part of it. You would appreciate that the Mersey hospital is part of the Tasmanian hospital system.

Senator COLBECK—A tender closed on 5 February, I think.

Ms Flanagan—If it is the one that I think you are going to ask about, then yes.

Senator COLBECK—I do not think you have let any other tender in respect of the Mersey hospital that I am aware of. That report was an ICU feasibility study.

Ms Flanagan—That is correct.

Senator COLBECK—That tender has been let?

Ms Flanagan—It has been, yes.

Senator COLBECK—Can you tell me who is the contractor?

Ms Flanagan—Yes.

Mr Currall—The tender was let to Spencer Smith and Associates of New South Wales.

Senator COLBECK—Who are the principals behind the business who will be working on the project?

Mr Currall—The team leader will be Dr Michael Smith and other team members include Associate Professor Anthony Burrell and Dr Hugh Burke.

Senator COLBECK—Have they had any cause to be involved with assessments at the Mersey before, that you are aware of?

Mr Currall—Not at the Mersey, that I am aware of.

Senator COLBECK—Has work commenced on site?

Mr Currall—Not yet. It is due to commence next week.

Senator COLBECK—How does that fit in with the program that was part of the tender that was called for? Is that behind time?

Mr Currall—It is a little behind time. The people involved in the tender process had to travel to Tasmania for a few days late last week.

Senator COLBECK—Has any variation been granted to the contract with respect to its completion dates or interim reporting dates?

Mr Currall—We have had discussions with Dr Michael Smith about that, and he is confident that the project can be completed by the required date, which is 25 March.

Senator COLBECK—What about the interim reporting date?

Mr Currall—The interim report is due about a week before that time. He reports that that should be deliverable at that time as well.

Senator COLBECK—The tender documents refer to some operational standards for the operation of ICUs. Do you have any information on how many hospitals nationally meet those guidelines for their ICUs?

Ms Flanagan—No. I think that the guidelines that were being proposed were those that would be appropriate to a hospital of that size.

Senator COLBECK—I am not sure whether I have the tender document with me. The document referred to some standards. It has a range of standards from HDU to level 1, 2 and 3 type ICUs, so it is a general standard put out by the College of Critical Care. I do not think that is quite the correct name, but it refers to different levels of critical care types. The department does not have any information on how many hospitals in the country would comply with the classification of ICU that operates within their facility?

Ms Flanagan—No, it is not something that would necessarily be relevant to the Mersey. We are interested in the clinical standards that will be delivered at the Mersey to ensure that they meet published standards.

Mr Kalisch—Could I just add one other piece of information. The state departments of health obviously would be interested in standards and would monitor them on a regular basis, given that we do not regulate any other hospitals.

Senator COLBECK—I understand that. Just to diverge for a moment, might that be part of the national scorecard that we are putting together as part of the new national agreements? Might that be something that could be considered as part of that process?

Mr Kalisch—Certainly quality and safety aspects across the health system. This is looking at a very specific aspect. Quality and safety will be key components of the performance framework.

Senator COLBECK—This is perhaps a question for you, Parliamentary Secretary. When the then opposition committed to the policy of the Howard government, your Tasmanian health policy package committed to the Mersey hospital takeover, but the condition of that

$50 million package—I think that is what it was in total—was that all of the funding from the Mersey be spent in the north of the state. We have had our discussions about your intentions to maintain your election commitments. Can you tell me how you intend to enforce that commitment, given the state government's decision to spend $8 million at the Royal Hobart Hospital, which is in the south of the state? That is obviously in conflict with your policy.

Ms Flanagan—The commitment that the Rudd government agreed to honour on the aspect that you are talking about was that the money that was paid through the healthcare agreements was going to be freed up by the Commonwealth running the Mersey. That was around $45 million. I would need to look at the actual wording, but I think that what was agreed to be honoured was that that money would remain in, or mainly in, the north-west of Tasmania.

Ms Halton—I think it was actually in respect of patients. In fact, there was an explicit conversation about this, as I recall. Some patients do need services from the Royal because the nature of the services that they require have to be provided in that particular hospital.

Senator COLBECK—Ms Halton, that is the first time I have heard anything of that nature. In fact, full-page election advertisements were run across the north of the state in both Bass and Braddon stating that the full amount from the Mersey would be spent in the north of the state. Spending money in Hobart, even if it is for operations that are conducted on people from the north of the state, is not spending money in the north of the state.

Ms Halton—It depends on your definition of 'spending the money'. I can assure you that that funding is to the specific benefit of patients from that part of the state. You just asked a series of questions about clinical safety. The reality is that some services are more safely provided at the Royal. Professor Horvath can give you chapter and verse on why that is the case clinically.

Senator COLBECK—I understand what you are telling me. But it is good to have some explanation at last of what has been going on, because no-one has been able to say anything in respect of that. The local members, quite rightly, have been very diligent in saying that the money will be spent in the north of the state. Conversely, the state government has been saying that $8 million has been allocated to the Royal Hobart Hospital. There has been no suggestion at any point prior to this morning that it would be for services provided to people from the north of the state. At least that is a progression in the information that has been available to the community in that region at this time.

Ms Halton—Let's be very clear. We cannot speak on behalf of the Tasmanian government and the clinical services there.

Senator COLBECK—I understand that.

Ms Halton—But, as I said, I can assure you that in conversations we have had with people from Tasmania there has been an acknowledgement that some of the patients from the north-west do need to go to the Royal for services.

Senator COLBECK—I understand what you are telling me. I am not sure how that is necessarily going to be received, but at least it provides an explanation. Do you have any provisions in place to document or certify that that is actually happening? Are there any

benchmarks or reporting processes that you are going to put into place so that you and the local members are able to assure the community that that process has occurred?

Mr Kalisch—One of the aspects that Ms Flanagan referred to was Heather Wellington's work on redoing the Tasmanian Clinical Services Plan. It is probably fair to say that the Tasmanian government is still sorting out what they are going to use that extra money for right across the board. We understand that that will become apparent towards the end of March. As Ms Halton said, we are also having discussions with Tasmanian government officials about this and other related issues.

Senator COLBECK—I understand that quite a deal is going on in the broader health sphere. We talked a bit about that on Tuesday and I will come to that a little bit more in a moment.

Senator ADAMS—While you are on that, I would like to ask about the money that has been allocated for the Patient Assistance Travel Scheme. I am not quite sure what amount the previous government committed for people in the area that Senator Colbeck is talking about for patient assisted travel so that they could go to Hobart. Will that commitment be kept?

Senator McLucas—We might need a bit more detail about the commitment of the previous government.

Ms Flanagan—We actually have the figures. The former government announced a package for the north-west totalling $35.1 million, I think, that had patient assisted travel in it. The Rudd government announced a $50 million package for the north-west that also had patient assisted travel in it, and I think it was a higher amount. So $10 million has been committed in that package to patient assisted travel. I think it was $8.5 million in the package of the former government, but it is now $10 million.

Senator ADAMS—Now you have $10 million, so that will get your patients there and back, won't it?

Ms Flanagan—Yes, $8.35 million.

CHAIR—Ms Flanagan, is that just for the northern regions?

Senator COLBECK—It included a capacity to move people down to Hobart because of the overall dynamics of the health plan. With respect to the current community board, are plans being progressed to ratify that board?

Ms Flanagan—The governance arrangements for the Mersey are currently being considered by the government, and they will make an announcement when they have finished that consideration.

Senator COLBECK—My recollection is that the timeframe to complete that process is 30 June?

Ms Flanagan—The heads of agreement with the Tasmanian government goes to 30 June. That is the timetable we would be working towards where these interim arrangements are in place. So we intend to have new governance arrangements in place on 30 June.

Senator COLBECK—So at the moment there are no significant barriers to completing that timetable?

Ms Flanagan—Not that we are aware of.

Mr Kalisch—It is quite possible that 30 June is really the end point at which something needs to be in place.

Senator COLBECK—I understand that.

Mr Kalisch—Something may well be in place at an earlier stage.

Senator COLBECK—I was reluctant to ask for a time frame.

Ms Halton—And we are not going to give you one!

Senator COLBECK—I did not expect to get one, so I was asking a question that might provide it. My question was basically whether there are any obstacles to that. Obviously, if there are none that you are aware of, that covers that off. I will move on from the Mersey. Thanks very much for that. On the funding that has been allocated through COAG for elective surgery waiting lists, can you give me some indication on the formula that was used to divide the $150 million that has been allocated to each of the states?

Ms Flanagan—It was a process of to-ing and fro-ing. In the end, the formula to divide up the $150 million took into account the need for and cost of additional services, and the capacity of jurisdictions to increase the volume of elective surgery. The distribution has been formally announced and we can give you that, but I presume that you have it there.

Senator COLBECK—I have the communique, yes. So the amounts were dependent on a nominal cost of providing a particular service in each jurisdiction? Was that one of the elements of the formula?

Ms Yapp—Each of the states put forward proposals. Essentially, the states concentrated in different areas. Some states were particularly keen to concentrate on patients who had waited a long time and who might be very expensive to service—things like hip replacements and a lot of orthopaedic surgery. Other states felt that they had a greater capacity to increase the number of elective service procedures for services that were perhaps a lesser cost—things like lens procedures and so on. So there was not an average cost; it really was dependent on where states themselves felt that they could make the most impact in the time frame available.

Senator COLBECK—Has the money started flowing?

Ms Yapp—Yes, it has.

Senator COLBECK—So the money has been paid to the states or there is a commencement process?

Ms Yapp—Funding agreements have been provided to all states. Bit by bit the states are signing, and as states sign the funding flows within seven days.

Senator COLBECK—So they get their entire allocation?

Ms Yapp—They get one-third of their allocation seven days after signing and the remaining two-thirds will come on 1 July.

Senator COLBECK—There are no benchmarks or hurdles that they have to meet as part of those agreements?

Ms Yapp—As part of the funding agreements they need to provide data on a quarterly basis to be able to show what it is they have been doing—what they have achieved.

Mr Kalisch—And those performance benchmarks were within the communique that came out of the meeting of health ministers and treasurers.

Senator COLBECK—Have you had any information back yet on patient numbers flowing through the system, or is it too early for that yet?

Ms Flanagan—I think it is too early for that. I think the first quarterly reporting was December, but you would appreciate that they have not yet received their money, or the money has only just started to flow. So we would not be expecting to see the benefit of having that additional money in the system for another few months.

Senator COLBECK—Will the quarterly reports and information provided by the states be made public?

Ms Flanagan—Yes. A commitment has been made that there will be public reporting. I am not sure whether all the performance indicators will be reported, but the intention is that there be public reporting, yes.

Senator COLBECK—The states provided information with respect to the general categories of work that they are going to carry out. Do you have any information on that? People in Tasmania who need hip replacements have been on the waiting list for more than 12 months. Is there any specific information on the categories from each state?

Ms Yapp—Each state has indicated the sorts of categories, but it tends to be quite spread, so it is not the sort of thing that I can necessarily read out now.

Senator COLBECK—Is it possible to provide us with a copy of that information?

Ms Yapp—Yes, that should be possible.

Senator COLBECK—I would appreciate that.

Ms Flanagan—I think that we can give you—and I thought it might have been in the communique anyway—the number of procedures that each state intends to undertake with the money. That is already publicly available.

Senator COLBECK—Yes, that is in the communique. I think the total was about 25,278 for the $150 million. I have the numbers but I was interested in getting some sense of the classifications and types of procedures that might be carried out. Is that broken down by state?

Ms Yapp—Yes, it is.

Senator ADAMS—I would like to ask about the guidelines for waiting list money. Does anything in the communique stipulate that the states should spend X amount on rural patients who are on waiting lists?

Ms Flanagan—No, Senator, there was not a performance indicator like that. As I said, this first amount of money is a blitz on the waiting lists. It is not necessarily geographically located; we are looking at trying to reduce elective surgery waiting lists where they occur. As you would appreciate, many of those are in metropolitan areas.

Senator ADAMS—Of course. I am from Western Australia and I know that most rural people have to go to the metropolitan areas. I was just asking whether any component had been set aside for rural people. So, in the main, it was up to the states to decide what they did.

Ms Flanagan—Indeed, yes.

Mr Kalisch—The intention, obviously, is to remove from those lists people waiting longer than they clinically need to, which impacts on people residing in rural areas as well as in metropolitan areas.

Senator ADAMS—It does. But there are complications associated with people, firstly, being able to get to the metropolitan area and, secondly, being able to get accommodation. Probably the hardest thing is that rural people miss out because they cannot get accommodation.

Senator COLBECK—Can you give me information on the progress of the proposal to develop a national scorecard system for hospitals?

Mr Kalisch—Broader work is happening within the Commonwealth and the states around developing a performance framework. Those issues are being discussed as part of that. As you are aware, the healthcare agreements are up for renegotiation. Within that context, further work is happening around performance measures as well as performance reporting and accountability.

Senator COLBECK—That will be something that is done as part of the work of the Health and Hospitals Reform Commission?

Mr Kalisch—We are also expecting that they will contribute and have a fairly significant focus of their activity in the next few months on performance reporting and benchmarks.

Senator COLBECK—I know that there have been discussions with the states at a ministerial level in respect of the scorecard issue. Is there a view that some progress is being made in getting agreement to the concept? I know that New South Wales, for example—

Ms Halton—Senator, I think we need to be clear here. Some people use the term 'hospital scorecard'. I have heard that term—

Senator COLBECK—It is a crude term. If you give me a better term I would be happy to use it.

Ms Halton—I think you put it very well, Senator. It is a crude term. Mr Kalisch is referring to the notion of system-wide reporting and performance of the system, of which hospitals are a component. Therefore, you would be looking to assess the performance of hospitals in the context of the performance of the system. As Mr Kalisch said, work is going on right across that front, and the hospital component will be an important part. But to say that there is a focus on hospital scorecards really is not an accurate reflection of what is going on.

Senator COLBECK—Just going on from those comments, is it intended to include private hospitals? Is that part of that process?

Ms Halton—There has been a conversation but there is not yet a decision on any of this. You will understand that this is in the category of a work in progress. But I think there is a

clear understanding that there needs to be reporting of the whole system—and, by definition, that includes the private sector. You would appreciate that what goes on in the primary and ambulatory care is in a private sector setting. Clearly, private hospitals are a crucial component of the health system. Indeed, public hospitals are also the venue for the provision of private services. The notion is—and I hear no disagreement about this notion amongst my colleagues—that we should have an ability to report in a consistent fashion right across the system. The private sector is represented at the Australian Commission on Safety and Quality in Health Care; there is a commissioner from the private sector there. This notion of consistency of reporting is something that has been quite extensively discussed. But we have not yet got to 'and it means it looks like this' part of that discussion.

Senator COLBECK—Again it is probably fairly early in the piece, but is there any thought or proposals with respect to making some of this information available to the public?

Ms Halton—Certainly. The whole notion of this is about public reporting and, by definition, therefore, accountability. Again, if I go to the Australian Commission on Safety and Quality in Health Care, the whole concept of reporting adverse events, for example, is about informing patients, the public, and anyone who is interested about what is going on. This is precisely what is intended. But because we are at the early stage of the discussion I cannot yet say to you, 'I think it will look like this,' because quite a lot of work has yet to be done.

Senator COLBECK—Again, I understand that it is at an early stage, but what about the impact on funding? Is that a potential issue coming out of the reporting process?

Ms Halton—That is a hypothetical.

Senator COLBECK—Is that an issue that has been considered as part of that process?

Ms Halton—At this moment in time the work is too preliminary to have got into any consequential policy issues. I cannot speculate on where it will go, but I can say to you that it is an early point in those discussions.

Senator COLBECK—Senator McLucas, my next question, which is addressed to you, is to clear up some funding issues. The initial announcement for your overall hospital plan was $2 billion. A little later the Prime Minister allocated another $400 million. But the overall policy document for the Northern Territory talks about $2.5 billion. I do not think I have the policy documents with me, so that makes it a little more difficult, and there has been some general discussion about that $2.5 billion since. Can you give me some advice on the actual amount ?

Senator McLucas—No, I cannot, but I can find out for you.

Senator COLBECK—I would appreciate it if you could get some advice on it.

Mr Kalisch—It is our understanding as well that it is a $2.5 billion program.

Senator McLucas—That is confirmed, then.

Senator COLBECK—In conjunction with that advice I would not mind an understanding of what the additional $100 million will be allocated towards. Do you have any information on the breakdown of the allocations? We know that $600 million is going into an initial

package, with $150 million going into the waiting lists. Do you have any further information on the breakdown?

Ms Halton—You quite rightly pointed to the specific allocations that have been announced in some areas, but you would also appreciate that the government is going into a budget process where some of the other allocations might be made. Given the announcements that are in the public arena, that is the information that is available. Obviously it is not up to us to make any further announcements on behalf of the government. That is the minister's prerogative.

Senator COLBECK—I do not think I will get any further there, so I do not think I will chase that rabbit down the burrow. I would appreciate advice in respect of that additional $100 million that I do not think has been formally announced but that has appeared in policy documents.

Ms Halton—I think we need to be clear. Prior to the election the government did say that there would be $2.5 billion, so that is the figure that we are all aware of. As I said, some component parts are in the public arena and the rest is the prerogative of the minister.

Senator COLBECK—The documents that I can find talk about a $2 billion announcement—another $400 million—and then $2.5 billion starts turning up, without necessarily any explanation. So you are confirming that it is a $2.5 billion policy. About $600 million has been announced and there is more to come as part of further elements.

Ms Halton—That is correct.

Senator COLBECK—I need to find my questions on dental. From recollection of our last experience, that comes under this outcome.

Mr Kalisch—The questions about the public dental scheme?

Senator COLBECK—Yes.

Ms Halton—I recall that we had the question: 'Where are the teeth in this program structure?'

Senator COLBECK—Yes.

Senator HUMPHRIES—I am trying to follow what is happening with the public dental program that you foreshadowed. On 18 September last year, the now health minister announced that there would be a commitment of $290 million to a new public dental program. The following day Ms Roxon announced that Labor would invest the $384 million that the Howard government had budgeted for a dental scheme associated with chronic conditions. I assume that the $384 million commitment superseded the $290 million commitment, or was it additional?

Ms Flanagan—I think, again, that the problem is that teeth are right through the outcome structure of this portfolio.

Senator HUMPHRIES—Yes, but we were told that we could talk about the public dental program here.

Ms Flanagan—We can certainly talk about the public dental program. The $384 million was for chronic disease, which is in another outcome.

Senator HUMPHRIES—It was for chronic disease but, as I understood it, the announcement that was made was that it would not be spent on the Howard government's proposals for chronic disease treatment. The treatment of dental conditions in association with chronic disease was being moved over to the public dental scheme that the new government was supporting.

Ms Halton—There are three components to this and Ms Flanagan and Mr Kalisch can comment on only one. The first component was the cessation of the Howard government's initiative in respect of chronic disease. That was the public commitment that was given, which caused the cessation of that program. Then there were two announcements of what was to be done as an alternative, one of which was the teen dental arrangements, which we talked about at some length.

Senator HUMPHRIES—Yes.

Ms Halton—The second announcement related to the public dental component. Senator Colbeck was trying to work out in what area to ask his questions until we said that teen dental, which we talked about, was under an earlier item. These officers can talk about the public dental component.

Senator HUMPHRIES—All right. On the first of those items, the cancellation of the previous chronic diseases scheme, about 450 items were added to the Medicare Benefits Schedule to facilitate the previous scheme because the benefits were available through Medicare by extending them to a number of dental services that had not previously been available.

Ms Halton—I cannot confirm the number because I have never counted them, but there were a significant number.

Senator HUMPHRIES—Have those items been removed from the Medicare Benefits Schedule?

Ms Halton—Work is underway. The minister and the department are responsible for effecting those changes. We have already discussed that I cannot give you any indication about the advice that has been given. But, yes, those items will be closed and the minister will make an announcement about that in due course.

Senator COLBECK—So people who previously accessed the scheme will be able to claim benefits from the schedule until the point where the schedule is closed. I would not like to have people who are undertaking treatment going to get their rebate and discovering that it is not there because the item has been removed.

Ms Halton—That is a matter for the minister to consider in terms of arrangements around finalising that commitment, which ceases the availability of those items. The minister will be making an announcement about that in due course.

Senator HUMPHRIES—I turn now to the public dental scheme, which will be the replacement for that chronic conditions scheme. I cannot see any details about this scheme in the additional estimates papers. Does that mean that they are concealed somewhere that I cannot see or are they yet to be announced and therefore included in budget papers?

Ms Flanagan—This was an election commitment, so the cost is already included in the budget. It is a payment that is intended to go to the states to reduce public dental waiting lists.

Senator HUMPHRIES—So it is not in the PAES at all and there is no point in looking for it there at the moment?

Ms Flanagan—I think Mr Eccles might advise on election funding. He is the expert on where you will be able to find that amount, or when it will appear.

Senator COLBECK—The $290 million?

Senator HUMPHRIES—My reading of the media releases suggests that it is $384 million—that what you were going to spend on the chronic diseases you now propose to spend on this?

Ms Halton—No.

Senator HUMPHRIES—It is not?

Ms Halton—No.

Senator HUMPHRIES—Can you explain why Minister Roxon said on 19 September:

Labor will invest the $384 million the Howard Government has budgeted for its failing scheme in improving the dental health of Australian families.

Does that mean that some of the money will be spent on the teen dental program?

Ms Halton—Yes. Without having that document in front of me, as I recall it when I read it, my understanding of that document was to indicate that there would be the cessation of the one program. If you took the investment to be made across all of the commitments in respect of teeth, there was to be a investment larger than that amount in teeth. So the saving from one was going to be redirected into expenditure in two other areas. So there was a net benefit—a net gain—in respect of the investment in teeth. But to say that a green dollar from that program can be directed over to another program, you would understand that that is not how it works.

Senator HUMPHRIES—I am grateful for your very good recollection of what was announced in the campaign, but we now have a government in place. I am hoping that the minister can tell me whether that is what will happen. What is going to be spent on this new dental program?

Ms Halton—I can answer that question. The commitment is that we will invest in teen dental and we will invest in the public dental program. The public dental program is scheduled to start in the next financial year and the amount will be appropriated in the budget. You have seen the commitment that is to be made in relation to the amount that will be appropriated in the budget. So there is a combination of the two amounts. We talked at some length the other day about the commitment in respect of teen dental. Teenagers between the ages of 12 and 17 will receive a $150 voucher under the teenager category. There is also the $290 million investment in public dental schemes. The public dental money will be appropriated in the budget.

Senator HUMPHRIES—Minister, what did the Labor Party commit to spend on dental programs in the election campaign?

Senator McLucas—I think the secretary just answered.

Senator HUMPHRIES—No, she has not given me any figure at all. I am asking you what figure you committed to spend.

Senator McLucas—I do not have the document you are referring of 19 September, but I do have a document of an announcement on 18 September. It talks about pledging to invest up to $290 million to a Commonwealth dental program. You will recall that that was one of the first programs that was scrapped by the Howard government when it came into power in 1996.

Senator HUMPHRIES—Yes.

Senator McLucas—Those funds will go to the states in order to reduce those waiting lists that I am sure you have heard about, as have I.

Senator HUMPHRIES—Yes. How much on top of that can we expect for the teen dental program?

Senator McLucas—We talked about that the other day. The teen dental program talked about up to $510 million over three years to assist over one million Australian teenagers between the ages of 12 and 17.

Senator HUMPHRIES—So the commitments add up to $800 million; is that correct?

Senator McLucas—Yes, up to $800 million. I have not added up these figures of $290 million plus $510 million in my head, so it is whatever they add up to.

Mr Kalisch—Senator, the teen dental figures are on page 19 of the PAES.

Senator HUMPHRIES—Thank you.

Senator COLBECK—That is the argument we had the other day. The minister is coming back to us on where the other $184 million that disappeared out of the budget is.

Senator HUMPHRIES—Indeed.

Senator COLBECK—We have a philosophical difference with respect to the previous dental scheme, which was a program put in place by the Keating government. It was not scrapped; it just was not renewed. It was not scrapped; it expired. That 10-year program was put in place by the previous government. So it was not a scrapped process; it was one that expired.

Senator McLucas—You are talking about the Commonwealth dental program that the Howard government scrapped in 1996?

Senator COLBECK—It was not scrapped. That program expired and did not go on. If you want to use that terminology, any program that you allow to expire and do not renew, you will obviously agree has been scrapped. We can have that philosophical difference now. I do not know what they are going to be, but we will remember that as time goes on.

Senator McLucas—The other thing you might want to keep an eye on, Senator Colbeck, is the different number of people who were assisted through the Howard government's chronic disease scheme, which I understand supported only 7,000 people over its three-year life.

Senator COLBECK—Senator, when you explain to us where that $184 million is, I think we will be able to sort a few things out.

Senator HUMPHRIES—Minister, where do we stand with dental waiting lists in Australia at the moment? How many people are waiting for dental treatment of the kind that these schemes are going to address?

Ms Flanagan—We can talk to you or give you information about the public dental scheme and the waiting lists. We have an estimate that is a bit rubbery. An estimated 650,000 people are on public dental waiting lists at the moment. That is the target audience for the money that will be flowing to the states for this initiative.

Senator COLBECK—Do you have a straight state-by-state breakdown of that?

Ms Flanagan—It is very difficult to do. The figures are quite old because the states do not report those who are on their public dental waiting lists. I think New South Wales does not report at all. So that is an estimate of who would be on the dental waiting lists at any one time.

Senator HUMPHRIES—When Minister Roxon announced funding for the dental program she said that the money, which I assume was the $290 million, would fund one million dental consultations.

Ms Flanagan—I think it was up to one million.

Mr Kalisch—Up to one million services.

Senator HUMPHRIES—I am quoting from the media release of 19, which I am quoting states:

Yesterday's announcement—

that was the $290 million—

of funding for 1 million dental consultations is the first instalment …

It does not make reference there to being 'up to', but I will check back with the other media release and see whether it says 'up to'. Let us suppose that it is less than that. With a waiting list of 650,000 and one million consultations, what do you expect to be the outcome of such a program? To what extent will we alleviate the 650,000 on the waiting list?

Ms Flanagan—You have the text there but I think it is services rather than consultations or patients seen. The idea is that we need to have a dialogue with the states, just as we have done with elective surgery. We will be asking them what they will be able to achieve in reducing public dental waiting lists with the allocation of that money.

Mr Kalisch—I think it is fair to say that with this measure a significant number of people will be treated who would not otherwise have been treated. Trying to give you an estimate of what the waiting list will be in, say, four years time is not possible because it is predicated on what happens to new people joining the waiting list in that time. As services improve and increase in their availability, we and the states are also expecting that more people will come onto the waiting lists.

Senator HUMPHRIES—Does it not also depend on the amount that the states themselves spend on their existing public dental programs?

Mr Kalisch—It depends on the efficiency with which they use that money.

Senator HUMPHRIES—What money?

Mr Kalisch—Sorry, the $290 million that will be provided for dental services.

Senator HUMPHRIES—With respect, does it not also depend on what they do? They all have their own public dental programs, haven't they?

Mr Kalisch—Yes.

Senator HUMPHRIES—Is it not a natural reaction for the states to say: 'Whoopee, the federal government has taken care of dental. We can forget some of that spending now and the feds will take care of it'?

Ms Halton—You well know that, in areas like this, probably the first conversation we ever have with our state colleagues when there is a bucket of money around involves the use the term 'maintenance of effort'. At the end of the day it is in no-one's interest if, as we come in the front door with an additional $290 million, they go out the back door with an equivalent $290 million. So be assured that the term 'maintenance of effort' will be sprinkled liberally throughout the dialogue.

Senator HUMPHRIES—Can you guarantee to us that the government will make as a condition of this funding to the state governments that there will be no reduction in their projected levels of spending on public dental programs?

Ms Halton—It is not my gift to make any such guarantee, but I can assure you that in the conversation that is yet to be had in detail with the states the objective is that this $290 million will be used to provide additional services to people who, as Mr Kalisch has said, would not otherwise have got them. I cannot anticipate how that will be reflected in the agreement because we have not yet had the conversation. It is not my gift to make it up. But I can assure you that that issue will be front and centre in the conversation.

Senator HUMPHRIES—Having sat in the chair of a state health minister, I can tell you that there would be a very strong temptation to want to say, 'It is a Commonwealth takeover. The Commonwealth can take care of it. What can I spend the money on elsewhere?'

Ms Halton—I know.

Senator McLucas—Senator Humphries, you seem to be talking from a lot of experience.

Senator HUMPHRIES—It is.

Ms Halton—I know that you know exactly what this dynamic is because in our time we have sat on other sides of the table from each other having this conversation. You will also understand that it is something we are very aware of. Be assured that it will be very prominent in the conversation.

Senator HUMPHRIES—Thank you.

Ms Halton—We would never have accused you of going out the back door with a bucket of money.

Senator HUMPHRIES—I am pleased to hear it.

Ms Halton—We might have suspected you of it, but we never accused you of it.

Senator COLBECK—Given that you have an estimated 650,000 people on the waiting list and you are talking about assisting one million Australians as part of this process, do you have a formula yet for the division of funds to the states? With the hospital waiting lists we talked about the states making a submission and then there were some negotiations—perhaps that is the best way to put it—between the states and the Commonwealth with respect to who got what depending on different scales. What process will be used to divide up the funding for this program?

Ms Halton—The minister has not yet got into that level of detail. We will be considering that, but in relation to the work that is currently underway, as I have already indicated, those funds will be appropriated in the budget. So we have not yet got firm decisions in respect of that.

Senator COLBECK—Who will qualify for access to the program? Are there parameters for that? Is it means tested?

Ms Halton—Refer to my earlier comment.

Senator COLBECK—I had to ask anyway.

Ms Halton—It is just a little too early for those questions. Obviously, we will have all those details in due course, but it is just too early to answer those questions.

Senator COLBECK—Due to start from 1 July?

Mr Kalisch—Yes.

Senator COLBECK—Do we have any idea what specific procedures will be provided?

Ms Halton—Refer to my earlier answer. I am not trying to be difficult, but, referring to priorities, I have to say that we and the minister will get to this one in good time before it commences.

Senator COLBECK—Has any work been done on the potential impact on the program or the capacity to achieve the program of workforce issues?

Ms Halton—We are very conscious of issues in the dental workforce. I think it is a well-known fact that there are dental shortages. Indeed, some new places have been allocated for dental schools to try to alleviate some of those issues, including in rural areas, which I think is very important. To say that there had been detailed modelling would be an overstatement. But I do think, as part of our broader issues and our concerns in respect of workforce availability, we are very conscious not only of the availability of dentists but also of people such as dental hygienists and all the supporting workforce.

Senator COLBECK—Bearing in mind that you have to start somewhere, and I understand that process with respect to increased training and capacity, what is the general time frame for churning out a newly qualified professional in the dentistry field, say, a dentist?

CHAIR—‘Churning out’?

Senator COLBECK—With the shortage that is what you would like to be doing. ‘Turning out’ perhaps is a better phrase.

Ms Halton—I would need my workforce people to answer this question. This is the point where I probably look hopefully at Professor Horvath to see whether he can remember.

Prof. Horvath—No.

Ms Halton—I think it is six or seven years, but I cannot swear to that.

Prof. Horvath—Their postgraduate training, like the other health professionals, is specialised. We would really have to take that on notice. I cannot give you an answer.

Senator COLBECK—I would be interested to get some sense of that because obviously it is an issue.

Ms Halton—We are not sure. The conversation we were just having was about whether or not there had been a conversation. I am aware that they need to do training on graduation. That is the point on which we are not quite clear, because there has been some dialogue about that. We will come back to you on those issues.

Senator COLBECK—Going back to 2002, for example, I recall when the former government made some additional training places available for doctors. It obviously takes a long time for that process to flow through.

Ms Halton—Yes.

Senator COLBECK—And a decision obviously has to be made at some point in time to make a start. But getting a sense of when that workflow might start to flow into the workforce I think would be of some use. If you could take that on notice that would be helpful.

Ms Halton—We will. We will check on what the postgraduate obligations are in respect of practice as well. Obviously it does not take as long as providing a doctor. But remember that once a new graduate is in their clinical training phase they are part of the workforce. So there is a grey area to this before they are fully qualified.

Mr Kalisch—There is certainly a sense that a newly graduated dentist who is in their first year of practice will not be as effective and efficient as other dentists. But certainly the profession indicates that after a year or two they are fairly fully functional.

Senator COLBECK—Does the new Defence Force family dental and medical scheme fit within this?

Ms Halton—No.

Senator COLBECK—Where would I talk about that?

Ms Halton—Defence. I am pleased to say that that is not one of my problems.

Senator COLBECK—I suppose it potentially is. If you met some of your dentists it might be.

Ms Halton—Senator McLucas is suggesting that I might like to take this on. That might be handy sometimes when dealing with other issues.

Senator COLBECK—I suppose it potentially could if you had Defence running around the country trying to scoop up some of your workforce.

Ms Halton—I think they scoop them up at university. I think they sign them up as commissioned officers whilst they are at university. I know this because several people I went to university with were in uniform for part of their undergraduate training, and then off they went to be Army dentists.

Senator COLBECK—Thank you. We will move on to aged care.

CHAIR—I would like to ask a couple of questions on acute care on behalf of Senator Carol Brown. Senator Carol Brown has been called to another committee and she has a couple of questions on organ and blood donation. The National Clinical Taskforce on Organ and Tissue Donation brought down its report this week. Previous information indicated that it would cease. When that report was brought down the original staff said that it would cease in December 2007. I expect that the reason the report was released in February was due to the intervention of the federal election. I have two questions from Senator Brown. Is the report public?

Senator McLucas—Yes.

CHAIR—Has the future of the task force arrangement ceased as a result of the report being given to you?

Senator McLucas—Yes. Senator Moore, thank you for the questions. The National Clinical Task Force report was received a week ago and published yesterday on the website of the department of health. If anyone has any trouble getting hold of it, please come to my office and I will give you a copy. It is an excellent report. I have described it as a blueprint for change and the way forward to increase organ donation rates in the country. I want to take this opportunity to thank Professor Jeremy Chapman for his excellent work and leadership in pulling together the diverse interests in the organ and tissue donation sector. With that, I thank the task force for its work. That piece of work is now complete, and we now move to the next phase. We have established a beautifully termed cognate committee, which will be the next phase. Its task is to look at the 51 recommendations of the task force and to make further recommendations.

The government has indicated that it will continue to fund what is called the National Organ Donation Collaborative—a series of pieces of work at 22 hospitals around Australia—that will ensure that systems are in place so that we get the best possible communication between all the various players in the donation transplant continuum. Those collaboratives will be administered by the National Institute of Clinical Studies, which is part of the NHMRC. It was important that there was a continuation of those programs and that we did not have any time off. So those programs have been committed for funding until June 2009 at least.

I urge all of you, if you have not already done so, to put your names on the organ donation register. I want you this week, in Organ Donation Week, to talk with your families about what your intention might be. I have witnessed four people filling in their forms, so if anyone is beating me, tell me, and I will go and find a couple more.

Senator BOYCE—People have to put in the time and energy to register. Suggestions have come from various fields about an opt-out system, similar to the one that is used in Spain. I think a variant of it is also used in France. I know that that is not covered by the report.

Senator McLucas—Yes, it is. I am happy to speak to that issue.

Senator BOYCE—It is not proposed by the report.

Senator McLucas—No. The national clinical task force has not recommended that we change our legal structure around opt in or opt out. It is important that we ask why. A lot of people have referred to Spain, and Senator Humphries has talked about Belgium. The reality is that when Spain changed its system from opt in to opt out, it took another 10 years for there to be any real change in Spain's organ donation rate. The key difference was that they inserted essentially the work that we are doing through the collaboratives. So someone who is at a hospital where a person may present must be able to manage the process of dealing with the family of the deceased person, talking with clinicians in the intensive care unit and in accident and emergency and getting systems in place so that the will of the deceased person is put into effect.

That is what changed Spain's organ donation rate. The other unfortunate thing about Spain is that it still has a very high road toll. Australia has reduced its road toll by about a half in the last 30 years, and it is not my intention to turn that around. We are going to keep that figure where it is and in fact make it lower. Spain has not been as successful as Australia in turning around its road toll. The United States of America has the second highest number of organ donations per one million population—Spain is at 33.8 and America is at 27. America has exactly the same legal structure as ours—an opt-in system. The difference, unfortunately, in America is that it has a very high toll from gunshot injury. We do not have that and we will not change that either.

There are an important number of factors. I urge people not to grab onto what seems to be a simple solution because it is not. In Australia an opt-out system would not change where we are. We have to tackle the fundamental reason why our organ donation rate is still sitting at around 200 people per year. The way we will do that is through the community, getting people on the register but, most importantly, talking to families. The families of about half of the people who could donate do not agree because they do not know—they just do not know. The other way we can tackle it is at the hospital end. Twenty per cent of people who could donate are not asked. So we can increase our rate from around nine to 10 people per one million of the population probably to 15—that is the goal of the task force—but hopefully to 17. That will save or improve the lives of hundreds in Australia every year.

Senator BOYCE—Have you set that goal, as a government,?

Senator McLucas—That is the recommendation from the task force. That recommendation will now go to the cognate committee, and we will look at how we can effect that. The Australian government and I are committed to working with the sector. An enormous momentum has built out of the clinical task force report. There is goodwill across the sector that we have not seen for a long time. That is due in no small part to Professor Jeremy Chapman's leadership on this issue. It is now our turn to pick up the ball, as a community and as a government, to increase that rate. We have the blueprint there.

Senator BOYCE—I have just one more question which concerns the perception issue. I am not sure whether this applies in other states, but for a number of years in Queensland you could tick a box on your driver's licence to indicate that you were in favour of donating

organs. A lot of people thought that that was sufficient to register them as a donor. Is there any intention to try to publicise the fact that those people are not on the list?

Senator McLucas—I understand that the Queensland list has been transferred to the national organ donor register. I am one of those people. A week or so ago I checked my registration on the organ donor register. That is an important point because I registered before 2005—apparently round 2002. My intent to donate is on the organ donor register, not my consent. So, if you are like me, an old donor—

Senator BOYCE—I am like you, Senator McLucas!

Senator McLucas—You are an old donor too; good on you. In effect, it means that your intent has been registered. If I were to be in car accident and I presented at a hospital, it would not change terribly much what happened. My next of kin would be asked. If my intent or my consent is registered, my family would be asked. That is why you have to talk to your family.

Senator BOYCE—Thank you.

Senator McLucas—The other day one of the committee members said to me, ‘We’ve got to get to the point in Australia where it’s an ‘of course’ option.’ People in those tragic circumstances have to deal with the issue of: shall we? Did this person want to donate their organs? You are in a traumatic situation and you are dealing with incredible difficulties. The situation and intent of that person has to be known by the family so that they can just say, ‘Yes, my partner wanted to donate their organs. Then I will get back to doing my grieving.’ It cannot be too intrusive. That is why families have to understand.

CHAIR—Senator McLucas, I have been very generous in the response time. It is an important issue, but I just wanted to draw that to your attention.

Senator COLBECK—I do not think my question is specifically related to this report. During debate on a certain piece of legislation in 2006, an amendment was moved that called for a study of legislation and guidelines around organ and tissue donation—in particular, tissue donation—across the country. That was the cloning debate. An amendment to that piece of legislation called for a study on that. Is this that study?

Senator McLucas—No.

Senator COLBECK—Do you know whether any progress has been made or whether anything is happening with that piece of work?

Ms Halton—I will take some advice on that. A number of pieces of work have been commissioned. We have a subcommittee of AHMAC, the official committee that has been doing a number of pieces of work in respect of these technical issues. I will have to go back and check whether that is in direct response to that issue. We will come back and give you some advice.

Senator COLBECK—During the process of researching for that debate it became apparent that the rules and regulations in each state were very variable.

Ms Halton—Yes, I remember it.

Senator COLBECK—I think there was a particular circumstance with one of our colleagues in respect of a very joyous event, the birth of his child, that was possible in one

state but not possible in another state because of this huge difference in state legislation and jurisdictions.

Ms Halton—Yes, I remember.

Senator COLBECK—I think a time frame was put on the process coming back—I am not necessarily so concerned about that—and it was a significant piece of work. I would be interested to know where that is at. If you could get back to me.

Ms Halton—I remember that part of it, and I am aware of some other stuff. But I cannot tell you whether the two are the same thing. We will check. We will take that on notice.

Senator COLBECK—Okay, that is fine.

Senator ADAMS—Minister, I would like you to speak to the minister about recommendation 12, which is to do with live donors. We are not just talking about deceased donors; we are also talking about live donors. As this is to do with the Patient Assistance Travel Scheme it came up in 'Highway to Health—Better Access for Rural, Regional and Remote Patients'. The issue was that a woman was donating her kidney to her son. The son lived in one state and the donor lived in another state. The person who was going to receive the kidney could be covered by PATS but the person coming from New South Wales into Victoria could not, which caused quite a lot of financial concern. Despite the fact that the woman had had her kidney removed, she still had to spend time in hospital. She still had to find accommodation because she was not allowed to go back to where she lived, which was highly complex. Recommendation 12 of our report states:

> That state and territory governments expand travel schemes to cover items on the medical benefits schedule, the enhanced primary care, and live organ donor transplants with assistance to the donor and the recipient and access to clinical trials.

That is contained within that recommendation. I wonder whether you would be able to take that forward to the minister at this time. Often this happens with interstate arrangements. The problems associated with it go right through the report, which is why we want the government to look at it as a whole rather than each state doing its own thing.

Senator McLucas—I appreciate that.

Senator ADAMS—It is specifically in your court.

Senator McLucas—I appreciate you bringing it to my attention, Senator Adams.

CHAIR—Are there any further questions under acute care? If we find any we will put them on notice, Ms Halton. We will now move to aged care.

Senator COLBECK—I refer to the government's $300 million zero interest loans policy. The government said that it would fast-track this program. Can you give me some indication of when the program will commence?

Mr Stuart—We expect the minister to make an announcement about that very soon.

Senator COLBECK—Including the process of how the program will operate and things like how the money will be made available or rationed across applicants?

Mr Stuart—Yes.

Ms Halton—Yes.

Senator COLBECK—And the allocation process determining areas of need?

Mr Stuart—Yes, all of the above.

Senator COLBECK—Including guidelines and time frames for repayment?

Mr Stuart—There will be an announcement from the minister very soon. That will be followed by a more detailed explanation from the department, and then subsequently by a call for applications.

Senator COLBECK—Is it intended that this be a rolling fund?

Ms Halton—You are asking for a level of detail that the officers cannot give you. As Mr Stuart has indicated, the minister will be making an announcement in relation to this.

Senator COLBECK—I will move on from that and look forward to the announcement. Do we have any information on the process of bringing transitional beds on line?

Mr Stuart—The election commitment was to bring forward an additional 2,000 transition care beds in partnership with the states and territories. The mechanism for that partnership is through the Commonwealth-state working group, which is currently meeting and which is considering the issues. The funding is available and the program is due to commence from 1 July this year. Consequently, it is being considered, along with the work which is proceeding towards the new health care agreement.

Senator COLBECK—It is a process that is happening alongside the health care agreement process?

Mr Stuart—Yes, that is right.

Senator COLBECK—There is a Commonwealth-state working group based in aged care that is negotiating this process?

Mr Broadhead—The transitional care initiative for the additional 2,000 places is being discussed with the states and territories. As recently as yesterday some consultation with the states and territories was taking place on a draft implementation plan. I believe it is up for discussion at the health ministers meeting on 29 February, next week. So, exactly as proposed, it is being done in conjunction with the states and territories and it is being discussed in those forums.

Senator COLBECK—So there is a health ministers discussion next week, on 29 February?

Mr Broadhead—Yes, there is. I have not seen the formal agenda but I understand that that is what is proposed.

CHAIR—Are there any further questions on aged care?

Senator HUMPHRIES—I wanted to go back to the subject of the Murwillumbah nursing home and clarify something that was said on Wednesday. It was pointed out that the Murwillumbah nursing home had an assessment done between 14 and 18 January this year. The Aged Care Standards and Accreditation Agency had discovered that it was non-compliant in 14 of the 44 accreditation outcomes.

We were told that normally there would be three months from the date of such a finding until the point at which a nursing home was expected to comply with the orders made by the accreditation agency with respect to lifting its standard. I note that there is advertising in the Murwillumbah area and reports in newspapers that suggest the home will remain open for a period of at least six months. We are told that normally it is three months, but is there a capacity to extend that period beyond three months?

Mr Brandon—The timetable for improvement for the Murwillumbah nursing home is three months; it expires on 8 May. In the lead-up to the expiration of the timetable for improvement we will be monitoring their progress. They have given us an action plan, so we will monitor their progress in the lead-up to 8 May—that is, the three months. If, at the end of that period, they are still non-compliant we will recommend sanctions to the department and we will then continue to monitor them. I can tell you that there is a full audit, which includes a review of whether they are sustaining their changes, due to take place in the July-August period.

Senator HUMPHRIES—When you say 'three months', the audit ended on 18 January and they have until 8 May. That is more than three months.

Mr Brandon—The decision was made on 8 February. It is three months. We made the decision. They had a timetable for improvement for three months from the date of the decision, which was 8 February.

Senator HUMPHRIES—When you say you made a decision, was it a decision to impose those conditions on the home?

Mr Brandon—That is correct. We imposed the timetable for improvement.

Senator HUMPHRIES—In applying that sort of period, is there any discretion to extend it beyond three months?

Mr Brandon—The legislation provides that the accreditation body may impose a timetable for improvement. The legislation does not provide a length of time for that timetable for improvement. Normally we apply three months; in fact, we would very rarely apply longer than three months. If, at the end of the three months, they were non-compliant, we would recommend to the department that it impose sanctions. I know that that is not exactly what you asked me, but there is no easy answer to your question.

Senator HUMPHRIES—The reports in the *Tweed Daily News* about a six-month extension are wrong? It is not six months?

Mr Brandon—I have not read the report, but it was just suggested to me that the report in the *Tweed Daily News* was about when their current accreditation expires. You may recall that the decision included a reduction in their period of accreditation. They are now accredited until 8 October. So we will be monitoring. We will be doing a full audit in July-August. I am not sure where the 'six months' comes from; it is certainly not from us. The key dates are the timetable for improvement, which expires on 8 May; a full site audit in July-August; and the expiry of their accreditation on 8 October 2008.

Senator HUMPHRIES—According to the newspaper, the 'six months' seems to come from Minister Elliott, but we will have to follow that up. You are telling me that 8 May is the deadline for them to comply with the orders of the accreditation agency?

Mr Brandon—I am saying that if they have any non-compliance in those 14 expected outcomes as at 8 May, and we do the support contact, we will recommend sanctions to the department. And we will be monitoring their progress in the period up to 8 May.

Senator ADAMS—My first question relates to staff working in aged-care facilities. I come from Western Australia in which, like in every other state, there is a shortage of labour. Wages just for packing shelves in the local supermarket are probably 1½ times the wages that can be earned by someone working in an aged-care facility. So we are having a mass exodus of our carers. So far as the delivery costs of care are concerned, they are now exceeding the fees and subsidies permitted by the Department of Health and Ageing by approximately $10 per resident. My question is: how can these aged-care facilities get their wages up to the equivalent of what nurses in public hospitals are receiving?

Mr Broadhead—I take your question to be in general about the capacity to fund wages from the subsidies that the government pays. Subsidies have been rising at 3¾ per cent roughly for the last few years due to a combination of indexation and the conditional adjustment payment. We believe, based on those numbers and information about the way in which the industry performs financially, that that is sufficient for providers to pay good wages to their staff. There is independent analysis of this from firms such as, for example, Stewart Brown which shows that the operating results for the top 25 per cent of homes are quite healthy. We believe that, if a home is well organised and well run, the subsidies are adequate.

That having been said, there are some changes coming through which will result in some increases in the funding available, particularly in two parts. One is the introduction, from 20 March this year, of a revised basis for allocating care funds. The largest subsidies that the government provides are care subsidies for residential care. That will move from the current system of the resident classification scale to the Aged Care Funding Instrument. As part of that, some additional funding is being provided. The ACFI, as it is called—the Aged Care Funding Instrument—alters the basis on which payments for care are made. It does so by simplifying the basic level and by introducing two new supplements. There was a decision at the time of the last budget to provide some additional funding as part of introducing those two new supplements.

Also, there are changes coming in on 20 March, with the recent passage of the aged care amendment act 2008, to modify accommodation payments as well—both resident fees and government subsidies. So there are a range of changes coming through from 20 March which will increase the funding available to the industry to meet costs.

Senator ADAMS—When this formula is worked out, will any consideration be given to states such as Western Australia and Queensland? They are paying a lot more money for wages, and it is really very difficult. It has got to the stage where beds are empty because they cannot be staffed.

Mr Broadhead—A decision was taken—I think it was eight or nine years ago now—to move away from having differential rates of subsidy between states and territories. This was eventually called the FEP—the funding equalisation program—or something like that.

Senator COLBECK—Coalescence.

Mr Broadhead—'Coalescence' was the original term and then it got renamed. The upshot of this is that, as of the middle of last year—the beginning of the current financial year—all states and territories are on the same rates across the country. Previously there were differences in the rates paid according to states and territories, but there was a decision to bring it all to a national set of rates over a period of several years. I think we got to that point in the middle of last year. We now do not pay different rates for different states and territories; it is the same set of national rates across the country.

Senator ADAMS—Unfortunately that still does not help with staffing in Western Australia and the fact that we have empty beds because they are trying to work under the standards—a safety factor for residents. Is there any way that this can be fixed?

Mr Stuart—I think that is asking us for policy.

Senator ADAMS—Okay. We will leave that.

Senator COLBECK—I have a quick supplementary question to what Senator Adams was talking about.

CHAIR—Around government policy?

Senator COLBECK—I am not asking for policy. Have any studies been done on the impact of the coalescence process over about five or six years, finishing last year? I have obviously had some anecdotal stuff put to me, particularly by some of the regional facilities, the smaller ones. Have you done any studies on the impact on the sector of that process?

Mr Broadhead—There have been no formal studies of it done, so we monitor what I suppose you might call the financial health of the sector in various ways. But there has been no specific study focusing on the results of coalescence.

Senator COLBECK—Does that financial monitoring give you any trend lines on impacts?

Mr Broadhead—The monitoring that we do gives us some idea of how the sector as a whole is performing financially—in other words, the relationship between costs and revenue, if you like. I have to say that there was a very widespread range of performance. The best performing homes in financial terms do quite well, there are a lot that do less well. It is a highly variable picture but we do not have any specific evidence around the impacts of coalescence state by state.

Senator COLBECK—Do you provide any support or assistance to those that might be at the wrong end of the variable scale that you have just talked about in respect of financial performance? I know you monitor closely to protect.

Mr Broadhead—We do provide a range of support to homes, for example, in rural and remote areas. This can be a viability supplement, for example, which is determined on the basis of things like rurality or remoteness. We provide capital grants which support

construction of facilities in areas where there are particular challenges in meeting the costs of capital construction. There are a range of things that we do that support the delivery of care or the capacity to develop and operate facilities in areas which are particularly challenging, but we do not have any state by state. In other words, there is no program that says that because it is this state or that state we will make a difference. It is more about the location or the particular circumstances.

Senator COLBECK—But generally you would have the data to enable you to undertake a study of that nature, would you not?

Mr Stuart—I think it would be true to say that there is more variation within states than there is between states. Those variations relate a lot more to the kind of auspicing organisation, the size of the facility, the nature of the client group being assisted and rural versus metropolitan.

Senator COLBECK—Are there any patterns that exist or that stand out in respect of that?

Mr Broadhead—That is an interesting question. That is a very broad question.

Senator COLBECK—If you are having trouble thinking of it, then obviously not.

Mr Broadhead—Well, yes. In general terms, there is no set of criteria by which you can predict the performance of a home absolutely—in other words, to say if it is has this, this and this characteristic then you can expect it to perform in this way. So, no, not in that sense. In general, we know, for example, that construction costs in remote areas can be very high, so that is why we have a capital program. Indeed, there has recently been an increase in the availability of capital grants to support development in remote areas. The loan scheme you mentioned earlier is to target areas of high need where there may be challenges in getting places up. But I cannot give you a picture that says systematically, ‘if it is this, then it is that’, if that is your question. I am not sure I have adequately answered it.

Senator COLBECK—I understand that it is difficult, but there has been such a significant change in the structure of payments to facilities. I can only presume that the variation in payments across states was to take into account some previously perceived differential in costs in providing the services in different states. I know that exists in other service areas, so I can understand that the basis for that might exist in the first place. Then there was obviously a policy decision taken at some point in time that there should be a flat scale of payments across all states. I would have thought that it would have been prudent to monitor that process. It has forced some changes in the way that services are delivered across the country but also within states.

There was an amalgamation of smaller sites as the number of beds that were required to make a facility viable crept up with the reduction in the amount of money available. As a whole range of those things have occurred, I would have thought it would have been prudent to actually study the impacts of that coalescence process, following on from the obvious policy decision at the end of the day. It may be something that Senator McLucas has to take on as something to consider for the government—I do not know—but I would have thought it would have been prudent to make that sort of study so you understood the impacts of that change, either before or after.

Ms Halton—But I guess the issue here is that in a very dynamic policy environment—and you would understand this—it is not just coalescence that has changed. In this period we have had any number of policy changes. I think, as Mr Stuart indicated, since that time we have done work looking at the financial performance of the whole sector. We do now know, based on a very solid piece of work, what the attributes are of well-performing providers. We do know that they can operate in a viable sense. I guess what I am hearing, particularly from what Senator Adams was saying, is a reflection of what is in fact the strength of the labour market. I think it is very difficult to disentangle some of the things that are being seen from the strength of the labour market.

Senator COLBECK—The piece of work that you have mentioned, is that available?

Ms Halton—That was the work done—

Senator COLBECK—That is the—I cannot think of his name now—the report that was done a couple of years ago—

Senator HUMPHRIES—The Hogan report.

Ms Halton—It was a Hogan piece of work, yes.

Senator COLBECK—Yes.

Senator ADAMS—Just to continue on the nursing side. Labor's policy is to have 1,500 new graduate nurses within five years and more nursing places at universities. Also they are paying cash bonuses for 7,750 nurses returning to the workforce. So, Minister, will the government be ensuring that some of these places are allocated to the aged-care sector?

Senator McLucas—The government is very aware of the need to address the workforce issues in both the acute sector and the aged-care sector. I might ask Mr Stuart or somebody else to indicate the specific policy around attracting currently trained nurses back into the aged-care sector.

Ms Smith—The measures to bring nurses back into the workforce which were announced by the Prime Minister and the Minister for Health and Ageing in January addressed both the needs of hospitals and the needs of aged care. There is provision in the measure to encourage a thousand nurses back into aged care, both through payment of bonuses to the nurses themselves and to the employing facilities for retraining of those nurses.

Senator ADAMS—Is there actually a number?

Ms Smith—A thousand nurses.

Senator ADAMS—For aged care?

Ms Smith—Yes. They will get the same dollar bonuses that apply to nurses in the hospital sector, which is $6,000.

Senator ADAMS—That might help. Good, thank you. My next question is on the ACFI. There is a problem with the negative financial impact. My question is: with the not-for-profit aged-care providers already in a significant funding crisis, what is the government doing to ensure the introduction of ACFI will not have a significant financial impact?

Mr Broadhead—There are a number of things happening in this area. Firstly, the transition to the ACFI is quite slow in financial terms. That is because existing residents remain on their current classification until that expires. At the moment the RCS expires every year and so. Depending on when a resident was assessed, it will expire at some point between 20 March this year when the new system begins and 19 March the following year. Many residents will remain on their existing RCS throughout the year.

The existing residents that are assessed under the ACFI then do not move to the ACFI unless the ACFI pays more. So, even when an existing resident is assessed under the new instrument, they will only move to the funding under the new instrument if the new instrument would pay more. The impact of the transition to ACFI is quite slow because the number of people that will be on the ACFI builds slowly over time as new residents arrive and as existing residents are assessed. The effects of this—we call it grandparenting, a term we use a lot in the aged-care sector—mean that there will be about $200 million in payments that are basically for people who remain on the old rate, even though the ACFI is coming in for new residents. So there actually will be a cushioning period, if you like, as the transition is made.

In addition, we are establishing a panel of management support, if you like, advisers, who will assist homes to look at what is happening—if ACFI is perceived to be having a negative impact, and whether in fact that is because the assessments are being done properly or whether there are other issues going on. So this will aim to support homes that are experiencing difficulties through the transition period.

The other thing that we are doing in the lead-up is working fairly closely with a number of providers who have done trial ACFIs—in other words, they are already assessing a number of their residents using the ACFI to see what the impact might be. There have been a number of claims coming out of this, early in the piece, that the ACFI was going to result in less revenue. To date, in the studies that we have done following up with these people, we have discovered that the way in which they implemented the ACFI was not appropriate—in other words, they had not done the assessments properly—and that was the basis for them believing that their revenue would decline. When we followed that up, we discovered that in fact the declines that they are predicting will not eventuate. That is a general finding, based on the work that we have done to date. That is ongoing. We are still working with various providers and with the peak organisations around these to make sure that people have properly understood the ACFI.

There is a risk, of course, in moving from the old system to the new system, that the new system might not be properly applied. In that regard there is currently training going on for 7,000 to 8,000 people, which is being run through the Western Institute of TAFE New South Wales, but being run nationally, to provide education to assessors in aged care homes. That began this month and runs through to early March so that people will be properly trained to conduct assessments using the new instrument.

One of the difficulties that we have had in some of the experimental applications of the ACFI in the lead-up to 20 March has been that people have been doing it off the documents on their best understanding of how it should be done, but have not necessarily properly understand stood how to do it.

We believe we will work through all of these issues. There will of course be some teething problems around the introduction of a new instrument, but we have mechanisms in place, we believe, to handle that in a variety of ways. So overall we believe it will be a successful transition. We believe that the level of funding available across the sector as a whole will increase under the ACFI, not diminish. It will increase in terms of the effect of the ACFI itself and it will temporarily be held up by the effects of grandparenting as well. So we do not believe there should be any great cause concern in the move from the RCS to the ACFI.

The other thing I would say is that, in general, from talking to the people on the ground who deal with this thing, there is a sense in the industry that the ACFI is a good thing and they have wanted to get on with it for some time. The RCS is not well liked in the sector at the moment, I think it would be fair to say. It is regarded as being burdensome in terms of documentation requirements; it takes staff time away from the care of people in terms of what has to be done to do it. So the ACFI is seen as an improvement as an instrument for determining the basis of funding, not only because it will better target the needs of residents but also because it will require less staff time and effort to do it. So, yes, of course, there is uncertainty; yes, there are concerns about whether it will play as it is expected to play; but, overall, people want to get on with it, and it has been welcomed.

Senator ADAMS—Right. Well, I hope that when I send the *Hansard* transcript to my providers they will be reassured. But I have another problem, with rural and remote areas, where there are many stand-alone aged-care providers. What is the government doing to ensure that they receive immediate assistance with difficulties with the introduction of ACFI? Are you going to help them?

Mr Stuart—Senator, I will just pencil in the number that Peter could not immediately find. The total increased funding under the Aged Care Funding Instrument over the next four years is $380 million in care subsidies, and that arises both from the grandparenting and from the increased subsidies for people with higher care needs.

Senator ADAMS—I have another question, on the medication management system. The provision of timely, appropriate and cost-effective medication management systems for residents of residential aged-care facilities is currently impossible given the legislative and structural framework governing this area. This system also provides a massive burden to GPs and registered nurses working in the aged-care sector. Is this something the government plans to address?

Senator McLucas—I am unaware of any proposals at the moment, but maybe Mr Stuart would like to add something.

Ms Smith—There are no plans for change at the Commonwealth level in terms of medication management. I am aware that a couple of states have proposals for change. There was a little bit of discussion earlier in the week about changes that are being proposed in South Australia.

Senator ADAMS—Obviously, it is a problem, because I have had a number of providers come to me about it. Is there any way, with accreditation—when this area is going through accreditation—that they can perhaps look at it at that stage? It must be assessed somewhere if

there is a problem and it is creating chaos for GPs and registered nurses, who are certainly in short supply.

Senator McLucas—What is the problem?

Mr Stuart—What do you see as being the issue? What is the problem that is being experienced?

Senator ADAMS—From what I can gather, they are having a lot of problems with the actual management of that particular system, and so this would go back to the accreditation.

Ms Halton—Sorry, I am not clear what you mean. Which system?

Senator ADAMS—It is the medication management system.

Ms Murnane—Which aspect of it? Is it the medication review or is it the—

Senator ADAMS—It is the provision of timely, appropriate and cost-effective medication management systems for the residents in the aged-care facilities. They feel that it is far too burdensome with the structural framework that they have to follow.

Ms Murnane—Is this the reception of the pharmaceuticals into the home and their allocation to residents, their bundling-up?

Senator ADAMS—I would think that is what it is.

Ms Murnane—That is something that nursing homes have been doing forever. Many of them, particularly in rural areas, have arrangements with the pharmacy. The pharmacy comes in—there is a commercial name, but there are others—and makes up Webster packs. Usually a pharmacist is there. The pharmaceuticals are then wheeled around in a trolley and dispensed according to that pack. There are also medication reviews, but I would not think that they would be in any way impeding the efficiency of the home. Sometimes in the community GPs have complained about medication reviews. Something has been sent to the GP saying that they did not believe this drug should have been prescribed and the GP gets annoyed, which I suppose is understandable.

Senator ADAMS—This has come from the division. This question is from one of the division's networks.

Ms Murnane—If you tell us which division it is, I think the best thing we can do is to talk to that division, which we will do quickly.

Senator ADAMS—That sounds good. I will certainly provide that.

Ms Halton—You speak of a system, which is why I am confused about the question. I think we need to get to the bottom of the issue.

Senator ADAMS—I have not had a chance to speak—

Ms Halton—We are very happy to look at it; we just need to work out exactly what the issue is.

Senator ADAMS—Obviously it is a problem with the GPs and registered nurses.

CHAIR—Senator Adams, can you give me an idea of how many more questions you have?

Senator ADAMS—I have one more.

CHAIR—I do not want to interrupt you but we are trying to balance the time.

Senator ADAMS—I realise that. This particular one is about the building of new aged care homes and Labor's policy of low-interest loans for new beds in areas of need—of $300 million for up to 2,500 beds. Once again, this comes back to the enormous cost in Western Australia. The current cost to build a new aged care room is $257,000, and that excludes the land cost. If these beds were going into Western Australia, it would equate to only 1,100 being able to be built. My question therefore is: will the government provide extra funding that factors in the unique circumstances in Western Australia? It is just one of those things. Once again, and I would say that Queensland is probably in the same position, aged care providers are not able to afford to build new aged care beds or new aged care facilities.

Ms Halton—I think Senator Colbeck has already gone to a series of questions where we have said, I hope very politely, that the minister will make some announcements about that shortly. I have to say that the figure you just quoted is not a figure I have ever heard. It sounds to me like a particular anecdote, so I would question that. In terms of how this program will operate, there will be an announcement soon.

Senator ADAMS—The other question is: will the government be addressing the major issue of accommodation bonds for high-care residents?

Ms Halton—That is a policy question. I think the government has basically indicated that it is maintaining the current policy.

Senator McLucas—There is no intention to change current policy settings.

Senator ADAMS—Thank you.

CHAIR—We have a couple of questions from Senator Humphries and then I intend to close aged care and move onto Indigenous health.

Senator HUMPHRIES—I am afraid I have to return to the Murwillumbah Nursing Home. I am a bit concerned about some answers that were given on Wednesday to the committee about this. You will recall that Senator Patterson asked a number of questions repeatedly about the home, and she was told that the information could not be provided because the decision had been made on the accreditation of the home on 8 February and that a 14-day appeal period operated to protect the release of information about the home's accreditation status. That is what you told Senator Patterson on Wednesday. She specifically asked how many of the standards Murwillumbah Nursing Home failed, and she was told repeatedly that that was protected information. As it happens, today is the 14th day so, presumably, I could now proceed to ask those questions about how many standards the home failed. However, I do not need to, because in the House of Representatives yesterday the minister, Mrs Elliot, provided that information. She said:

> I am advised that from 14 to 18 January this year, the Aged Care Standards and Accreditation Agency conducted a review audit of the Murwillumbah Nursing Home and the agency found the home to be noncompliant with 14 of the 44 accreditation outcomes.

Ms Halton—There is a simple answer to this, Senator, which I will ask Ms Smith to explain to you. I should also tell you by way of interest—although you have no interest at

all—that it happened that my 14-year-old son was having Senate estimates demonstrated to him by my husband. At precisely that moment they were watching on the net and when I got home he said, 'Why was Senator Patterson so cross, Mum?' I then had to explain to him about protected information. At that point his eyes glazed over and he said, 'Oh, it's very boring, Mum.' So I do not know whether it was necessarily a good introduction to the democratic process. But there is a very good answer to your question.

Senator HUMPHRIES—I am glad to hear it.

Ms Smith—There is a range of information that is protected information under the Aged Care Act. It is certainly true that in the general course of events we would not make available information about the nature and number of non-compliant outcomes before the 14-day reconsideration period had expired. That was the discussion we had on Wednesday night.

Senator HUMPHRIES—Yes.

Ms Smith—But we have had instances on more than one occasion when there has been a degree of community interest in the issue. There are also provisions within the Aged Care Act that enable a delegate of the secretary to make certain information available. The delegate has to sign an instrument authorising the release of that information. That instrument has now been signed and that information was duly made available yesterday.

Senator HUMPHRIES—To Minister Elliott.

Ms Smith—To Minister Elliott, who then made it publicly available.

Senator HUMPHRIES—For what reason did the delegate make the instrument available? Was there a request from Minister Elliott for the information to be made available?

Ms Smith—I think it was clear from the discussion on Wednesday night that there was a degree of community interest in having that information available.

Senator HUMPHRIES—There was a degree of Senate committee interest as well. If the instrument was signed yesterday to release information, why couldn't that have been provided to this committee, because it requested it repeatedly on Wednesday night.

Ms Smith—The instrument had not been signed on Wednesday night, so we could not have made that information available on Wednesday night.

Senator HUMPHRIES—You misunderstand my question. I appreciate that the instrument was not signed on Wednesday night; it was obviously signed on Thursday, some time before 3.22 pm, when the question was asked of Minister Elliott. But this committee has been meeting since nine o'clock this morning and there were questions about Murwillumbah Nursing Home this morning and the information was not provided to us, even though it had been asked for repeatedly on Wednesday night. If I had not raised it, when was it going to be provided to us?

Ms Halton—There were a number of questions that were taken on notice on Wednesday night.

Senator HUMPHRIES—Not that one.

Ms Halton—Which one?

Senator HUMPHRIES—The one about how many standards the Murwillumbah Nursing Home had failed.

Ms Halton—All the questions that were asked today were answered. And Ms Smith is indicating—

Senator HUMPHRIES—Today's questions have been answered but not Wednesday's.

Ms Halton—Yes, because the instrument had not been signed. The delegate had not taken a decision in respect of the public interest element of this to release the information. Based on the level of interest, there was a consideration by the delegate and the delegate decided that it would be an appropriate step to release the information.

Senator HUMPHRIES—Ms Halton, I put it to you that if this committee asked for that information and was told that it could not be provided because it was protected and subsequently an order was made by a delegate to unprotect the information, it should have been brought back here and provided to the committee. Are there any other questions that were asked on Wednesday night that we were told we could not have answers to that we can now have answers to because the information has been unprotected by the delegate?

Ms Halton—I will ask Ms Smith to answer that question; however, I do not agree with you, Senator. At the end of the day, we come and we answer questions. That is what we are doing. If that question had been specifically asked it would have been answered. Essentially, the delegate decided that, because of the interest, this matter should be considered. The matter was considered and the delegate took that decision. The information is now in the public arena. And indeed, you are aware of it.

Senator HUMPHRIES—I understand that there is information which you cannot provide because it is not available to you. For example, if I had asked, 'How many nursing homes are there in Queensland?' and you had said, 'We can't tell you. We'll get the information and provide it to you later,' you could not have given me the answer because you did not have the information available to provide to the committee. Isn't this exactly the same? You could not provide the information because it was not available to you on Wednesday night, but it was available as of this morning.

Ms Halton—It was available to us. We were not permitted to disclose it, because it was protected.

Senator HUMPHRIES—You were this morning.

Ms Halton—Because a decision has been taken to release it publicly.

CHAIR—Ms Halton, who is the delegate?

Ms Halton—Ms Smith, in this particular case.

CHAIR—I will work as part of the committee and do a follow-up at the end of the hearing, when we do our response and so on, but I tend to agree with Senator Humphries in terms of the process. I am just interested in when we went through the series of questions the other evening and Senator Patterson was quite persistent in her questions around this. The fact that there was a place where the delegate could make such a decision was not given in evidence to the committee. Senator Patterson asked several times and she disagreed about

whether it was privileged or not. I am interested to note that, when she was questioning, no-one from the department said, 'The only way this could happen would be if there was a decision done by a delegate that it could be released.' That option was not shared with the committee. That interests me.

Senator McLucas—I can provide some assistance in a historical context. I recall last year the previous minister took the, I think, unusual action to release information that would usually be protected under the act. It is because there is a level of community interest. The previous minister used the opportunity only on one occasion. That may be incorrect, but I only know of one occasion in the last 12 months and possibly even longer. It is an unusual step and it is because of increased community interest in a particular matter that the step to release information that would be protected under the act is taken. I do not think that departmental officials have been trying to be unhelpful at all. The instrument has to be signed. If it is not signed, anybody who releases information that is protected under the act will be prosecuted. It is a very significant—

CHAIR—That is understood, Senator McLucas.

Senator McLucas—offence under the Aged Care Act.

CHAIR—Can we have a copy for our records of that guideline or the provision that actually makes that statement about how delegates can make that decision. It would be a useful thing for our committee to have in terms of process. Then we will follow up.

Ms Halton—Can I make one more comment. You made a comment that we should have told you about that. Again, I actually do not agree with that. I have to say that, exactly as Senator McLucas says, this is an unusual step and it has to be considered on balance. I think to have speculated about that in front of the committee would have been improper—and that is what it would have been, because a delegate actually has to consider the evidence and whether or not this is actually in the public interest. A process of consideration is not something that should be speculated about in evidence to a Senate committee. In fact, if any of my officers did that I would regard it—

Senator HUMPHRIES—No-one is suggesting that it should have been, Ms Halton.

Ms Halton—No, but my point—

Senator HUMPHRIES—It is today's lack of information I am talking about, not Wednesday's.

CHAIR—Senator Humphries, we have the issue on the record. We have the process and we will follow up with it, if we can have a copy of that.

Ms Halton—Yes. I am happy to give you that.

CHAIR—And I take it Senator Patterson has received this information?

Senator HUMPHRIES—Not that I am aware.

CHAIR—We will do it, but I think it might be useful for the department to send something to Senator Patterson—

Ms Halton—Yes, I am happy to do that.

CHAIR—about the process and to follow up on her questions the other evening.

Senator COLBECK—Was the delegate asked by anybody to consider the release of the information?

Ms Halton—Not by me.

Senator COLBECK—No, that is not the question. It is a good answer, but it is not the question. Was the delegate asked by anybody to consider the release of the information and signing the document?

Ms Murnane—Yes. I suggested to the delegate that she could give her attention to that matter.

Senator COLBECK—Were you asked by anybody to consider it?

Ms Murnane—I was not.

Senator COLBECK—Okay, so essentially you instigated that process?

Ms Murnane—I did.

Senator COLBECK—Thank you.

Ms Halton—Senator, I should say that, after the estimates hearing and after that matter was canvassed, we actually did have a conversation about the level of interest in this matter. So, reflecting on that conversation and the level of interest in it, we did have that conversation the other evening.

Ms Murnane—I should say that, in terms of the exercise of any delegation, the decision was the delegate's and the delegate's alone.

Senator COLBECK—I understand that. I understand that fully.

Senator HUMPHRIES—At this stage, I will put some other questions on notice about this matter.

CHAIR—On that basis, we will call an end to questions on aged care.

Proceedings suspended from 11.05 am to 11.12 am

Office of Aboriginal and Torres Strait Islander Health

CHAIR—Welcome Ms Podesta. There is considerable interest in the area of Indigenous health, so I want to dedicate the committee's time until at least a quarter past twelve. If necessary, we will go a bit longer but that will be the minimum commitment.

Senator McLucas—So that we have a bit more of a feel for the use of the time, are you saying that we have indigenous health until 12.15—

CHAIR—That is right.

Senator McLucas—and then we have three-quarters of an hour.

CHAIR—For the rest.

Senator McLucas—Do you expect that we will do outcomes 10, 11, and 14?

CHAIR—My hope is that we will do at least outcome 11. Looking at the number of questions in the other outcomes, I think it will make it easier if some of them are placed on

notice. However, I will have to check with senators who are wishing to ask questions in those areas, and so I do not want to release those officers yet.

Senator McLucas—Thank you.

Senator SIEWERT—I have a series of questions. I have some overview questions and some specific petrol-sniffing ones, following on from yesterday, as well as questions on some specific mechanistic health-related issues. I must admit that I am slightly confused about how much in additional resources has now been allocated to Indigenous health. Is somebody able to give us an overview of where we are at with funding? I have seen multiple announcements. There was talk of extra money yesterday. If someone could give us a clear overview, that would be helpful.

Mr Thomann—Senator, could you give me a base line from which year you want us to describe where funds are moving from. Are you talking about the additional resources we now see in the portfolio additional estimates statements?

Senator SIEWERT—Yes, and the additional $400 million that was talked about yesterday for Indigenous health. You are looking at me very strangely.

Mr Thomann—I am very excited, Senator.

Senator SIEWERT—Maybe I have misinterpreted what was said yesterday, because when we asked about health —

Ms Podesta—Was this when you asked FaHCSIA?

Senator SIEWERT—Yes. We were told about the health checks that are going on now, and the extra money that is being contributed. Maybe I got the figure wrong, but there are extra resources going into Aboriginal health to begin dealing with the issues that have been identified. Maybe I heard the figure wrongly, which is why I want to see if we can get a clear picture of just what funding is being committed now. I appreciate that the NT intervention money is only for this year, but what the forward estimates are—

Ms Podesta—Just to clarify, are you interested in details on the money to do with the intervention this year and subsequently in the Northern Territory?

Senator SIEWERT—Yes.

Ms Podesta—Thank you, Senator.

Mr Thomann—In relation to the Northern Territory emergency response, the appropriation of administered funds for this year, 2007-08, is $72.735 million.

Senator SIEWERT—That is for health?

Mr Thomann—That is for the delivery of the child health checks and the immediate follow-up treatment, drug and alcohol services, and special children’s services for those children identified as being traumatised by abuse. That is for the stabilisation phase, if you like, in 2007-08. Then there is the normalisation phase in 2008-09 and 2009-10. In 2008-09, $38.952 million has been appropriated for the improved and expanded service delivery of primary health care across the entire Aboriginal population in the remote Northern Territory. In 2009-10, it is a figure of $50 million in administered funds.

Senator SIEWERT—Is that money for the expanded health care on top of existing funds?

Ms Podesta—Yes.

Mr Thomann—Yes, that is on top of the existing funds in the base.

Senator SIEWERT—I think we were told yesterday that, of the $72.3 million, $14.9 million has been spent.

Ms Podesta—As of 31 January, there was money spent on the delivery of the child health checks to deliver that.

Senator SIEWERT—And that was $14.9 million?

Ms Podesta—Yes, that was administered and other funds, and that is as of 31 January. The roll-out of the health component of the intervention has continued, so that figure—

Senator SIEWERT—There has been another month.

Ms Podesta—Precisely.

Senator SIEWERT—That is way off the $72.3 million that has been allocated. Is the rest of the money being allocated? You have four months to go. Will you in fact spend $72.73 million and, if so, what is the bulk of that expenditure likely to be on in the next four months?

Ms Podesta—The funds that were appropriated to the department this year on a no win, no loss basis—I am sure you heard that expression many times yesterday, Senator —is based on an estimate of the cost to deliver the child health checks and the follow-up treatment. The follow-up treatment is being provided and the cost of the follow-up treatment is being met. The funds will be expended on additional primary healthcare services to deliver the additional child health checks in communities and the follow-up treatment from the initial child health check for specialist ear, nose and throat treatment and for dental services and for other specialist services that are required to meet the follow-up treatment from the child health checks.

Senator SIEWERT—We heard yesterday that about 60 per cent of children had been checked. There were 6,199 who had been treated through the healthcare checks and approximately 2,000 who have been checked—

Ms Podesta—Would you like me to give you the information about that, Senator?

Senator SIEWERT—Yes.

Ms Podesta—As of yesterday, there were 6,244 child health checks.

Senator SIEWERT—You did quite a few yesterday.

Ms Podesta—Every day the teams conduct a range of child health checks. Depending on the day of the week and the circumstances of the family and the children, more turn up. As of 18 February, that has involved about 92 teams, with about 250 healthcare professionals. So far, they have gone to 49 communities and to 12 town camps.

The first cut of analysis of the follow-up treatment for that group has been undertaken. It is important I think to recognise that we do not do an analysis on the day of the follow-up treatment. We receive that information in batches and we do an analysis. So the analysis on the first group of about 4,900 children has been undertaken. So we certainly have a sense of a

trend there in regard to the follow-up needs of those children. I am very happy to give you that information. But I want to stress this will be an iterative process as the children go through the system and the healthcare services analyse what comes out of the child health check and what the treatment path is for those children. Most of the children who require follow-up care will require that care by primary healthcare services.

The important process that has been put in place is that the child health check information goes back to their usual treating doctor or health service and that they make the arrangements. We fund that health service to undertake that follow-up care. We will talk about Central Australia first because that is where we started and that is where there is more complete data. If the children require other treatment—specialist treatment or hospital treatment—the information goes to the Paediatric Liaison Unit, which liaises back with their treating service. For example, if the children require ENT, they need audiology treatment beforehand; they need to be tested. So arrangements are put in place for audiologists to come and do that work. In some cases they need medical treatment. If they have to have an ear operation—for example, they might have wet ear—they get treatment for their ears to be mopped regularly before they are scheduled for hospital. We are very careful to try to make sure people understand that the treatment paths for the children are followed appropriately, depending on the condition and the nature of what is found in the check, and the important interaction between the child's health service and the hospital or tertiary services.

I just want to make that will clear because it is important to know that, when a child is checked, it does not mean that you immediately put them into hospital the next day. Of course, if it is something immediately serious, that is exactly what happens. But for the vast majority of the children, they need to have a range of things happen. In most cases, it is primary health care but for other cases there are a range of other conditions. We can certainly provide that information. I think FaHCSIA gave you the information yesterday in broad categories but we are happy to give you additional information on that.

Senator SIEWERT—If you could, that would be much appreciated. There were issues raised in the media, as you know, about people who have been doing some of the checks not having dealt with rheumatic fever, scabies and things like that before. Is that an issue for you or is that just an issue that the media has been canvassing?

Ms Podesta—Senator, if you do not mind, I will just let you know who the two people sitting at the table are because we are going to share some of these questions. The two staff in OATSIH who have been looking after the Northern Territory—obviously, most of the department in some way has—are Joy Savage, who is the assistant secretary looking after the Northern Territory Emergency Coordination Centre. Joy came back to the department after being the CEO of the Wuchopperen Health Service, the Aboriginal medical service in Cairns, and Dr Tim Williams, who is our senior medical adviser and who came to the department after being the medical director of Wurli Wurlinjang remote area Aboriginal health service in Katherine. So we are very fortunate we have extraordinary expertise leading this.

Between Dr Williams and Ms Savage, we have been able to make sure that we have covered all of the aspects we need to around the intervention to make sure that clinically it is appropriate and that we are absolutely working within the health system within the Northern Territory. We did not want to walk in and walk out without leaving a capacity to manage this

process in the long term. If you like, we will give you some information about the people who have been deployed to the child health checks and the training that is provided.

Dr Williams—The personnel who go out to do child health checks consist of doctors and nurses and administrative staff in some cases. We have selected those doctors and nurses from people who have nominated their services to work in the Northern Territory. We have screened the people who have nominated and we have been looking for people who have the most experience in remote health care and in Indigenous health. All the doctors who we deploy need to have a number of years of experience in general practice for us to feel comfortable that they are going to be able to provide the services that are required in a remote setting. Many of the nurses have been experienced remote area nurses, and we try to ensure that every team has at least one remote area nurse in it, if possible, to ground the team in what is required to work in a remote area and in Indigenous health.

Once we have selected the teams, they go through a training process prior to going out to a community. We have a one-day clinical training process for those teams, together as a team, and we have a following day of cultural awareness for all of the teams as well because we feel that is extremely important. The training process is run by CRANA on our behalf, which is the Council of Remote Area Nurses of Australia. So we have experienced remote area nurses providing the training and we have also been fortunate enough to have in Alice Springs and in Darwin, where we have had training in both places, ex-community paediatricians who have worked in remote conditions in the Northern Territory and who have provided the training also for the doctors and for the rest of the team.

It is an important part of the training to outline to the staff what are the serious conditions that they might find and what are the common conditions that they might find and need to deal with. But apart from the training they are also provided with resources, such as the CARPA Standard Treatment Manual which is used in the Northern Territory for treatment, so that they have the actual resources to treat those conditions adequately. They are not sent out into an isolated situation. They are actually being sent into a situation where there is an existing primary healthcare service. Our staff liaise and work hand in hand with that existing healthcare service. If there is support required for diagnosing a condition or deciding on a clinical pathway, apart from the resources and the training we have already given them, they have the resources of the local primary healthcare service, the district medical officer, the visiting paediatrician for that community, and our staff are instructed to follow the usual clinical pathways for treating children in the Northern Territory.

We feel we have got a good support structure around our teams. The teams ring into our central office in Canberra every day, talk to us about logistic issues, and they also have access to me and to my other medical officers, who can give them advice if there is some clinical issue that they have trouble with. Our community paediatricians who do the training are also on call to answer questions if a question comes up regarding some clinical matter. Although, generally speaking, we prefer our clinicians to go to the local health service, the district medical officer and the existing system within the Northern Territory.

Senator SIEWERT—When you are talking about the local health services, you are talking about community based services as well as government services.

Dr Williams—Both. Whether it is a Northern Territory department of health service or an Aboriginal medical service, they both have well-developed primary healthcare structures and they have a common referral and clinical pathway, whether it is the AMS system or the DHS system, into the specialist and hospital services in the NT.

Senator SIEWERT—Thank you for that outline. The delivery of additional funds for primary care, how is that being delivered? Is it being delivered also through existing community based services, where they exist?

Ms Podesta—Yes. The additional primary healthcare follow-up is undertaken in two ways. We are providing additional funding for the services. We are also providing a workforce support service through the database that we are managing to be able to assist them. We also are providing additional logistical support through the arrangements that we have put in place to be able to assist them logistically.

Ms Savage—In addition to what Ms Podesta has said, funding is for the existing network of services, whether they be Northern Territory government or AMSs, and we are working with them to ensure we have a coordinated approach to the delivery of follow-up services on a regional sort of basis. The department will continue to provide and supplement workforce, in addition to any local efforts that can made to recruit logistic support through that process.

Senator SIEWERT—Does the process you are undertaking include training, in particular, Aboriginal health workers?

Ms Savage—There is a trained Aboriginal worker workforce in the Northern Territory and they also have their own registration. We have not sought to, directly: however, we have capacity and flexibility to engage and support the engagement of Aboriginal health workers in the child health check, the deployment of teams and indeed in the follow-up. Implementation of the follow-up will largely be through existing services, and in most or in all instances we would imagine that there would be Aboriginal health workers involved in that effort.

Ms Podesta—And, irrespective of the Northern Territory intervention, the department has to continue to provide additional resources for training of Aboriginal health workers, and that is to continued. We continue to have contracts with, in particular, the Northern Territory around that.

Senator SIEWERT—What are the additional resources that are going into the training? I appreciate that there are existing Aboriginal health workers. I also understand that there is a need for a large increase.

Ms Podesta—OATSIH attempts to be everything that is Aboriginal health in the department. However, we also work very closely with our mainstream colleagues. The specific issue regarding support for workforce initiatives for Aboriginal health workers now resides with the mental health and workforce division. We are happy to take it on notice, but I think they might be listed to appear. If that is okay, we might ask if that can be referred to them. They have the specific responsibility for that area now.

Ms Savage—Suffice to say, I should add that any of the workers—Aboriginal health workers, nurses doctors—who are engaged with the follow-up will be provided with similar training to that which has been provided for the child health check teams.

Senator SIEWERT—I am sorry to labour the point, but can I go back to the resources. The resources that you have outlined for me in terms of the response: is that the extent of the additional resources that are being put into Aboriginal health in the Northern Territory? I also want to touch more broadly on the other states. I understand there have been commitments of additional resources outside the NT resources.

Ms Podesta—And in regard to the additional resources in the NT, there were a number of election commitments. There is a specific Northern Territory election commitment of $20 million, which relates to primary healthcare capital works, renal dialysis services and sexual assault services. And also, clearly, the Northern Territory will be a beneficiary of the broad election commitments with regard to new directions for maternal and child health.

Senator SIEWERT—The extra $20 million that was committed, where is that being delivered through? I am sorry, I do not know if I am making sense. How is that being delivered? Is it topping up the resources that you just told me about? Is that included in the money that is being spent?

Ms Podesta—No. It is in addition to the figures that we gave you with regard to the Northern Territory intervention.

Senator SIEWERT—I am sorry. I am probably not making myself clear. I want to get a picture of the total resources that are now being delivered to health care in the Northern Territory, but I also want to go broader than the NT and look at Aboriginal health as a whole and look at the additional resources that are being put into Aboriginal health. You will know where I am coming from, and that is the closing the gap process, and the repeated call for additional resources to go into Aboriginal health. I am trying to get a picture of how much money is actually now going into health.

CHAIR—Ms Podesta, the same questions were asked of FaHCSIA to ensure what the overall spend was and what was peculiar to these programs so that we can get a full picture.

Mr Thomann—As a result of the additional estimates process, the total amount of administered dollars for outcome 8 is now $526.224 million.

Senator SIEWERT—How much of an increase is that?

Mr Thomann—It depends on where we take it from.

Senator SIEWERT—You see why I am confused!

Mr Thomann—If we take it from the 2007-08 budget, the budget in 2007-08 brought forward $447.232 million of administered funds.

Senator SIEWERT—Yes.

Mr Thomann—As a result of the supplementary estimates for the Northern Territory emergency response, that was increased to $519.967 million. As a result of the current year impacts of the additional estimates process, we are now up to the $526 million I just mentioned.

Senator SIEWERT—Can you tell me the 2008-09 figure?

Mr Thomann—I am not in a position to give you that figure, I am afraid. But what I can do is give you a summary of the measures that have been agreed to in the additional estimates

process and their implications, if you like. So we have the new directions measure, an equal start in life for Indigenous Australians, and the child maternal health services, which will deliver $90.3 million over five years within the Health portfolio.

Senator SIEWERT—It is broader.

Mr Thomann—It is a broader measure, but that is the amount that we are looking at in OATSIH. There is an additional $11.2 million as a result of that measure, over the five years, being provided for the rheumatic fever strategy, through outcome 5. We have the Link-Up and Bringing Them Home measure, which is $15.7 million over four years, and that is another election commitment. We have already discussed the $20 million boost to the health services in the Northern Territory as part of the Better Outcomes for Hospitals and Community Health package. That is basically it.

Senator SIEWERT—Thanks. What period of time is the $20 million to be spent over? Obviously it is not boosted up. There is nearly $520 million and there is basically a $6 million difference from what you had at supplementary estimates to additional estimates.

Mr Thomann—That is right.

Senator SIEWERT—That is essentially $6 million. So where has the other $14 million gone? Does that get delivered over the next couple of years?

Mr Thomann—You are talking about the $20 million?

Senator SIEWERT—Yes.

Mr Thomann—It is over four years.

Senator SIEWERT—Okay. Thank you. That is what I wanted to clarify.

Mr Thomann—So there is $5.1 million delivered this year of that $20 million measure.

Senator SIEWERT—Yes.

Mr Thomann—The remaining three years will see $15 million rolled out.

Senator SIEWERT—And just so that I am clear: that is on top of the other funding that you have just outlined to me in terms of delivery through the NT intervention.

Mr Thomann—That is correct.

Senator SIEWERT—There is $5.1 million on top of that for this year, so in effect the additional healthcare measures—

Mr Thomann—No, the $5.1 million is part of the original figure I read to you of $526 million.

Senator SIEWERT—Yes. I mean, of the $72.73 million that is for this year—

Mr Thomann—It is on top of that.

Senator SIEWERT—It is on top of that.

Mr Thomann—That is correct.

Senator SIEWERT—So, in effect, we are talking about nearly $78 million.

Ms Podesta—And, as the $90 million health component of new directions is rolled out and as the $15.7 million Bringing Them Home measure is rolled out, some component of that will also go to the Northern Territory. We do not have a breakdown—because in the case of the $90 million that has not been spent yet—of how much goes to the Northern Territory. So that is not the complete amount of additional resources going to the Northern Territory.

Senator SIEWERT—Okay. I take your point. Obviously some of that is going to be going to the other states around Australia.

Ms Podesta—Precisely.

Senator SIEWERT—I actually have lots more health related questions, but I think somebody else might want to ask specific NT emergency stuff.

Senator ADAMS—As far as CRANA goes and the program that is offered, could you just give us a brief outline of that?

Ms Podesta—Would you like some details of the training program that is being provided?

Senator ADAMS—Yes.

Ms Podesta—Certainly, Senator. I will ask Dr Williams to answer that.

Dr Williams—The program obviously has to include a lot in the course of one day, so we try to focus on the things that are going to be most important—as I said before, the things that are commonly seen and the conditions that are going to be important and the linkages that staff are going to need to have into the Northern Territory health system. That includes explaining the clinical and referral pathways within the system, explaining to people what the communication mechanisms are with Family and Community Services, as well as, as I said, talking about common conditions and a focus also on how to perform a child health check, which is really the basis of why we are sending these teams out there.

We are not sending them out to become experts in emergency care or chronic disease care for elderly people et cetera. They are not people who are suddenly able to perform at all levels within an Aboriginal medical service, but we feel quite confident that we are training them so that they can perform the sort of service that these children require—a comprehensive child health check. So there is certainly a large focus on running through the skills required to perform that child health check and the data collection required for that child health check.

Senator ADAMS—How many hours are involved in their training?

Dr Williams—The clinical day is a full day, so it is about an eight-hour day. The following day of cultural awareness is also a full day. On the previous evening, on the Sunday night, when teams have arrived at the deployment location or the training location, they are given orientation by ADF personnel as well as health personnel about how to cope with living in an isolated situation. So there is separate training for that, although also on the day that we do the clinical training we talk to people about what their psychological needs might be and what to do if they feel that they are particularly stressed or finding it difficult in the circumstance that they are in. We have an agreement with the Bush Crisis Line that people can ring that service and utilise that service if they are finding that the rather foreign situation they find themselves in, sometimes in an isolated community in a place they have not worked at before, is a

problem for them. They have got support structures for that, as well as the team around them and the local health team. There is also psychological support, if necessary.

Ms Podesta—One of the things that is important is that we take a lot of time in the development of a team. While there have certainly been a significant number of people who have indicated their willingness, one of the things that we take really seriously is making sure that we have the right balance of skills and experience. So, most of the people who are deployed have had previous rural or remote experience. We have only taken doctors who have significant general practice or paediatric experience at this stage, and all teams have to have at least one member who has had rural, remote or Aboriginal health experience.

One of the things that we do within the team building is to get people to share that experience and support each other, because we recognise this is about deploying significant numbers of, in many cases, urban based professionals who have an enormous will to do something, but we need to make sure that they are as well equipped as possible to be able to work together to do that. By and large, the teams have been extremely successful—I guess surprisingly so, because it is a big challenge; it is a big stretch in many ways.

Senator ADAMS—It certainly is. I have a lot to do with CRANA, so I am fully aware.

Ms Podesta—They have done a fantastic job.

Senator ADAMS—I thought the program was longer than one day.

Ms Podesta—They were extraordinarily positive and helpful to us. We would not have been able to have delivered the training at such a professional level without their early involvement.

Senator ADAMS—I tried to ask a question about CRANA's funding and somehow I ended up in the wrong place. But I might just say now that probably their biggest concern is the fact that they are only funded every six months for a six-month cycle. Therefore, they have difficulty trying to keep staff. Because they cannot keep them they do not have that continuity. They do not know whether their contracts are going to keep going. So that might be something that you could look at on their behalf because it is very difficult.

Ms Podesta—We would be happy to raise that with our colleagues in the workforce division, Senator.

Senator ADAMS—Good, thank you. We found it rather difficult trying to work out where all our questions fit in. That was one that escaped me. Something I would like to ask about is the nurse home visiting program. You were saying how important it is to have rural and remote nurses involved in the child health checks Why does the nurse home visiting program only have one nurse on it?

Ms Podesta—Senator, are you making reference to the program reference group?

Senator ADAMS—Yes, that is correct.

Ms Podesta—Okay. Senator, the program reference group has met twice for the nurse home visiting program. It has been looking at the evidence in regard to the replication and adaptability of the program that has been delivered in the United States and the UK. We have

brought together a range of people with expertise in regard to paediatric nursing and Aboriginal health experience to provide that advice to the department.

We have certainly been approached by CRANA recently offering their services to us and we are certainly talking to them. We are going to bring together a range of nursing organisations to talk with us about how nurses can contribute further to the development of the program, Senator. I will just state though that it is important to know that the program is not intended to be delivered in the first sites in remote communities. The program is going to be based in communities with significant numbers of newborns born within that area. We do not anticipate that remote communities will be the focus of the program, certainly in the beginning.

Senator ADAMS—The next question is: why is the nurse who is there not a specialist in remote or Indigenous nursing?

Ms Podesta—The nurse who has been providing advice to the program reference group is a nurse who is a specialist in home visiting Aboriginal families. That is what she does now. Now she runs a very successful and important Aboriginal and home visiting program. Her experience in that program has been invaluable to the program reference group, Senator.

Senator ADAMS—Thank you. That is good. Coming back to the child health check program, I just want to know the process for the follow-up monitoring and specialist treatment when it is required.

Ms Podesta—Do you want to know the process?

Senator ADAMS—Once a child has to go further for specialist treatment, what is the process that is required for that child to receive it?

Ms Podesta—I will start and we can add additional information if I have not given enough information. The planning and the follow-up service delivery is undertaken on a regional basis and it occurs in tandem with the child's health service and the Northern Territory government in terms of hospitals to be able to make sure that there is a smooth transition for the child through the health system. As we indicated when we were replying to a previous question, it is important in regard to this that the treatment pathways for the child are made appropriately and that the child is not just referred without any linkage back to their regular health service.

That is one of the reasons that, when children get their child health check, the information goes back to their usual health service and a decision is made about making sure that any additional treatment that is required before specialist services are undertaken. The paediatric liaison unit, which is based within the hospital system part of the Northern Territory government supported by us as part of the child health check, does the coordination between the hospital, the child health check and in most cases the family. So depending on the nature of the follow-up treatment that is required, there is a different pathway for different things. It really will depend on what the presenting symptoms are, what the diagnosis is and what the child needs. It varies significantly.

In most cases, about 30 per cent, the follow-up treatment that is required is undertaken by the child's normal health service, the primary health care system. The child health check

information goes back. Their doctor, and in most cases a nurse, follows through with the follow-up treatments. If the child also requires referral to a specialist service, that is undertaken in conjunction with the child's doctor or nurse at their clinic, the paediatric liaison unit and the hospital, if that is the most appropriate place. So it is a process of working in tandem to make sure the children are not lost.

Senator ADAMS—We are getting through the practical issues with some of the families. If the child has to go to Adelaide or to Darwin —we will just look at the Territory—and the parents are not able to speak English or communicate or have not been to a city, what support have you got for them?

Ms Podesta—Senator, I think that is a really important question, and it is one of the reasons that we have made sure that this process is undertaken and embedded within the normal health care system. What will happen is in most cases the child will be referred. If they are going to a service which is a hospital-based service, in most cases the children will be referred to the regional hospital. We will use Central Australia, which is where we started and about which we have the most information so it is probably the easiest to explain. In most cases the children will be referred to Alice Springs Hospital. What we have done is we have organised transport and accommodation support for the children and their families, interpreter support, if that is what is required as well. So all of those additional services are provided as part of the follow-up treatment and the follow-up funding that is provided through us.

Senator ADAMS—So they have a liaison person to meet and greet, and make sure they get back?

Ms Savage—Certainly the services will be provided, particularly the hospital-based services, by the Department of Health and Community Services. Because that is their normal business anyway, it is done in a more concentrated way. Certainly the hosting, escorting, and all of those other issues that are so important to make the child and family feel comfortable about their medical care, will be available.

Senator ADAMS—Right. It is good to hear that that is happening because when we did our patient assisted travel inquiry in Alice Springs, the evidence that came forward was certainly not what you are telling me. So if that has improved, that is very, very good.

Ms Podesta—Senator, I guess it is fair to say that the child health check process and follow-up has a guarantee of a range of services that are made available as part of the follow-up. That is why we have worked so closely with the primary health care services and with the hospitals and the Northern Territory government to make sure about things as much as possible—and, Senator, let me really emphasise this: we do not want to underestimate how hard this is. This is a very complex process. All of us who work in Aboriginal health know that the transport of patients from remote communities to a hospital for a successful follow-up service is a big ask. Every hospital knows that that is a big ask. It is about being able to undertake the cultural and the logistical issues. But to the degree that it is possible, the planning and the additional resources have been put in place to make sure that happens. I do not want to leave you with the impression that for every single child, it will work smoothly. We know it is hard. We know it is going to be hard.

Senator ADAMS—No, that is all right.

CHAIR—Ms Podesta, do they take the kids home as well?

Ms Podesta—Yes, Senator, they do. So the children and their family are transported to the hospital. They are accommodated and if they need follow-up care as a result, they also get the transport back in. Really part of it has been about being able to schedule within resources, and we use Alice Springs because we know that the best.

CHAIR—Sure.

Ms Podesta—Within Alice Springs, it is the additional accommodation, the transport arrangements as well as theatre time, theatre staff, nursing staff. That is why we have done it in particular around ENT. There are four blitzes that the hospital has set which is about bringing the children in. So the children for those ones, for example, if they have needed medical attention at home, and they are having their ear-mopping antibiotics, if that is what they need, have their operations scheduled and the liaison is happening back to their primary health care services, their communities, the transport and the accommodation. To the degree that it can be managed as well as possible, knowing that these are people with chaotic lives in some cases, being able to bring kids in at the right time, I think, we are feeling confident that it is on track.

Senator ADAMS—Great. I am very pleased to hear about that. I just want to come back to the actual checks that have been done with the intervention. How many of these checks have determined evidence of abuse? What is the process, if abuse is suspected or determined?

Dr Williams—The processes that we ask our teams to follow are the processes that usually apply in the Northern Territory. As I was saying before, we have not set up a parallel process. We expect our teams, as per the training that we give them before they go out there and the resources and documentation we give them, to report any case of suspected child abuse or neglect through family and community services in the normal way, and there have been cases of referrals to family and community services. We do not have a breakdown of whether children are being referred for one reason or another. There are a number of reasons why you might be sent with a referral or a report might be made to family community services, and it may be because of poor growth or difficulty establishing the care circumstances of the child. Another example is sexual abuse. We do not break down our referrals into why a referral was made for a particular child in the data collection that we do, but we do measure how many children from our process do have a referral to family and community services. We know that at the moment about 0.7 per cent of children who are seen are referred, for one reason or another, to the Northern Territory family and community services.

Senator ADAMS—And, if any abuse has been reported, they then have a process to follow through?

Dr Williams—Exactly.

Ms Podesta—That is right, Senator. Mandatory reporting guidelines are very specific about the pathway there. One of the things that I think Dr Williams referred to, one of the things that we make clear to the teams, are the guidelines in the CARPA treatment manual about sexual abuse and sexual assault of children—what they need to do if they suspect, how they refer, how that is undertaken. As Dr Williams indicated, we are not interested in trying to set up a parallel reporting system. We want to make sure that this is done appropriately with

the same protocols, respect and responsiveness that would be required by any healthcare professional working within the system.

Senator ADAMS—What requirement is there of parents to ensure that their children attend the child health checks? I mean, you can only have the children who appear. It is very difficult to get other children who have not been brought in. Is there any requirement on the parents?

Ms Podesta—No, there is not. There is no requirement. It is a voluntary check.

Senator ADAMS—So it does not fall as part of the shared responsibility agreement at all.

Ms Podesta—No, it does not.

Senator ADAMS—What is the number of additional health workers who have started work in the Northern Territory since the Commonwealth intervention—as in health workers who have decided to stay in the Territory and work, not just transient ones?

Ms Savage—We have deployed 250 to do child health checks in teams. We have feedback that up to 10 people have gone back and provided locum services for a longer rather than shorter period of time. Some are contemplating or have taken up employment. So the feedback so far is looking very positive about the extension, I guess, of people's interest in taking up positions permanently in the Northern Territory. It is a small number, and I do not have a fix on how many there are at this point in time, but it is looking very positive.

Ms Podesta—But that is an amazing number, in reality, because the 250 people in nearly every case already have a job. So what has happened as a result of 250 people being deployed from, in most cases, other parts of the country is that they have come, they have had three weeks in an Aboriginal health service or in a community and they have said, 'This is something I want to do.' We think that is an extraordinary thing. It is not as if they are a group of people who are unemployed. They were working somewhere else and they have just made a decision they want to keep going, either in ongoing employment or in some other kind of ongoing commitment to this area. That is great. From the anecdotal feedback that we have had from the teams, as people reorganise their lives as a result of the experience, we think that we will be able to build on that significantly.

Senator ADAMS—What about Aboriginal health workers? Through having the teams going in and having local people involved, have you been able to encourage any more people to become Aboriginal health workers?

Ms Podesta—That has not been an objective of it. Aboriginal health workers are probably one of the greatest groups of employment of Indigenous Australians now. Health is one of the largest employers of Indigenous Australians anyway. One of the things that we know is that successful delivery and successful Aboriginal health services do attract Aboriginal people to work there because it is stable employment, they are important, they are good workplaces et cetera. We certainly have not been measuring whether we have had an increase in Aboriginal health workers as a result of the intervention, but I believe our workforce colleagues would be able to give information on the growth of employment of Aboriginal health workers because there has been an ongoing increase, particularly in the Northern Territory, where, because they are registered, they have a broader range of tasks that they can do.

Senator ADAMS—What is the breakdown of paid workers and volunteers with the intervention?

Ms Savage—The 250 personnel that we have deployed are all engaged on non-ongoing contracts. Although they have expressed their interest and registered as volunteers, certainly in the first call they are engaged as non-ongoing employees. All of them, therefore, have been paid.

Senator SIEWERT—I want to specifically turn to the provision of information to Aboriginal health services. I am aware of the time, and I have questions on petrol sniffing and a specific set of questions that hopefully will not take long. Do service providers such as Aboriginal medical centres and health councils have access to service activity reporting and Medical Benefits Schedule data?

Ms Podesta—The service activity reporting data is owned by the Aboriginal health service and that provides that information to our department.

Dr Williams—They receive their own Medicare billing. Each service would be aware of what their own billing circumstances are. In the course of information sharing and education from Medicare Australia, they visit Aboriginal medical services and talk about the billing patterns and practices in medical services, and basically try to encourage medical services to maximise their use of the MBS, particularly with regard to preventative healthcare items. So in the course of that services would become aware of what other services and doing and what they are achieving in terms of MBS income, but you would certainly have access on a real-time basis to what you are billing.

Ms Podesta—And we do an annual report of service activity area reporting, which is a national profile of the funded activities, which is published by ourselves and by NACCHO. It is de-identified data, but it is able to report on the types, nature, prevalence et cetera of activities undertaken by Aboriginal health services. That is a public document which I am not going to table because I do not have 12 copies.

Senator SIEWERT—That is produced every 12 months? You said it was annual?

Ms Podesta—Annually.

Senator SIEWERT—The issue that has been raised with me is that some of the organisations want more regular updates of the information to assist their decision-making analysis. Would that information be available more regularly if they ask for it?

Ms Podesta—We have an ongoing investment program in patient information recall and IT systems within Aboriginal health services, and we have a contract with the Aboriginal Health and Medical Research Council of New South Wales to do a thing called SAMSys, which is a data collection and analysis project. We have invested in that project. It has been very successful. That information is made available to services. I do not know what else we might help.

Senator SIEWERT—How often is that information made available.

Mr de Carvalho—The data that is made available to services through SAMSys is available as soon as it is done, when it comes to us, or they have a choice of entering their own data online into SAMSys. Most services choose to enter their SAR data either directly to

the department—or there is now, since just this year, an online mechanism for entering that SAR data. Before we can provide it back to services we have to go through a process of what we call cleaning or cleansing that data. We take the view that we are not necessarily responsible for providing data back to the services, even though it is the data that they have provided. But, if it is coming from us, we need to ensure that it is actually correct. What we find is that often the data either has been misentered or is inaccurate. So we go through a process, which unfortunately at this time takes a lot longer than I would like it to, of cleaning. There are two processes of cleaning. The input edit process is the time-consuming process. It actually involves checking all the forms that are submitted and then ringing up the services and making an appointment time to go through with them the reports that they have provided to check that what we have got matches their own records. That is done by OATSIH in house. We have three staff who work on that and, as I say, it is a time-consuming process that I would like to speed up.

Senator SIEWERT—When you say time consuming, what is the turnaround? Is it months?

Mr de Carvalho—It is months, yes.

Ms Podesta—There are a lot of services. Because we want the data to be accurate, the quality of the input has meant that there is a very high investment of resources to ensure the accuracy of the data. Something that is under active review within the office is how we can make that more efficient and more effective.

Senator SIEWERT—Thank you.

Senator HUMPHRIES—I am not sure if this has been asked already, but I was looking at the New Directions: Indigenous Children policy document, where it talks about replacing the home visiting program which had previously existed with a comprehensive nurse led home visiting service which promised 20 visits in the first year and 12 visits in the second year. Is that under that program outcome?

Ms Podesta—The New Directions program includes a home visiting component, and the health at home program has been continued by the government.

Senator HUMPHRIES—Has that been continued?

Ms Podesta—Yes.

Senator HUMPHRIES—So is the commitment to provide $37.4 million for this new service in addition to what is already in existence with the home visiting program?

Ms Podesta—The $37.4 million is the home visiting program. It is help at home plus. It was the program that was announced in the previous budget.

Senator HUMPHRIES—I understand, but the commitment that was made before the election, and I will read it, was that they would build on the $37.4 million fund for home visiting provided in the 2007-08 budget to provide a comprehensive nurse led home visiting service of up to 20 visits in the first year and 12 visits in the second year. So that has continued. That is simply a continuation.

Ms Podesta—Yes, it is.

Senator HUMPHRIES—But I note that on 21 November a savings proposal was submitted to Treasury—that was, of course, before the election—indicating that they intend to cut the program through which the $37.4 million was provided from 1 January this year. Has there been any cut to the program through which this service is provided?

Ms Podesta—No, there has not.

Senator HUMPHRIES—Where can I find information about that? So the program is operating exactly as it was before? There is no change in either its funding base or the nature or scope of the program?

Ms Podesta—The nurse home visiting program is consistent with New Directions. The government has announced that the program will be rolled out and it will, as well, be part of the New Directions program, which will also include home visiting services within Aboriginal health services.

Senator HUMPHRIES—How was the commitment measured for 20 visits in the first year and 12 visits in the second year? Is that 20 visits to a particular community, a particular household, or what?

Ms Podesta—It is to families—to mother and child.

Senator HUMPHRIES—Who will be eligible for those 20 visits?

Ms Podesta—The program has an eligibility requirement. In Australia the program will be made available to an Aboriginal woman who chooses to register with the program, who is pregnant with an Aboriginal or Torres Strait Islander child.

Senator HUMPHRIES—Is this intended to replace the sorts of services that might be available in an urban area, through a child health centre, a GP or something of that kind? Is it intended, for people in areas where these services are not abundant, to provide for pregnant women?

Ms Podesta—No, it is not. It is an additional service provided to families who will require additional support as part of the transition through pregnancy and through early childhood. One of the important components of this program is to link in extensively with the prenatal services and early childhood services within a community. The nurse home visiting component will provide a personalised support program for that family, for the mother, the child and other members of that family, to help them have a successful transition through early childhood.

Senator HUMPHRIES—Are there enough nurses to provide the program?

Ms Podesta—Our experience has been that since this program has been announced there have been nurses constantly calling us to tell us they want to do it. Despite what people thought—that there would not be nurses able to do this —the international experience has been that the workforce requirements have not been difficult and that the retention of nurses within this program, because it is a very satisfying program with very satisfying outcomes for most people, has been very high.

Senator HUMPHRIES—That is very good. I have just one last broader question which this program perhaps cannot answer, but it is about the commitment to closing the 17-year gap

in life expectancy. Obviously that is a very laudable objective. The commitment that was made by the government was to close that gap within the next generation. Can I be clear about what that means in terms of the time frame? What do we call a generation?

Mr de Carvalho—The general understanding of the term ‘within a generation’ is 25 years.

Senator HUMPHRIES—So we are hoping that the objective of aligning the life expectancy of Indigenous and non-Indigenous people can be met within 25 years?

Mr de Carvalho—That is the target that the government has set and that has been endorsed by COAG.

Senator HUMPHRIES—If I am here in 25 years time, I will be asking about how well that has gone. Thank you.

CHAIR—Are there any further questions under this program outcome?

Senator SIEWERT—I have some on petrol sniffing. I have a number so I will put some on notice. Can you provide an update on the take-up of Opal in Alice Springs? Are all the petrol stations now stocking Opal?

Ms Podesta—All 11 services stations in Alice Springs have been supplying unleaded fuel since March 2007.

Senator SIEWERT—So there is no premium unleaded? Is any non-Opal fuel being supplied?

Ms Podesta—Premium unleaded and diesel continue to be available in Alice Springs.

Senator SIEWERT—What is the process? I know we have talked about this ad infinitum. What is the process of ensuring that access to premium unleaded is restricted?

Ms Podesta—We have done a number of things. It is one of the things that concern us as well. We have asked fuel companies to take steps to secure premium stocks to ensure that it is not misused. We are also developing the guidelines for the responsible sale of premium unleaded petrol. That will be provided to the fuel retailers. These outline the preferred standards for the responsible sale of that petrol. We have also had extensive discussions around security measures.

Senator SIEWERT—Are the petrol stations securing bowsers with premium in them?

Dr Walker—The petrol stations are doing it differently in different places, but the petrol stations have provided training to the bowser operators and console operators. While there are a few service stations which are securing their bowsers, most have taken the view of trying to ensure that small quantities of premium are not sold in jerry cans et cetera which are more likely to be used for petrol sniffing. That is the approach that the majority of service stations are taking. It is more of a practical approach than trying to lock up every single bowser.

Senator SIEWERT—Thank you.

Ms Podesta—As you know, Senator, there are no regulations.

Senator SIEWERT—I know.

Ms Podesta—So it has been a mixture of education, community pressure, support and ongoing communication.

Senator SIEWERT—When are the guidelines that you spoke of likely to be ready?

Ms Podesta—That will be very soon. We are just getting some final verification about data in those guidelines.

Dr Walker—The majority of the fuel distributors and outlets have seen a draft version and are providing some comments. We are now finalising that document. Hopefully we will get it out very shortly.

Senator SIEWERT—I understand that in central NT there are a number of roadhouses that still are not supplying the non-sniffable fuel. Is that correct?

Dr Walker—As Ms Podesta has mentioned, we have no powers to mandate the use of Opal fuel. The majority of retailers have come on board and are using it and have been very supportive of the government's program. There are still some in the expanded central desert region which are not currently supplying Opal fuel.

Senator SIEWERT—What has been done to encourage them?

Dr Walker—We have taken a number of approaches to try to encourage them. My staff have had a number of conversations, phone calls, as well as visiting many of these service stations. We are also talking with the local organisations in those communities and in those regions to ask them to put some pressure on those fuel companies, fuel distributors and outlets.

Ms Podesta—I believe some people have named them in parliament.

Dr Walker—Some people named them in parliament.

Senator SIEWERT—Yes! But that does not seem to have had an effect, by the sounds of it.

Dr Walker—No, Senator.

Senator SIEWERT—Is there a greater incidence of petrol sniffing associated with those roadhouses that are still not stocking non-sniffable fuel?

Ms Podesta—We do not have evidence of that. There are lots of stories and anecdotes, but there is no evidence which directly correlates to location of sniffers and access to roadhouses that are not supplying Opal.

Senator SIEWERT—Is that because that information has not been collected?

Ms Podesta—People who choose to sniff petrol come from different parts of Central Australia, and if they wish to access that petrol they are prepared to travel to get it. It would be extremely difficult to draw a correlation between where they normally reside and where petrol that is not Opal is supplied.

Senator SIEWERT—I have also had it reported to me very recently that there has been a noticeable increase in the number of sniffers in the Pitlands. Have you heard that? I have just had a couple of phone calls and that is why I am asking—because I do not know if it is true or not.

Ms Podesta—The latest information that we have from the Nganampa Health Service does not correlate with that. There might be anecdotes and stories about that. We know there have

been some reports of occasional outbreaks of petrol and paint and glue in Alice, and we have certainly worked with CAYLUS in regard to that and other local services who immediately go in and work. We work very closely with Nganampa Health. As you know, the secretary has an ongoing relationship with the Pitlands, so we continue to share data with Nanapa Health around conditions. We have had no information provided to us at all that there has been an increase in petrol-sniffing on the land.

Senator SIEWERT—I will place the remainder of my questions on notice.

CHAIR—Ms Podesta, I thank you and your team. We will now move on to outcome 11.

[12.17 pm]

Senator BOYCE—I start off with one that you may or may not be able to answer. Minister O'Connor, the Minister for Employment Participation, announced some developments in consultation around the Welfare to Work program, particularly in terms of getting people with mental health issues back into the workforce. What involvement, if any, has the department had in that?

Prof. Calder—We have not had direct involvement.

Senator BOYCE—Would you anticipate being involved in the consultations? What experience resides in this section in terms of people with mental health issues in the workplace?

Ms Halton—Senator, obviously we have had quite a deal of expertise in the whole range of mental health issues. We are consulted by other departments. It is not our business to intrude into their business, but if they are looking for specialist information assistance advice, we have done this on a number of actions historically. As the officer, I think, has indicated I am certainly not aware of any approach on this, but if we were approached, obviously we would be in position to provide whatever specialist advice or indeed contacts or whatever that were required.

Senator BOYCE—Again, a general question: I spoke to a number of people who provide respite services and the like preparatory to this meeting and found a level of satisfaction that I must admit I had not come across for some considerable time with the amount of funding that is now available and about to become available. I have a general question in terms of where you see yourselves being at with rolling out that package of funding that came in 18 months or so ago. Some of it has begun to hit the ground and some of it is still to come. Is that the case?

Prof. Calder—Most of it is ready for full implementation this financial year and then it will be a case of maintaining and working closely with state and territory mental health authorities around some of the aspects that are for us to organise. Better care coordination is one of them and that is quite hard because it is an alignment of services between clients as well as around them. So there is an ongoing round of meetings that are focused on getting our services systems working more collaboratively around clients, and that will take probably the life of the program to maintain continuous improvement. We have a progress report that we are happy to table against all of the measures that are under the COAG better access measure.

Senator BOYCE—That would be very helpful, thank you. That would be great.

Prof. Calder—It is on the website.

CHAIR—Can I just clarify something. That is the same progress report that is on the website?

Prof. Calder—Yes, it is. We just routinely update it every month.

CHAIR—I just want to make sure it was the same one.

Senator BOYCE—What level of the funding has been expended to date or to a convenient date?

Prof. Calder—Just bear with us, Senator.

Mr Smyth—The measures now go over three government departments. I have some information here in relation to how much expenditure took place last financial year and what are the budgeted amounts for this financial year, for the 18 measures that the Commonwealth government is responsible for.

Senator BOYCE—And this includes under- and overspends?

Mr Smyth—I do not have a figure that is as of today because, as I said, that relates to other departments. There are contracts being written as we speak in relation to a number of measures. I suppose it is a bit of a moving program in relation to that, but I am more than happy to table what those budgeted amounts were and what the expenditure was last year as well, Senator.

Senator BOYCE—Could you just give me the overall figure?

Mr Smyth—Senator, I do not have on overall figure for everything. I have it under each of the measures that the department is responsible for: what was spent last year and, as I said, what the budget forecast for this financial year is as well.

Senator BOYCE—Thank you. That would be good if you could table that.

Mr Smyth—I am happy to table that.

Senator BOYCE—Anecdotally, I have had people tell me that there has been some difficulty in getting staffing for respite service development. Has that come to the attention of the department?

Prof. Calder—Senator, respite services are within FaHCSIA and at the state and territory level. Ours are around the clinical service delivery.

Senator BOYCE—All right. On that point, my questions are in the wrong area so that is it.

Senator WEBBER—There have been some changes since we met last time but some things never change. How is the relationship between the work you are doing and FaHCSIA going? What is the interconnection there? Is it all working well in terms of the delivery of mental health services?

Prof. Calder—There are regular meetings between ourselves. We have an interdepartmental committee, which we have discussed before, and we have state and territory COAG coordination committees. They meet very routinely and regularly.

Senator WEBBER—And we are effectively and efficiently rolling out program delivery?

Prof. Calder—It is very tightly collaborative rollout, yes.

Senator WEBBER—The last time we discussed these issues, particularly on all the new Medicare rebates, numbers and whatever, I was after any evidence as to whether these programs were actually reaching new mental health patients or whether it is just a transferral of existing patients into new services. Have you got any new fresh data on that for me?

Prof. Calder—Can I start by saying that we will not claim it to be evidence at all because that would require a fairly extensive evaluation process, which we are in the process of planning.

Senator WEBBER—I was going to say that I am a lot sloppier in the use of the word 'evidence' than you are, Professor Calder.

Prof. Calder—There is some data that I will get Mr Smyth to take us through in terms of the volume of the client groups that are accessing services, but it is fair to say that it is a reasonable deduction to assume that there is a high rate of new client use as well as, possibly, realignment or reassignment of client services.

Mr Smyth—Senator, as of 31 December 2007, we are now up to about 2.7 million occasions of service under the better access initiative. That is 2,726,144 occasions of service. The vast majority of items nationally are the registered psychologists items which are approaching one million—that is, 986,730. The next highest item number is GP mental health care plans of which there have been 530,713. Following that, we have the clinical psychologist items of 485,582 and then GP mental health care consultation items, 452,937. So it is a significant uptake across the board. There have been 726,000 patients who have received services under the better access initiative.

Senator WEBBER—That is good news. With the GP mental health care plans, the last time we met I raised some concerns that have been brought to me about the robustness of these plans: some people were just writing a one-page letter and claiming it was a plan. Has there been any work done on ensuring that these are actually adequate, decent mental health plans and therefore we are effectively delivering services to these people?

Prof. Calder—Senator, I think we probably went into the detail last time of how we were approaching that. There has been a great deal of work done on education and training and information and orientation approaches, so we have been working with the Australian General Practice Network on information and orientation through all the divisions to general practitioners involved into this program as to how it works, what is expected, and how they can engage within it and how they can best support their clients. We have been working with the Mental Health Professionals Association, which is a combination of four of the key providers in this area, including RACGP and psychiatrists, mental health nurses and psychology—all their associations —and that is developing a quite extensive education and training program that we will roll out over the next several years, once we have it in place.

Senator WEBBER—When do you think we will have it in place?

Mr Smyth—Towards the end of this financial year, hopefully in the next two to three months. We are awaiting finalisation of a draft report which is the draft package that they have developed for the rollout. As Professor Calder said, in the interim there are information

and orientation sessions being conducted across the general practice network at the moment. But we would anticipate before the end of this financial year to have put that into contract potentially with the Mental Health Professionals Association, auspiced, at this stage, by the Royal Australian and New Zealand College of Psychiatrists, and to commence rollout hopefully before the end of this financial year.

Prof. Calder—And the work that has been underway, Senator, has been an environment scan to find out what the issues were in the sector, what they did not know, what they needed to know and what practices were in place. That has then informed the development of the draft package, which is being brought together now.

Senator WEBBER—And we are confident that that package is going to make? I am not in anyway reflecting on the work you are doing. It is just that I remember when some of us were on the Senate Select Committee on Mental Health, we met with—I do not think they were called the AGPN then; they were called something else—and we talked about the old Better Outcomes training. The issue that was raised was that six hours of training was a big chunk of time and it was a bit too onerous. That made me quite alarmed, which is why I am pursuing this in terms of what they know and how they go with mental health problems.

Prof. Calder—From our perspective, the most exciting thing about this process and package is that it has been developed by four professional bodies working together in collaboration around each of their issues and those of each other. That is almost unique in health, education and training. Because it has those four bodies working together, we have a reasonable level of confidence that the professional membership will be similarly enthused and able to work together to share education and training on the ground. The emphasis will be on locally delivered education and training, regionally coordinated, so there is backup and support. So it is close to an ideal type —

Senator WEBBER—How is that going to go in rural and regional areas? I will return to the hoary old thing—how is that going to work in my home state outside Perth?

Prof. Calder—It will work through the members on the ground. Wherever there are members, there will be a conduit for this educational training. The professional body is looking hard at how to resource people to be involved in the education and training in local areas.

Senator WEBBER—There are some places in Western Australia where the divisions have only just established themselves or where they do not have any coverage.

Prof. Calder—But it is not just the divisions.

Senator WEBBER—No, I understand that. But if you cannot find a GP you usually cannot find a psychiatrist or whatever.

Prof. Calder—But you may be able to find a psychologist.

Senator WEBBER—Yes. You can find more of them than you can other professionals.

Prof. Calder—It is very good coverage in that sense.

Senator WEBBER—Absolutely. But we have discussed that. I have plenty more questions, but I know my colleague Senator Humphries has some questions and I know we are running out of time.

Senator HUMPHRIES—Thank you, Senator Webber, and thank you, Chair. I have just a couple of questions. I just want to be reassured that the COAG mental health initiative from the 2006-07 budget, to the extent that it was in place before the election, is still in place now—that is, there are no proposals to alter or —

Prof. Calder—Are you talking about, as it has been described, the $1.9 billion package?

Senator HUMPHRIES—Yes.

Prof. Calder—That is what we have tabled a progress report about, Senator, so all the detail of where it is tracking is in that report and it is on the website.

Senator HUMPHRIES—There are no programs which have been discontinued, but there are some modifications to those that are already there. Is that correct?

Mr Smyth—Any modifications—there was a minor shift in some finances with the better access initiative education and training component to rural and remote and drought assistance—occurred last year. But in terms of the overall package, nothing has changed and Minister Roxon has made statements in relation to a commitment to the ongoing implementation of the COAG package.

Senator HUMPHRIES—I read the speech of the now Minister for Health and Ageing, Minister Roxon, of October, entitled 'Leadership in Mental Health'. I just want a bit of information about some of the things she spoke about there. There was talk of an $85 million plan to tackle antenatal and postnatal depression. Do we have any information about where this policy will be rolled out and how many visits or consultations it will generate?

Prof. Calder—Senator, we are working with the states and territories on developing an implementation strategy, so it is somewhat early to answer the detail of this, but I will ask Ms Krestensen to take you through some of that.

Ms Krestensen—As Professor Calder explained, it is an election commitment at this stage and has not yet been converted through the budget process into a budget commitment. We are in the early stage of discussions with states and territories in the context of the perinatal action plan produced by beyondblue, but it is very early days. The detail of this particular measure has not yet been settled, Senator.

Senator HUMPHRIES—But it is expected to be rolled out via the states and territories rather than directly by the Commonwealth?

Ms Krestensen—The actual million commitment itself, Senator, involved a total of $85 million, of which $5 million was to go to beyondblue for oversighting the implementation of the plan; $20 million was to go to the expansion of the Better Outcomes ATAPS program, access to allied psychological services; $30 million was to go to states and territories to roll out aspects of implementation of the plan and a further $30 million was to be sought from the states and territories through an invitation to them to invest in the plan as well.

Senator HUMPHRIES—We will get progress on that, hopefully, at the next budget estimates. One last question: there was a comment in the speech about seeking the release of data which will allow proper evaluation of the MBS mental health items to ensure these important services are getting where they are needed most. I am not sure whether this question should be addressed to the minister or somebody else, but is that information going to be released now that the Labor party is in government? There was a reference in the speech of now Minister Roxon in October last year to problems that she had encountered in obtaining release of information to allow the proper evaluation of MBS mental health items. She said, '… to ensure these important services are getting to where they are needed most.' Can I ask: will that information now be released to allow that evaluation to occur?

Ms Halton—Senator, that is a matter that has not yet been put to the minister for consideration.

Senator HUMPHRIES—All right, I will ask about that in May.

Senator WEBBER—I have one last question, as time is pressing. I want to go to the issue of improving the capacity of workers in Indigenous communities. I note one of the recent programs involves funding for ORYGEN to deliver mental health first aid to OATSIH funded services. Can you give me some more detail on that?

Mr Smyth—Senator, that program was actually managed in OATSIH. Unfortunately I do not have the actual specifics in relation to that. I do know that ORYGEN have the intellectual property rights for mental health first aid so that is why.

Senator WEBBER—I will follow that up at a later time.

CHAIR—Senator McLucas, in terms of the process we asked FaHCSIA about yesterday, with the community affairs mental health committee being convened at the moment, we would like to arrange a briefing with the department before their formal submissions and hearings. I think it is more useful to have discussions.

Senator McLucas—We would be very happy to help that process.

CHAIR—We are doing the same with FaHCSIA. It might even be useful to have them together but it will probably be in the next sitting week. We are talking to the secretary about that in terms of time. We will go through the process of getting that.

Senator McLucas—And you might put your mind to whether or not you want the briefings together or separately, and we will accommodate the request.

[12.39 pm]

CHAIR—We are now moving to the final agenda item, which is outcome 10, National Health and Medical Research Council. We have two senators asking questions on this one.

Senator HUMPHRIES—I have some questions for NHMRC about diabetic retinopathy guidelines. I understand that the current guidelines are now more than 10 years old and that for some time a process has been under way to review them. Has the NHMRC received a final version of the review of the guidelines yet?

Prof. Anderson—I am informed that the draft guidelines were completed in the middle of 2006 and then they came to the National Health Committee, which is one of our principal

committees. That committee felt that there were significant issues and that needed further work. We returned the guidelines then to the department with a request for further work. That work has been negotiated with those who might do it, and the work commenced in the last quarter of 2007. We felt that the rework was pretty important and needed to be completed. We are still waiting to hear back where they are up to.

Senator HUMPHRIES—I would imagine that, in an area like this, having guidelines which are 11 years old must present a problem to practitioners and that there must be some urgency in getting new guidelines in place.

Prof. Anderson—Yes.

Senator HUMPHRIES—How much funding has been allocated to this review so far?

Prof. Anderson—The funding is through the department.

Senator HUMPHRIES—Can anyone else answer that question?

Ms Halton—Not here, no; we will have to take it on notice.

Senator HUMPHRIES—Okay. You might also take on notice the question of how much of the allocation was spent on the literature review.

Ms Halton—Yes.

Senator HUMPHRIES—I indicate I am actually asking some questions here on behalf of Senator Patterson. Were the committee members paid? I assume this is a reference to that panel that you spoke about before, Professor Anderson.

Prof. Anderson—My expectation is that they would be paid a sitting fee, but we should take that on notice.

Senator HUMPHRIES—I might put the rest of these questions on notice because I think they all go into further depth. Obviously I need to get that taken on notice. Thank you.

CHAIR—Professor Anderson, I am asking these questions on behalf of some of the other members of the committee. These are to do with the Cancer Australia link with NHMRC. We asked questions of Cancer Australia two days ago. In the research area, which has been of particular interest—the research and the focus on clinical trials—on the websites there is a cross-reference between working cooperatively between Cancer Australia in the research component and the NHMRC process. It would be useful for our committee, because we have an ongoing interest in this area, to have something from you about how that operates, where the current round of funding is—my understanding is that there is a batch going through at this time—and also exactly what the focus is in the cancer network at the moment.

Prof. Anderson—Thank you for the question. I guess most cancer research funds in Australia would be funded by the NHMRC.

CHAIR—Yes.

Prof. Anderson—When I get a moment, I will flick and I will give you the number. The agreement with Cancer Australia—which, as you know has focus in a particular area—is that we look at applications that come to them, or come to both of us, for project grant funding and do the initial peer review through our standard processes, which look at the scientific quality,

the relevance and importance of the research, and the ability of the researchers to undertake the research. We have committed to funding through the NHMRC all grants that apply to us, or perhaps to us and to Cancer Australia, that we would normally fund—in other words, before our funding cut-off. We then provide Cancer Australia with both the written peer review and the recommendations of our peer review panels. We provide all that material to Cancer Australia. They then run their ruler across it, according to their priorities, and undertake the decision making there. For the people who apply directly and only to Cancer Australia, we do the peer review and they do the decisions. If people apply to both us and Cancer Australia, if it meets our cut-off, we will fund it; if it does not, it goes over to Cancer Australia and they may, because there is still much excellent research there that could be funded. I hope that is clear. It is a complicated system.

CHAIR—I think because it is still relatively new there still is working through to see, from the point of view of people who want to get research dollars, what is the best model to go with and how they can best progress their actions. The other particular area was the audit of research that Cancer Australia have done. One of their core tasks was to do an audit of the all the research that has been done up until now. I spoke with Cancer Australia about that and they also said they work very closely with your organisation on that as well, which you would expect. How does that work?

Prof. Anderson—I must say very well, I am pleased to say.

CHAIR—That is positive.

Prof. Anderson—Just on the audit issue, we have a very good branch of the organisation that does evaluation and a lot of that material is on our website. It often requires a little bit of digging but it is there for the public. On the other issue of Cancer Australia and the process, I take the view that that is entirely a matter for Cancer Australia and its board, and the way they want to do it. If they wish to use our process, I am delighted to do so. We do the same for the cancer councils. This year we will do it for the National Heart Foundation. We also do it for a number of small charitable bodies. It means that, with our large-scale effort, the overhead cost to do the review of the grants can be reduced, and that is one advantage. But, as I say, we are here to help Cancer Australia and we will make decisions that best suit their objectives.

CHAIR—Is there any cross-membership in terms of your board and people the who work in the NHMRC umbrella and the various specialist groups that Cancer Australia have?

Prof. Anderson—I would have to take that on notice for the detail, but certainly from memory many of the people who serve on our panels, our advisory panels, our peer review panels—the hundreds of panels we have in NHMRC—are the same people, basically.

CHAIR—I would expect it would be, but I do not know. That is why I put the question there. I would expect that, with the knowledge that is across the country, there would be in some of those specialist research areas some crossover.

Prof. Anderson—Absolutely. As I say, from memory I can remember some names. We would be happy to map that for you.

CHAIR—That would be really useful. We have been asking generally about Indigenous services and some questions about programs and research programs that are funded through

NHMRC that have either a particular Indigenous focus or a number of Indigenous researchers. The other point we have talked with you about before is that there is academic qualification and academic professional research. Then there is a school that says that in some areas there is a great wealth of knowledge that does not meet that academic criteria. If we could get something on record about that.

Prof. Anderson—I am delighted to answer it because I think we have developed a good way of working on this over the last seven or eight years. First of all, on your general point about the research capacity of Aboriginal and Torres Strait Islanders, we have had a number of schemes—one, at least, an international scheme with Canada and New Zealand on the same issue—to try and build research expertise in younger Australians but also people who are working in the health system. More generally I have an Aboriginal and Torres Strait Islander Health Research Advisory Committee that reports directly to me. We have a road map that sets up what the organisation regards as relevant Indigenous health research. Each year special panels of both community members and researchers look at the grants that come in and provide our peer review panels with their view of the applicability—or anything they wish, actually—for the research grants. So, if people put up a proposal that they say will be of direct benefit to Aboriginal and Torres Strait Islander communities, it will have this extra grid run over it. We have committed to spending five per cent of our medical research endowment fund on Indigenous health. We are not there yet. As usual with academics, there are definitional issues around that, but it is increasing rapidly. It consists of not just research grants but these capacity-building grants that I talked about earlier.

CHAIR—The last question I have—and it disappoints me that there is 10 minutes left—is to ask whether there is any link between the research that is done under the NHMRC umbrella and the specialist research area at the Menzies centre in Darwin, which has a particular Indigenous health focus? I know I have used their work a lot.

Prof. Anderson—The Menzies school and Professor Carapetis and the other staff there hold a number of our grants, particularly in this area but not just in Indigenous health. Members of that institute are on our various committees, for example, including on the Aboriginal and Torres Strait Islander advisory committee. I guess a disproportionate amount of Indigenous health research goes there. But it is one of about a hundred organisations that we fund around the country—not just universities, institutes; other bodies.

CHAIR—That is it. Thank you very much. Ms Halton, as I said, it disappoints me that we have 10 minutes left. I did not organise this well at all. We could have used that 10 minutes more effectively in a program area. But I thank you and your team very much. I also thank Senator McLucas and, I think, Senator Stephens. Was she here?

Ms Halton—She was.

CHAIR—I am getting confused over the number of days. As always there will be a number of questions put on notice, and we will be in contact with the department for follow-up and any further discussion around that area. I thank Hansard and, of course, as always, the secretariat, who keep us honest.

Committee adjourned at 12.52 pm