COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

ESTIMATES

(Budget Estimates)

THURSDAY, 4 JUNE 2009

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SENATE COMMUNITY AFFAIRS

LEGISLATION COMMITTEE

Thursday, 4 June 2009

Members: Senator Moore *(Chair)*, Senator Siewert *(Deputy Chair)*, Senators Adams, Boyce, Carol Brown and Furner

Participating members: Senators Abetz, Back, Barnett, Bernardi, Bilyk, Birmingham, Boswell, Brandis, Bob Brown, Bushby, Cameron, Cash, Colbeck, Jacinta Collins, Coonan, Cormann, Crossin, Eggleston, Farrell, Feeney, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Hanson-Young, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Ian Macdonald, McEwen, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Nash, O'Brien, Parry, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

Senators in attendance: Senators Abetz, Adams, Barnett, Bilyk, Boyce, Carol Brown, Cormann, Colbeck, Crossin, Fifield, Heffernan, Humphries, Lundy, Moore, Siewert, Williams and Xenophon

Committee met at 9.00 am

HEALTH AND AGEING PORTFOLIO

Consideration resumed from 3 June 2009

In Attendance

Senator Jan McLucas, Parliamentary Secretary to the Minister for Health and Ageing

Department of Health and Ageing
Whole of Portfolio
Executive

Ms Jane Halton, Secretary
Ms Rosemary Huxtable, Acting Deputy Secretary
Ms Mary Murnane, Deputy Secretary
Professor Jim Bishop, Chief Medical Officer
Mr Richard Eccles, Acting Deputy Secretary
Mr David Learmonth, Deputy Secretary
Mr Chris Reid, General Counsel

Business Group

Ms Margaret Lyons, Chief Operating Officer
Mr Stephen Sheehan, Chief Financial Officer
Ms Samantha Palmer, General Manager, Communication and People Strategy
Mr Nathan Smyth, Assistant Secretary, Communications Branch
Ms Tracey Frey, Assistant Secretary, Business Group Task Force
Mr Joseph Colbert, Assistant Secretary, Corporate Support Branch
Mr Neil Dwyer, Acting Assistant Secretary, Legal Services Branch

Mr Leo Kennedy, Assistant Secretary, People Branch
Ms Sharon McCarter, Acting Assistant Secretary, IT Solutions Development Branch
Ms Ida Thurbon, Acting Assistant Secretary, IT Strategy and Service Delivery Branch

Portfolio Strategies Division

Ms Linda Powell, Acting First Assistant Secretary
Ms Shirley Browne, Assistant Secretary, Ministerial and Parliamentary Support Branch
Mr Dave Hallinan, Acting Assistant Secretary, Budget Branch
Ms Cath Patterson, Assistant Secretary, International and Inter-Governmental Policy Branch
Mr Damian Coburn, Assistant Secretary, Portfolio Strategies Branch

Audit and Fraud Control

Mr Colin Cronin

Outcome 1 - Population Health

Population Health Division

Mr Peter Morris, Acting First Assistant Secretary
Ms Jennifer Bryant, First Assistant Secretary
Ms Julianne Quaine, Acting Assistant Secretary, Population Health Programs Branch
Ms Sharon Appleyard, Assistant Secretary, FOBT Special Project Team, Population Health Programs Branch
Ms Jenny Bourne, Assistant Secretary, Immunisation Branch
Ms Cath Peachey, Assistant Secretary, Healthy Living Branch
Dr Masha Somi, Acting Assistant Secretary, Population Health Strategy Unit
Mr Bill Rowe, Assistant Secretary, Sport Branch
Ms Linda Addison, General Manager, Immunisation Procurement Project

Regulatory Policy and Governance Division

Ms Mary McDonald, Acting First Assistant Secretary
Ms Jenny Hefford, Assistant Secretary, Blood and Regulatory Policy Branch
Ms Alice Creelman, Assistant Secretary, Governance, Safety and Quality Branch
Ms Kylie Jonasson, Assistant Secretary, Research, Regulation and Food Branch
Mr Richard Bartlett, Assistant Secretary, Office of Hearing Services

Mental Health and Chronic Disease Division

Professor Rosemary Knight, Principal Adviser, Mental Health and Chronic Disease Division
Ms Virginia Hart, Acting First Assistant Secretary, Mental Health and Chronic Disease Branch
Mrs Colleen Krestensen, Assistant Secretary, Mental Health and Suicide Prevention Programs Branch
Mr Simon Cotterell, Assistant Secretary Drug Strategy Branch
Ms Meredith Taylor, Acting Assistant Secretary Chronic Disease Branch
Mr Jake Matthews Acting Assistant Secretary, Mental Health Reform Branch
Professor Harvey Whiteford, Principal Medical Adviser, Mental Health and Workforce Division

Therapeutic Goods Administration (TGA)

Dr Rohan Hammett, National Manager

Dr Ruth Lopert, Principal Medical Adviser
Mr Charles Maskell-Knight, Principal Adviser Regulatory Reform
Mr Craig Jordan, Chief Financial Officer, Business Management Group
Dr Larry Kelly, Head, Office of Devices, Blood and Tissues
Dr Leonie Hunt, Head, Office of Prescription Medicines
Mr Michel Lok, Head, Office of Manufacturing Quality
Dr Peter Bird, Acting Head, Office of Non Prescription Medicines
Mr Michael Smith, Head, Office of Complementary Medicines

Australian Institute of Health and Welfare (AIHW)
Dr Penny Allbon, Chief Executive Officer
Mr Andrew Kettle, Head, Business Group

National Industrial Chemicals Notification and Assessment Scheme (NICNAS)
Dr Marion Healy, Director, National Industrial Chemicals Notification and Assessment Scheme

Food Standards Australia New Zealand (FSANZ)
Mr Steve McCutcheon, Chief Executive Officer
Ms Melanie Fisher, General Manager, Food Standards Australia
Dr Paul Brent, Chief Scientist
Mr Dean Stockwell, General Manager, Food Standards New Zealand
Mr John Fladun, General Manager, Legal and Regulatory Affairs

National Breast and Ovarian Cancer Centre
Dr Helen Zorbas, Chief Executive Officer

Office of the Gene Technology Regulator (OGTR)
Dr Joe Smith, Gene Technology Regulator
Ms Elizabeth Flynn, Assistant Secretary, Regulatory Practice and Compliance Branch
Dr Michael Dornbusch, Acting Assistant Secretary, Evaluation Branch

Outcome 2 – Access to Pharmaceutical Services

Pharmaceutical Benefits Division
Mr Stephen Dellar, Acting First Assistant Secretary
Ms Sue Campion, Assistant Secretary, Community Pharmacy Branch
Ms Linda Jackson, Assistant Secretary, Pharmaceutical Evaluation Branch
Mr Declan O'Connor-Cox, Assistant Secretary, Access and Systems Branch
Ms Gay Santiago, Assistant Secretary, Policy and Analysis Branch
Dr John Primrose, Medical Officer
Mr Kim Bessell, Senior Pharmacy Adviser

Outcome 3 – Access to Medical Services

Medical Benefits Division
Mr Tony Kingdon, First Assistant Secretary, Medicare Benefits Division
Dr Brian Richards, Executive Manager, Health Technology and Medical Services Group
Ms Yvonne Korn, Assistant Secretary, Diagnostic Services Branch
Ms Samantha Robertson, Assistant Secretary, Medicare Benefits Branch
Mr Peter Woodley, Assistant Secretary, Medicare Financing and Analysis Branch

Professional Services Review
Dr Tony Webber, Director, Professional Services Review

Ms Alison Leonard, Executive Officer, Professional Services Review

Outcome 4 – Aged Care and Population Ageing

Ageing and Aged Care Division

Mr Andrew Stuart, First Assistant Secretary
Mr Keith Tracey-Patte, Assistant Secretary, Community Programs Branch
Ms Melinda Bromley, Assistant Secretary, Office for an Ageing Australia
Ms Bernadette Walker, Acting Assistant Secretary, Residential Program Management Branch
Ms Sallyanne Ducker, Assistant Secretary, Indigenous Aged Care Taskforce
Dr David Cullen, Assistant Secretary, Policy and Evaluation Branch

Office of Aged Care, Quality and Compliance

Ms Carolyn Smith, First Assistant Secretary
Mr Iain Scott, Assistant Secretary, Prudential Regulation Branch
Ms Fiona Nicholls, Assistant Secretary, Quality, Policy and Programs Branch

Aged Care Standards and Accreditation Agency (ACSAA)

Mr Chris Falvey, Acting Chief Executive Officer
Mr Ross Bushrod, General Manager, Operations
Mr Victoria Crawford, Acting General Manager, Corporate Affairs and Human Resources

Outcome 5 – Primary Care

Primary and Ambulatory Care Division

Ms Megan Morris, First Assistant Secretary
Mr Alan Singh, Assistant Secretary, GP Super Clinics Branch
Ms Judy Daniel, Assistant Secretary, Policy Development Branch
Mr Lou Andreatta, Assistant Secretary, Primary Care Practice Support Branch
Ms Jan Bennett, Principal Adviser, Office of Rural Health
Ms Sharon Appleyard, Assistant Secretary, Rural Health Services and Policy Branch, Office of Rural Health
Ms Vicki Murphy, Assistant Secretary, Service Access Programs Branch
Mr David Dennis, Assistant Secretary, Workforce Distribution Branch

General Practice Education and Training

Mr Erich Janssen, Chief Executive Officer
Mr Rodger Coote, National General Manager, Program Improvement and Workforce Branch

Outcome 6 – Rural Health

Primary and Ambulatory Care Division

See Outcome 5

Outcome 7 – Hearing Services

Regulatory Policy and Governance Division

See Outcome 1

Outcome 9 – Private Health

Acute Care Division

Prof. Rosemary Calder, First Assistant Secretary, Acute Care Division
Dr Andrew Singer, Principal Medical Adviser, Acute Care Division
Ms Veronica Hancock, Assistant Secretary, Medical Indemnity and Dental Branch

Ms Gail Yapp, Assistant Secretary, Acute Care Strategies Branch
Ms Penny Shakespeare, Assistant Secretary, Private Health Insurance Branch
Ms Louise Clarke, Assistant Secretary, Healthcare Services and Information Branch

Private Health Insurance Administration Council (PHIAC)

Mr Shaun Gath, Chief Executive Officer

Outcome 10 – Health System Capacity and Quality

Primary and Ambulatory Care

See Outcome 5

Regulatory Policy and Governance Division

See Outcome 1

Cancer Australia

Professor David Currow, Chief Executive Officer, Cancer Australia

Mental Health and Chronic Disease Division

See Outcome 1

National Health and Medical Research Council

Professor Warwick Anderson, Chief Executive Officer
Ms Hilary Russell, Deputy Head and General Manager, Research Strategy
Dr Clive Morris, Deputy Head and General Manager, Translation and Implementation
Ms Fran Raymond, Chief Financial Officer, Finance
Mr Tony Krizan, Strategic Finance Officer, Strategic Finance

Outcome 11 –Mental Health

Mental Health and Chronic Disease Division

See Outcome 1

Outcome 12 – Health Workforce Capacity

Health Workforce Division

Ms Kerry Flanagan First Assistant Secretary Health Workforce Division
Mr Allan Groth, Assistant Secretary Nursing, Allied and Indigenous Workforce Branch
Ms Natasha Cole, Assistant Secretary Workforce Development Branch
Ms Maria Jolly, Assistant Secretary Medical Education and Training Branch

Outcome 13 – Acute Care

Acute Care Division

See Outcome 9

National Blood Authority (NBA)

Dr Alison Turner, General Manager and CEO
Mr Peter Hade, Chief Finance Officer
Mr Andrew Mead, Deputy General Manager

Australian Organ and Tissue and Transplant Authority

Ms Karen Murphy, Chief Executive Officer

Outcome 14 – Biosecurity and Emergency Response

Office of Health Protection

Ms Cath Halbert, First Assistant Secretary, Office of Health Protection
Ms Fay Gardner, Assistant Secretary, Health Protection Policy Branch
Ms Sally Goodspeed, Assistant Secretary, Surveillance Branch
Dr Gary Lum, Assistant Secretary, Health Emergency Management Branch

Ms Sandra Gebbie, Acting Assistant Secretary, Office of Chemical Safety and Environmental Health
Dr Bernie Towler, Medical Officer, Office of Health Protection
Dr Jenean Spencer, Acting Assistant Secretary, Pandemic Planning and Forward Activity, Office of Health Protection

Outcome 15 – Sport
Population Health Division
See Outcome 1
Australian Sports Commission (ASC)
Mr Matt Miller, Chief Executive Officer, Australian Sports Commission
Mr Brent Espeland, Director, Strategic Planning and Implementation
Professor Peter Fricker, Director, Australian Institute of Sport
Mr Greg Nance, Director, Sport Performance and Development Division
Ms Judy Flanagan, Director, Community Sport Division
Australian Sports Anti-Doping Authority (ASADA)
Mr Richard Ings, Chair, Australian Sports Anti-Doping Authority
Mr Kevin Isaacs, Chief Operating Officer
Ms Geetha Nair, General Manager, Anti-Doping Programs and Legal Counsel

CHAIR (Senator Moore)—Good morning. We are going to start with the aged-care area. I see the officers are here. Welcome. There will be a break at 10 o'clock when the aged-care people have to go to a meeting and then they are going to come back. My proposal is that we will start with aged care and go through until about 10 to 10, and then we will go through, at 10 o'clock, to the three agencies under outcome 10, which are Cancer Australia, National Breast and Ovarian Cancer Centre, and National Health and Medical Research Council. At the end of that questioning, we will go back to aged care if we have not completed it. Welcome, Senator McLucas, Ms Halton and your officers.

Senator McLucas—Thank you.

CHAIR—My understanding is that Senator Fifield will be starting and we will go straight into outcome 4: aged care and population aging.

Senator FIFIELD—I have got some questions in relation to the Continence Aids Assistance Scheme.

Mr Stuart—I can help with that.

Senator FIFIELD—Thank you very much. I am aware that the budget contains a change in the way that the continence aids assistance will be delivered to those in need, but just before I get to the new scheme, could you just briefly take me through how the current scheme operates?

Mr Stuart—I will give a broad sketch and then I might call on Melinda Bromley. We currently have a contract with a sole provider called Intouch, and that sole provider is paid by the department to manage a scheme in which they keep an order book in which they keep a list of clients that are eligible for the scheme and in which they administer, on behalf of each individual client, orders up to a total value of $479.40 over the course of any one year. The clients are obliged under this scheme to use the sole provider, Intouch, and to order their

products from that provider and so are quite limited in the scope of products to Intouch's order book. That is basically how the scheme currently works, through a sole provider contract.

Senator FIFIELD—Thanks for that. What is the current age range for eligibility?

Ms Bromley—Five and above.

Senator FIFIELD—Thank you for that. Do you have any handle on what percentage of costs incurred by consumers the payment scheme actually covers? I know it will vary from individual to individual, but do you have a handle on the range of the extent to which recipients are out of pocket?

Ms Bromley—It does range significantly.

Senator FIFIELD—That is all I am after: a broad range—there will be some people for whom this would cover all costs and there will be others. I am just trying to get a handle on this.

Ms Bromley—Yes, some, but not the significant proportion of the number of clients on the program. For those people who have severe and permanent incontinence—dependent on their particular medical needs for particular medical items, catheters et cetera—some can incur costs of up to $3,000 and $4,000 per annum.

Senator FIFIELD—Do you have any idea as to the percentage of people who receive payments under the scheme who would be at that higher end, of $3,000 to $4,000?

Ms Bromley—No, I do not have that information.

Senator FIFIELD—Thank you. How many people receive assistance under the scheme?

Ms Bromley—Currently around 58,000.

Senator FIFIELD—Thank you. Just out of curiosity, why does the scheme fall under the aged portfolio? Perhaps the genesis of the scheme was for the aged?

Ms Halton—Actually, no.

Mr Stuart—Actually, not so, ironically, Senator.

Ms Halton—There is a long bureaucratic history here, Senator, which we will not bore you with.

Mr Stuart—Actually the scheme did start being a scheme for working-age people, to promote work force participation, but the Office for an Ageing Australia not only manages the kind of strategy for Australian ageing; it also managers a number of whole-of-community programs that are in the aged-care division, and they include an eye health program, which is all ages; a continence program, which is all ages; a palliative care program, which is all ages; and a dementia program, which is also not limited to the aged. So we have a few of these grouped together in one place.

Senator FIFIELD—I am just checking that there was no particular rationale that I was missing.

Mr Stuart—No.

Senator FIFIELD—Thank you for that. Now, I think you said Intouch were the current sole provider.

Mr Stuart—That is correct.

Senator FIFIELD—How long have they been the sole provider?

Ms Bromley—Since, I believe, 2005, when they won the contract in an open tender process.

Senator FIFIELD—Since Intouch became the sole provider, has the scheme expanded in scope from what was envisaged with the original tender?

Ms Bromley—Yes.

Senator FIFIELD—In what way?

Ms Bromley—Last year, the scheme expanded, for those aged five and above and for eligibility. The previous eligibility criteria were based on neurological conditions, so a neurological basis for your severe and permanent incontinence. A decision was made to expand that to people aged five and above for eligible neurological conditions, and it was opened to other conditions causing permanent and severe incontinence, if you hold a pensioner concession card.

Senator FIFIELD—By how many people did that increase?

Ms Bromley—The client numbers at the time were approximately 33,000, and they are now 58,000.

Mr Stuart—The number is expected to increase to about 86,000 by the end of June 2011.

Senator FIFIELD—So if you were Intouch and you tendered on the basis of one lot of eligibility criteria, you would be quite happy, as the sole provider, that the criteria were changed and the number of people who came on expanded? It is a substantially different contract to the one for which they originally tendered.

Mr Stuart—The contract expanded, yes.

Senator FIFIELD—So, even if you were not moving from a sole provider basis to one with greater choice, there could have been an argument that it would be due to retender anyway. But anyway, that situation does not arise because you are moving to a new scheme. When was the current contract due to expire?

Ms Bromley—End of this financial year.

Senator FIFIELD—End of 2009?

Ms Bromley—Yes.

Senator FIFIELD—That has been extended, has it, for the transitional period?

Ms Bromley—Correct.

Senator FIFIELD—Thank you for that. When was the current sole provider told that there was to be a new scheme in place? Did they find out on budget night?

Ms Bromley—Yes, Senator. I believe so.

Mr Stuart—There was a phone call to the provider on budget eve.

Senator FIFIELD—What were the administration costs for the scheme, if you have them to hand, for 2007-08, 2008-09 and 2009-10?

Ms Bromley—I have administration figures that are approximations for this current financial year.

Senator FIFIELD—Sure. Thanks.

Ms Bromley—The current financial year contract amount is around $32.4 million and a significant component of the program allocation goes to products, and so the $479 is for clients. There is a component of approximately $7 million in program administration costs, but that includes freight costs and costs to the provider for salaries, running a call centre, running a website, mailing, and updating the product catalogue. There are a range of activities that the provider undertakes in terms of administration of the current scheme on our behalf.

Senator FIFIELD—The clients will receive the same value under this scheme of $479.40.

Ms Bromley—Correct.

Senator FIFIELD—Is that indexed?

Ms Bromley—Yes, it will be.

Senator FIFIELD—And is that paid directly into clients' bank accounts?

Ms Bromley—Because we have a 12 month transition period, we are currently working through the details of that transition, but, yes, that is to be the case.

Senator FIFIELD—It may be a silly question, and clearly the individual would want to, but is there a requirement that the money be spent on continence aids? Are the clients required to keep receipts?

Ms Bromley—The clients will, as they currently do, need to have a health provider assessment of their condition. For those people who are permanently and severely incontinent, it is not a choice that they need the products.

Senator FIFIELD—No, as I appreciate. I really just want to get a handle on the administration of the scheme, not suggest that anyone would not use the money for—

Mr Stuart—We want to keep the administration as light as possible in recognition of the high level of product need. We will be taking further advice on precisely what we are required to do under accounting requirements of government, but we will be trying to ensure as few administration overheads as possible.

Senator FIFIELD—That is good. Are there any plans to change the eligibility for the scheme?

Ms Bromley—No.

Senator FIFIELD—Budget Paper No. 2 states that by moving from a sole provider to a payment scheme, there will be savings of $10.7 million. Where will those savings come from?

Ms Bromley—That is $10.7 million over the four year period.

Senator FIFIELD—Sure.

Ms Bromley—It will come from the streamlined administration costs for which I gave you the figures before. So, over the four years, the administration costs will be lower.

Senator FIFIELD—And that is not the administration costs of the department; that is the administration which was undertaken by the sole provider?

Ms Bromley—Yes.

Senator FIFIELD—Where are those savings going? Have you been able to keep those for the portfolio?

Mr Stuart—Those savings are a saving for government as a whole.

Senator FIFIELD—Was there any discussion about keeping those savings to provide additional assistance?

Ms Halton—The reality—and you understand this well, probably better than most—is the way the portfolio budget is managed on a whole-of-portfolio basis. The net spend in the portfolio outweighed significantly, actually, the net save in the portfolio and, as you well understand, individual saves are not necessarily then attributed to one particular component of the spend.

Senator FIFIELD—Sure. Thanks for that. Have stakeholders raised any concerns about the current continence aids scheme—from the point of view of the consumers but also other stakeholders?

Mr Stuart—Yes. I am aware of two kinds of concerns, and I will ask Melinda to paint in any that I miss. On the consumer side, there has been some dissatisfaction from clients finding that their favoured product is not on the Intouch product list. These are often quite intimate products and clients have their preferences. There is also, from time to time, an issue where when you have $479.40 to spend you end up having to order little bits and bobs of things at the end of your allowance to make up that amount. We have also had some complaint from others in the marketplace who supply similar products as to why we do not open this market more generally to other suppliers.

Senator FIFIELD—Were stakeholders consulted before designing the new scheme?

Ms Bromley—We took into account stakeholder feedback in designing the scheme but, as it was a budget consideration, not specifically on the new scheme.

Senator FIFIELD—It makes it tricky sometimes, doesn't it, to liaise with stakeholders. So you took on board those views which they had already expressed but you did not put design options to stakeholders for their feedback?

Mr Stuart—That is not something we can do in the budget context, but we certainly have a history of the kinds of issues that I outlined to you which we take into account in designing any change, and we now have a year of potential for thought on specific implementation.

Senator FIFIELD—So there will now be consultation with stakeholders on implementation?

Mr Stuart—Yes.

Ms Bromley—Yes.

Senator FIFIELD—Does the department currently pay postage for deliveries to clients under the current scheme? Is the coverage of the postage part of the funding?

Ms Bromley—Yes.

Senator FIFIELD—Is there a limit on the number of deliveries per year for which you cover postage?

Ms Bromley—I would have to actually ask one of my colleagues. I believe it is up to four a year.

Senator FIFIELD—And the funding for that postage is not deducted from the $479; that is a cost that the department covers or the sole provider covers for the department?

Ms Bromley—Correct.

Senator FIFIELD—They get reimbursed for it?

Ms Bromley—Yes.

Senator FIFIELD—Thank you. Is that cost going to be continued to be covered under the new scheme?

Mr Stuart—Under the new scheme the client has the opportunity to purchase from a much wider range of outlets, including by mail order but also from the local pharmacy, through internet shopping or at the supermarket, even.

Senator FIFIELD—This is sounding like a no.

Mr Stuart—The answer is no.

Senator FIFIELD—So at the moment the client can get the delivery of continence aids up to four times a year with the postage paid. Under the new scheme, no client will have the postage for delivery of aids paid at all? What saving does that postage represent to the department?

Ms Bromley—I do not have a breakdown. The postage costs are actually part of the administration costs that the provider is currently contracted for, which includes salaries, phones, admin and postage. I do not have that breakdown.

Senator FIFIELD—Could you get that break down?

Ms Bromley—Yes, I can.

Senator FIFIELD—Is it relatively straightforward to get figures for the postage? Would it be possible to seek advice and get that information today?

Ms Bromley—Yes.

Mr Stuart—We can see what we can do today.

Ms Bromley—We will see what we can do.

Senator FIFIELD—Thank you. So the new scheme is going to cost clients money in some cases? I am not saying in all cases, because—

Mr Stuart—I would like to just talk about the swings and roundabouts there a little, if I could.

Senator FIFIELD—Sure.

Mr Stuart—At the moment there is a sole supplier with a single product list and purchase must be by mail order. In the future, there will be significantly more choice—not only an opportunity for preference but also an opportunity for competition between suppliers on cost and availability, and many different ways to purchase the goods, not only through mail order.

Ms Bromley—I would add that a number of the clients will also already have existing relationships with other providers via mail, so they bear that cost with the additional supplies that they need to purchase.

Senator FIFIELD—Thank you, and if you could take on notice the postage costs and also what is the average postage cost that the department incurs on behalf of a client over the course of a year.

Ms Bromley—That also depends on where they live.

Senator FIFIELD—Of course.

Ms Bromley—But we will try and get as clear a cut picture as we can.

Senator FIFIELD—Thank you for that. It is of some concern that there will be an increase in the cost burden on some clients. I appreciate it is not all, and that for some, hopefully, there might be somewhere close to them that they can purchase the products from. But for some people there will be an increased cost. As you say, for some people, it is $3,000 to $4,000 that they could incur. I guess every little bit makes a difference for some people. Obviously, the current sole provider would hold personal records of eligible recipients. So those records will be transferred to Medicare, or does the department have those same records?

Ms Bromley—The sole provider will be transferring the records of the clients as part of the transition arrangements to the new scheme.

Senator FIFIELD—Will the sole provider be allowed to keep a copy of the personal records?

Ms Bromley—We are working through the transition arrangements and receiving advice on what information is available for the current provider.

Mr Stuart—I think, Senator, in general the answer there is no.

Senator FIFIELD—You have the legal capacity to require them to not keep the records?

Mr Stuart—The records are all matters which are property under the contract and, yes, we have the legal capacity to ensure the complete destruction of those records. The single reason, I think, for Melinda's slight reticence on this point is that there may be clients who express a preference for continuing their business relationship with Intouch and, as part of the transition process, we need to be sensitive to that. To enable that relationship to occur we do not want to bureaucratically get in the way.

Senator FIFIELD—But Intouch will not be in a position where they can keep the records and they would have a clear advantage over other providers—

Mr Stuart—That is correct.

Senator FIFIELD—because they could use that if they get to market their product.

Mr Stuart—That is right.

Senator FIFIELD—They have got that assurance, subject to the transitional arrangements so as not to inconvenience clients. Thank you for that. This might be a silly question, but how are records such as this actually transferred to Medicare? Does someone jump in a car and take a disk down? I am just curious about how these things happen.

Mr Stuart—We still need to work that out. I think the general answer is 'securely'.

Senator FIFIELD—So safe hands, maybe. This might be outside your turf. Will Medicare be allocated additional funding to administer this payment, or is that something they can do within their existing resources?

Mr Stuart—No, there will be funding for Medicare Australia. There are administration savings as well as costs in this proposal. The savings outweigh the costs. But there are costs of administering the scheme.

Senator FIFIELD—That $10.7 million of savings over four years takes account of the additional costs to Medicare?

Mr Stuart—That is right.

Senator FIFIELD—Thank you. Do state and territory governments also provide their own continence assistance?

Ms Bromley—Yes, they do. There is a range of schemes. The government's Bladder and Bowel Health website has links to those, as does the Continence Foundation of Australia website.

Senator FIFIELD—Can you receive both, whatever the state or territory assistance is and the Commonwealth assistance?

Ms Bromley—It differs between the states and territories. But, yes, we try and work in a complementary way with our colleagues. For example, the New South Wales scheme takes people on once they have expended their CAAS allowance. With Victoria, for example, you can take both CAAS and the Victorian scheme. Do you want all of that information, Senator? It is available on the website but I am happy to—

Senator FIFIELD—If there is an easy spot on the website, I will look there. Thank you for that. Under the new system will clients be able to buy their products anywhere, or will there still be a list of approved providers?

Ms Bromley—They will be able to buy them anywhere. However, in our transition plan and planning for changing to the new scheme, clearly we will need to have a range of communication activities for current clients and the sector. Currently, the Continence Foundation of Australia website also lists places where people can get specialist medical supplies.

Senator FIFIELD—So recipients will receive some information as to where they can go to receive continence aids?

Ms Bromley—We are still working through that in terms of the detailed plan.

Senator FIFIELD—I appreciate that.

Ms Bromley—Yes, the idea is that they will be given options.

Senator FIFIELD—I appreciate that there are not approved providers, that there will not be approved providers, as such, and that people can go where they want. But, in providing a list of places where people can go to, I guess you would want to make sure that it was an exhaustive list so that you were not preferencing some providers over others.

Ms Bromley—That is why I am saying that we will be providing communication to people. Also, people on the scheme are required to have a health professional assess them for their requirements. Health professionals and other stakeholder groups will be providing information as well.

Senator FIFIELD—As there will not be a list of approved providers, that means therefore, as a matter of logic, there are not any particular standards that providers have to meet?

Mr Stuart—They do, but not to participate—

Senator FIFIELD—Is there some form of accreditation for providers of continence aids?

Mr Stuart—No. But many of the products are themselves medical devices which need to be registered products and therefore safe and efficacious. The idea here is provide choice to the client. We do not want to limit the choice of how and where they source their product. But there are more general mechanisms to ensure the safety and efficacy of products in the marketplace.

Senator FIFIELD—It is not so much the safety and efficacy of the products themselves that I am concerned about, because I think we have got an adequate regime in place to ensure that. It is probably more the advice that clients receive at point of purchase. Can you take me through what your thinking is there?

Ms Bromley—Most of the providers of specialised continence products have health advisers on their teams. Intouch certainly does as part of our contract, and I have met with other industry organisations that provide continence products and services and they also have health professionals on staff and call centres and advice. There is also the Continence Foundation of Australia, which has a list of where people can go should they require specialist health advice in managing their condition.

Senator FIFIELD—What sort of advice does the sole provider provide under the current arrangements? As you say, it is all mail distribution.

Ms Bromley—Yes.

Senator FIFIELD—Does the sole provider have an advice line?

Ms Bromley—For the current scheme, yes. And it also has health professionals on its team.

Senator FIFIELD—Is that the National Continence Helpline? Who provides the National Continence Helpline?

Ms Bromley—The continence helpline is done by the Continence Foundation of Australia, I believe, and the Continence Aids Assistance Scheme line is run by Intouch.

Mr Stuart—The continence helpline is a broader, more generally available helpline, not specific to this scheme that the department also funds.

Senator FIFIELD—And that will continue as is?

Ms Bromley—Yes.

Senator FIFIELD—I think you referred to it as the continence aids assistance helpline or continence aids scheme helpline, which Intouch currently provide?

Ms Bromley—For clients, yes.

Senator FIFIELD—Will there be something to replace that?

Ms Bromley—Again, we are talking about details of the transition plan and planning for the implementation of the new scheme in 2010. We do plan to have support for people who wish to call about their medical and supply needs. We have not yet discussed with particular groups who may take that role on, but we do fund the Continence Foundation of Australia under a separate agreement to provide its expert advice when required.

Senator FIFIELD—I am totally in favour of, obviously, providing choice for consumers, but I have already flagged my concern about the possible postage costs which clients might have to incur. My remaining concern is that the new scheme could see a huge shift to commodity suppliers whose interests are not necessarily in optimising the health outcomes of individuals. So I think it would be very important that there is still a very strong capacity for individuals to seek advice as to which products would be best for them.

Mr Stuart—That is also an objective of the department and, in consulting further, we will look at the existing arrangements with alternative suppliers in the marketplace with our continence helpline and also how people generally access information, to start with, about what products are best for them. We will take that on board and consult further about that.

Senator FIFIELD—Thank you, and I will just wrap up on this point. How many individual products does Intouch currently stock?

Ms Bromley—I have that figure, but I have to actually find it. I think it is around 1,500, from memory—no, it is 1,200.

Senator FIFIELD—I think about 2,500 or 3,000 continence aids products are available across the spectrum. Another concern is if there will be suppliers who will cover that large range of a few thousand products.

Mr Stuart—It may well be that individuals will source some products from one supplier and other products from another supplier. Their favourite catheter may be from one supplier and their favourite cream from another and that just provides for flexibility and choice.

Senator FIFIELD—It might also provide for a higher postage bill as well, which, again, comes back to my earlier concern. Anyway, I will leave it there. Thank you for that.

CHAIR—My understanding is that Senator Humphries has asked to have the call, because he has got a couple of questions about medical services and aged care.

Senator HUMPHRIES—Yes, thank you, Chair, for that indulgence. I just have a couple of questions arising out of the recent inquiry by the Senate Standing Committee on Finance

and Public Administration into aged care, and particularly some points that were raised in the course of that inquiry by doctors, including the AMA, about the level of medical care being provided to residents of aged-care facilities. I do not think that there was much discussion in that inquiry of the government's view about those issues that were being raised by the AMA and others, but does the government have a concern at the moment about the level and quality of care being provided to residents of aged-care facilities with respect to medical services and allied health services?

Mr Stuart—It is hard to answer a question about whether a government has a concern, but there have been, over recent years, a number of measures put in place to seek to increase funding levels for GPs and also put in place supporting mechanisms to encourage GPs, in particular, to visit aged-care homes. I do not have the detail to hand. I think that the primary care division certainly will. I am not aware whether they were on yesterday or later today.

Ms Halton—Later today.

Mr Stuart—There is some sign that those measures are having some success.

Ms Halton—We should be clear here that just because you are a resident in an aged-care facility you do not lose any of your entitlements to all existing arrangements under Medicare. That has been a longstanding matter. We have had a number of programs over a number of years looking to further encourage medical practitioners to attend aged-care facilities. Exactly as Mr Stuart says, we know quite a bit about that. The primary care people can probably talk in a bit more detail about it. To say we have a concern is probably putting it a little strongly. I think we are aware, as is everybody, that, particularly in some regional areas where there may be issues about waiting lists and people with their books being closed, there can be some access issues. But, exactly as has been mentioned, we have put in a number of arrangements which are actively designed to encourage medical practitioners to visit and to take on patients who may happen to be resident in aged care.

Senator HUMPHRIES—Clearly, the arrangements at the moment are largely in the hands of the providers of aged-care services.

Ms Halton—No, they are not, actually. Essentially, a person would retain their medical practitioner, if they lived in a particular area and if that was close to where, perhaps, they had been in a family home. As to the issue about access to that medical practitioner: sometimes it is the case that the provider may facilitate that access and they need to ensure, if someone needs medical care, that that is provided.

Senator HUMPHRIES—The evidence before that particular inquiry suggested that providers take a fairly active role in ensuring that a resident has access to medical care, and that often involves, particularly if a person is travelling from some distance from where they used to live, often it means that they cannot bring their usual GP into the new facility, often the providers organising that to happen sometimes have doctors come and do a job lot and they do a number of residents.

Ms Halton—Yes, a 'round' so to speak.

Senator HUMPHRIES—Yes. The question I am getting to is: are there any plans by government to attempt to encourage innovation in that model? Bodies like the AMA were

suggesting that some investment needed to be made in getting a better approach to these issues, to try and make sure that we did better screening of people when they entered aged-care facilities, a better ongoing assessment of the health needs of these people and perhaps engineer better outcomes than we are getting at the moment.

Ms Halton—Yes.

Ms Murnane—Some years ago, the government put into place a measure whereby all residents entering aged care—in fact, the way it was done was that people of a certain age, I think it was 70—would be comprehensively screened for their clinical needs. That scheme was piloted at the North Brisbane division of general practice. It was funded by the department under the Divisions of General Practice Program. Following that, a number of other measures came into place that involved panels of doctors. That has now been replaced with another measure, but that will focus more on bringing medical care into aged-care homes.

As well as that, where we are made aware that there is a problem in attracting doctors, we work with the provider through the division of general practice, now a well-established program of the department, to rectify the problems that exist. An instance of that that I recall, a few years ago, was in the Hunter, where we worked with the Hunter division of general practice and a number of the large aged-care providers, including Baptistcare. In addition to that, there are ranges of matters that we take up with divisions of general practice that have a particular interest in geriatric care. There is a division in Adelaide, for example, that has that special interest.

We are working now, through the Palliative Care Program that Mr Stuart mentioned in aged care, with the NHMRC on the possibility of having some aged-care homes of excellence, or teaching aged-care homes, that would specialise in end-of-life care. This would involve drawing together research, clinical care through both specialist doctors and GPs, and nursing home care. What we are trying to do across a range of measures through the department is to raise the level of professionalism in aged care and to raise the level of professional reward for both doctors and nurses.

And I should say here, too, that the nurse practitioner program that the various states are undertaking and that our minister, Minister Roxon, has had very encouraging things to say about, with the work of our chief nurse, is also going to—these things will converge. It will take a time. We know there is a problem. We know that we are facing a situation where the clinical needs of residents are greater—they are entering much, much frailer than once was the case—and we also have workforce shortages in this area. But we are very active in a policy way. This is, in fact, an exciting policy area, and I think over the next few years you are going to see a lot of developments there.

Ms Halton—And, if I can add to that, the other thing that we are currently working on is the development of the primary care strategy. You talked about innovative models. The reality is—and I think Minister Roxon is on the record as saying—that there is a capacity to innovate quite significantly in relation to primary care, and—

Senator HUMPHRIES—Primary care in aged-care facilities or—

Ms Halton—No, primary care more broadly. If you think about it, aged care is part of the community, and essentially what we want to do is ensure that aged-care residents get the same access to an improved quality primary care situation, so they will be part of that.

Senator HUMPHRIES—I wonder if I can get some information provided on notice about those other measures you are referring to, Ms Murnane, please?

Ms Murnane—Yes, we will do that happily.

Senator HUMPHRIES—Thank you.

Senator CORMANN—As an opening question, Ms Halton, are you concerned about the negative perceptions about the Ageing and Aged Care Division of your department that are increasing in recent times? I just refer to the Senate standing committee report into residential and community aged care; the ABC Radio National program, on 22 May 2009, in *The National Interest*; again in *The National Interest* on 31 May 2009; *Four Corners*, on 1 June; *Life Matters*, on ABC Radio National on 2 June; and the release of the Australian National Audit Office report on planning and allocating aged-care places and capital grants. There really is an accelerating body of evidence that something is wrong in the Ageing and Aged Care Division of your department, isn't there? What are you doing about it?

Ms Halton—Frankly, Senator, I reject that most strenuously. To start with, that little list that you have just read out includes this particular audit, which is an overwhelming endorsement of the approach to the allocation of places, so to say that that is in any sense negative I think is distinctly inappropriate. We will, no doubt—

Senator CORMANN—So you think everything is good in aged care?

Ms Halton—Senator, we are happy to talk through the detail of a number of those particular matters in great detail, if that is what you wish. We more than welcome that opportunity. But I think to just come out with a blanket suggestion that there is an increasing concern about the division is not only unfair; it is unfounded.

Senator CORMANN—So you are satisfied that the perception across the industry of the culture in the Ageing and Aged Care Division in your department is a positive one?

Ms Halton—Senator, in my experience—and I think Ms Murnane would say the same—we know that ageing and aged care are one of the most complex parts of this portfolio. It is undoubtedly a difficult area to administer, and we do not profess always to get it right. As I said to you, I am more than happy to go through with you, case by case if necessary, issues in this space. We have no need to be defensive in relation to those issues, but I do think we need to accept that, in an area which is highly sensitive for families, sometimes people are unhappy. We accept that, and if we get it wrong I am more than prepared to say that we have got it wrong.

Secondly, in respect of the industry, we also know that there are large matters which often go to severe contest between industry and sometimes government, particularly where money is involved, which, sometimes, people are unhappy about. That is a reality. We do not shy away from talking about those things, Senator, but I think to make a blanket statement of the kind you made is both unfair and unreasonable.

Senator CORMANN—So, Ms Halton, there is nothing that you are doing to address the perception across the industry and across a range of public issues that have arisen in recent times that there is a negative culture in that part of your department?

Ms Halton—Senator, you are suggesting that there is a perception that there is a cultural problem. I am not necessarily accepting that. I am agreeing with you that there may be some people who might be unhappy about some things. I am prepared to talk to you about those matters in detail, if necessary, but just to make a blanket statement about culture without any detail I think is unfair and unreasonable.

Senator CORMANN—But, Ms Halton, for the last eight or nine months—and I readily concede I have not been involved in this for a very long time—I am yet to meet one person in the industry who has got a positive view (1) of the work that is done by the Ageing and Aged Care Division and (2), more concerningly, about the way it is done and the attitude with which people across the industry perceive that they are approached by the department. Now, you might dismiss it, you might say that I am making inappropriate blanket statements, but I invite you to reflect on it, and perhaps, into the future, to consider whether there are things that need to be done. Anyway, I leave it—

Ms Halton—Senator, let me reiterate. I do not dismiss what you have said. What I am simply saying to you is that it is very easy, with one smear, to make that kind of comment. It is better to go through the circumstance—

Senator CORMANN—I object to that, Ms Halton. I have not done a smear. I have listed a series of—

Ms Halton—I think it is a smear.

Senator CORMANN—Well, I disagree with that. I have listed a series of media stories. I have listed a few things that have arisen publicly, and I have referred you to statements that I have received from people right across the industry. You show me some people who think that there is a positive, constructive attitude and I will reconsider. But I am still trying to find somebody who would be prepared to say to me that they feel that they are being listened to and that they feel that the things that they are saying to the Ageing and Aged Care Division of the department are being taken on board.

Ms Halton—Indeed, Senator, I understand that that is what you are saying, and my point to you is—

Senator CORMANN—Well, that is not a smear. I am relating to you—

Ms Halton—No, it is a smear. Senator; I am sorry—

Senator CORMANN—Well—

Ms Halton—There are a significant number of officers who work tirelessly in aged care. You have just comprehensively smeared the lot of them. Now, I have said to you that I will more than happily take each issue one by one by one and discuss it with you. That is what I have said to you that I am more than prepared to do, and I have explained to you—and I, of all people, understand how difficult this area is, as, indeed, does Senator McLucas, as, indeed, does Ms Murnane. Now, the bottom line is that I am happy to work through those with you one by one, but just to make that kind of blanket accusation about officers who work

phenomenally hard—and, as I have said, there are issues which some people are not happy about externally, sometimes because matters of government policy mean that they have not got what they want. Now, if there are particular issues that you would like to draw to my attention, let's go through them.

Senator CORMANN—And we will, but, just before we go through them, the Ageing and Aged Care Division has to leave at 10 o'clock to go to a meeting.

Ms Halton—No, Ms Murnane has to go at 10 to 10 and will be back at about 20 to 11.

Senator CORMANN—And everybody else is staying, are they?

Ms Halton—No, we are going to go on to cancer et cetera.

Senator CORMANN—No. I understand that. But how long have you known that estimates was on today and that ageing—

Ms Halton—Sorry, this is a swine influenza crisis meeting called by the head of the Prime Minister's department.

CHAIR—Senator Cormann, it is very usual in this committee for us to rejig the agenda from time to time.

Senator CORMANN—All right.

CHAIR—We have a clear understanding from the department that this section and branch will be back later in the morning, so it is not unusual, and it was my decision that we would actually change—

Senator CORMANN—In relation to the commonwealth investigations scheme, the minister said in a *Four Corners* interview on Monday night that a review would be held into the commonwealth investigations scheme. When was that review announced? What are the terms of reference and closure date?

Ms Halton—I would just ask the chair, can we do all of aged care—

Senator CORMANN—Are we stopping now?

Ms Halton—We are going to stop at 10 to.

CHAIR—On that basis, I think we will stop and we can recommence questions later. With Ms Halton's agreement, we are now going to go into the agencies, beginning with Cancer Australia, then moving on to National Breast and Ovarian Cancer Centre, and then the National Health and Medical Research Council. Cancer Australia. Good morning, Professor.

Cancer Australia

CHAIR—Welcome, Professor Currow. While we are getting ready, perhaps you could just give us an overview of the staffing of Cancer Australia now. At different times you have given information to us on how you have actually set up your organisation, whether all the subgroups are now operational—just kind of an overview for the committee. That would be something we could start with.

Prof. Currow—Cancer Australia continues to deliver on administered programs across a range of issues. We have been charged by government to take charge of cancer research in an administered program which continues to deliver. We are working with cooperative oncology

groups from across Australia to ensure that we are able to maintain clinical trials infrastructure for them. In addition to that, we are running the National Centre for Gynaecological Cancers, and all of those programs are on time and on budget.

We are running the cancer support networks, and the government announced in the recent budget that that program is now non-lapsing and has been funded into the future. In the recent budget there were also announcements around lung cancer. A new program of work is about to begin in lung cancer nationally. Given that that is our No. 1 killer from cancer, it is an important commitment and an opportunity for the agency to further take leadership in national cancer control.

The government has also asked us in the recent budget to look at cancer data issues, particularly some intermediate outcomes from cancer, and that opportunity will be taken forward now that the budget announcement has been made.

A flagship program has been working with the states and territories in the cancer networking program to improve cancer care in rural and regional Australia. Again, that is on time and on budget and has had an announcement in the recent budget that that will continue into the future.

Professional development for cancer professionals, including those whose full-time work is not in cancer, such as general practitioners, has continued to grow. So, at the end of the day, Cancer Australia's work program is busy. At the moment, we have 18.4 full-time-equivalent staff in the agency and that is our expected staffing level. It is our long-term staffing level. The most recent budget announcements will see that increase in the 2009-10 year, as you can see from the portfolio budget statements, by about 2.75 FTE.

Senator CAROL BROWN—Were you involved in the national guidelines for the use of solariums?

Prof. Currow—No.

Ms Halton—No. It is actually one of the agencies.

Senator CAROL BROWN—Which one?

Ms Halton—I have gone blank.

Prof. Currow—We will get back to you.

Ms Halton—We will get you the solarium guidelines. It is ARPANSA, I think.

Ms Morris—Yes, ARPANSA.

Ms Halton—It is actually ARPANSA. And they are not here.

Prof. Currow—I got the wrong acronym last time.

Senator ADAMS—I know this question I am going to ask you is actually coming up in palliative care, but on the chemo wastage with the drugs, are you getting much feedback from your consumer group within Cancer Australia on that issue?

Prof. Currow—The consumer group is there to advise Cancer Australia on its work program, and its terms of reference are clearly framed around that. I think we would both be aware that Cancer Voices Australia, quite independently of that, put out a press release a

couple of months ago voicing their concerns about that. Really, the concerns that have been expressed to me have been through that press release and through Private Cancer Physicians of Australia, who made formal representation.

Senator ADAMS—As far as the process goes, when you receive that evidence from those people where does it go? Do you forward it on? What process do you use to do that?

Prof. Currow—Absolutely. We have had discussions with the relevant people in the department and it is being handled by the pharmaceutical benefits branch. They have briefed me and I have also received feedback from Cancer Australia as an agency.

Senator ADAMS—Once again I will come up with my acronym of Patient Assisted Travel Scheme. As far as access for rural patients coming in to specialists, have you had any feedback from, once again, the consumer group on that?

Prof. Currow—I think that is an issue that has been raised consistently again with both of us. There has been no new feedback recently to the agency about that, and I think everyone is awaiting with interest the response to the inquiry.

Senator ADAMS—I am, too, of course. I am having a mind blank, too; we focused on aged care and I then had to switch myself—

Prof. Currow—Cancer is a nasty distraction from aged care, isn't it?

Senator ADAMS—One of my colleagues might help me out for a minute and then I will have a think about what I was going to say.

CHAIR—I know that Senator Heffernan has some questions on an issue that is dear to his heart, but he has just stepped out for a short time. Senator Brown?

Senator CAROL BROWN—Perhaps you could give us some information on the linkages between Cancer Australia and other cancer groups, like the cancer councils from around the country, and Cancer Voices. If you can give us some information on how you all work together.

Prof. Currow—Absolutely. Cancer Australia was charged with national leadership in the legislation that created it. We work closely with cancer organisations across the country. In doing that, you would be aware that Professor Ian Olver, as chief executive officer of Cancer Council of Australia, is on the Cancer Australia advisory committee and certainly takes a very active role in several of our reference groups and committees.

We work with the state and territory cancer councils and our program there includes engagement across a number of areas, the most tangible of which is support for consumer networks where we are co-funding consumer networks with every state and territory cancer council. That program, I think, is strong evidence of a very good working relationship with those agencies.

The Australian Cancer Network is a subsidiary of the Cancer Council of Australia and their main role has been to look at clinical guidelines. We are certainly working closely with them and are on a number of their committees, as they look at other ways of developing clinical guidelines that can ensure their currency and a more efficient method of delivering those guidelines to the community. We work closely with the National Breast and Ovarian Cancer

Centre. We have a memorandum of understanding with them. We have recently had a joint request for tender out with the National Breast and Ovarian Cancer Centre, looking for agencies that would trial the national minimum datasets in ovarian, cervical and endometrial cancers. Importantly, that work was work that we originally commissioned the National Breast and Ovarian Cancer Centre to do for the latter two of those; for cervical and for endometrial cancers.

So I think we can show that we are working collaboratively and cooperatively, that we are value-adding in the relationships with national and state and territory cancer organisations. In terms of Cancer Voices, we meet with them regularly at a national level, and I meet with their state chairs and I am happy to go through those, but we have a strong working relationship with Cancer Voices, as an emerging peak body, as the voice for consumers of cancer services in Australia. We are delighted to work closely with them and I think it is a strong and effective, two-way relationship.

Senator CAROL BROWN—So the meetings with Cancer Voices, are they regular meetings or meetings that happen when one is requested or an issue comes up?

Prof. Currow—Both. So I would seek to meet with them at least twice a year with the issues that are always on our agendas, and we would meet at other times. Their national chair is on our national consumer advisory group. Their CEO, for example, learned Cancer Learning, the new website for cancer professionals, last November. So I think it is a strong and engaging relationship.

Senator CAROL BROWN—It is all working well, in terms of communication?

Prof. Currow—I think so.

Senator CAROL BROWN—The consumer networks that you mentioned, how many are there around Australia?

Prof. Currow—In that program, we have funded three rounds, two of which we inherited. So as Cancer Australia came into being, you will remember that there was a hiatus between the budget announcement and Cancer Australia being created. So the first two rounds were created by the department and we took over their management in October 2006. We have had a subsequent round, which, as I say, has, among other things, targeted each state and territory to ensure that we are getting good geographic coverage. We have also looked at partnering with Aboriginal and Torres Strait Islander organisations to ensure that we are looking at support for cancer consumers from those communities and a general round at that time. So overall, we have a very strong program that has been put together there and I am happy to go through those projects if that would be helpful, but there are three that affect Aboriginal and Torres Strait Islander communities, eight for the Cancer Council relationships around the country, and a number more that were from the general core. That program has been extended by the recent budget announcements and we are looking at how that can be extended further into the future.

Senator CAROL BROWN—You talked about reference groups. I do not want to take up too much time, but if could you just let the committee know what those reference groups are?

Prof. Currow—So our structure is that there is an advisory council, which is ministerially appointed. Below that, there are advisory groups to Cancer Australia. The first of those is the advisory group for the National Centre for Gynaecological Cancers, chaired by Professor Sanchia Aranda, who is on our advisory council and dean of nursing at the University of Melbourne. Our other advisory groups are a national research advisory group, which is clearly advising us on a flagship program in research, both project grants and clinical trials and infrastructure. We have the strategic forum, which brings together the states and the territories, together with the Commonwealth and other key stakeholders, including the National Association of Community Controlled Aboriginal Health Organisations, and that meets twice a year. That really is an important listening post for us, in terms of what is happening in the jurisdictions and how we can better interact with them; what are the issues across borders that can help us to work more effectively and provide, at a national level, the issues that cannot be generated at a state or territory level.

We have a national consumer advisory group and that has been in place since our inception. Again, it is an important sounding board for us. Consumers, as you will recall, Senator, are drawn from three areas for that particular program. Firstly, we have advertised in newspapers against a job and person specification. We have gone to national peak bodies and asked for nominees, and we have directly sourced, at times, consumers across our programs, because all of our committees have consumers on them. All of our working groups do, our evaluation teams do. We have more than 50 consumers who are very actively engaged in our work program. So across our programs, I think there is a strong engagement of the sector and particularly of consumers of cancer services.

Senator CAROL BROWN—Thank you.

CHAIR—We will go to Senator Heffernan and then to Senator Williams.

Senator HEFFERNAN—Thanks very much. I just want to ask a couple of questions to the Cancer Council in relation to the impact on cost of research. It is a patent issue. A study published in *Science* in 2005 showed that at least 20 per cent of the human genome, which is made up of approximately 23,000 genes, was the subject of US patents. This is a question also for the department. Does the Cancer Council have a view—

CHAIR—Excuse me, Bill. It is Cancer Australia.

Senator HEFFERNAN—Sorry, does Cancer Australia have a view on the likely long-term impacts on the cost of research of having to negotiate the patent field?

Prof. Currow—Thank you, Senator. I understand that the secretary yesterday addressed a similar question and we are part of the portfolio response to the Senate inquiry. I share your concerns and, as outlined at last Senate estimates, genetic issues in cancer do go hand in hand. There is no doubt that, either as a cause or as an effect, there will be genetic changes associated with cancer, and so, whether that is related to diagnosis, treatment or both, this is germane to cancer treatment now and into the future, whether that is in the context of research or in the context of delivering clinical care. How we as a community deal with that, I think, is the challenge at hand.

Senator HEFFERNAN—Madam Chair, for guidance, so to talk to your organisation about the possible fixed administrative overheads or the proportion of the public money or

whatever that is available that has to be used up, shall I say, in navigating the gene patenting licensing field, you have not done any work on the break-up of the—

Prof. Currow—We have not modelled that, Senator. I do not think that is within our brief, but I think the issue is that we have had advice sought from us on the breadth of genetic information that is relevant to cancer in both its diagnosis and treatment, and that has been provided and it has been incorporated into the portfolio response.

Senator HEFFERNAN—So would it be a reasonable thing to say that, since we have plotted the human genome and, as we heard the other night here, this has not be tested at law, the cost of paying licensing—and I have got some detailed questions, which I think probably will have to go to the department, another series of detailed questions, which I am happy to put on notice—

Ms Halton—Thank you, Senator Heffernan.

Senator HEFFERNAN—But obviously, with the phenomena of the case in the United States where the civil rights mob are taking Myriad to court over the breast cancer gene, can you see the inherent built in nightmare that is ahead of us in this area?

Prof. Currow—I would be giving an opinion as to whether it was a nightmare, Senator. I think I can reiterate that genetic issues are absolutely fundamental to the future of cancer treatment, and we have seen in the last 10 years a massive shift in our ability to treat previously untreatable cancers because of our understanding of the genetic effects that either are inherent, or are a consequence of cancer. So it is absolutely part of—not the horizon; the sun has already risen on this one day-to-day clinical practice and will only grow.

Senator HEFFERNAN—So is the threat of litigation et cetera having an impact on research in public laboratories, from your perspective, in recent times? Do you think that is intimidating the research?

Prof. Currow—I think any threat of litigation is going to be unsettling for a sector that does not deal with that on a regular basis. I think the challenge is how we, as a community, deal with this issue. It is an issue. I am agreeing with you, Senator. I share your concerns and from the comments yesterday, the portfolio shares your concerns. I think it is a matter of how we resolve these issues.

Senator HEFFERNAN—Well, I have got a lot of detailed questions here on whether the Crown has invoked division 163(1). That would be better off to go on notice, I take it.

Ms Halton—I think so.

CHAIR—On notice, and then through our committee hearing.

Senator HEFFERNAN—I will put them on notice. Thanks.

Senator WILLIAMS—Thank you, chair. Professor, are you familiar with a lady by the name of Jenny Barlow, who is a campaigner for a Dr Holt in Western Australia and a treatment for cancer?

Prof. Currow—No.

Senator WILLIAMS—No. I know she is a staunch campaigner. I have heard her on the media. I have spoken to her et cetera.

Ms Halton—We are aware of that particular case, Senator.

Senator WILLIAMS—Is your department looking at that sort of treatment to expand it in Australia, or have you researched it?

Ms Halton—Senator, there was an independent investigation done in relation to that matter by the NHMRC, which I am sure Professor Anderson can remind you of. I think you will find that that treatment was thoroughly debunked, would probably be the appropriate description.

Senator WILLIAMS—Has the Rotary Bowelscan program been successful through that side of things, do you know?

Prof. Currow—I think it is probably better to ask the screening section of the department about that, Senator.

Senator WILLIAMS—Thank you. In the budget papers, the government is to spend $1.3 billion, especially targeting regional cancer centres in New South Wales. Have you any idea where these cancer centres will be established?

Prof. Currow—Again, I think the department is far better placed to answer that question, as they are taking carriage of that, Senator.

Senator ADAMS—Just a follow-up on that particular one. I would hope that Cancer Australia will have some input into where those regional cancer centres are going.

Prof. Currow—Cancer Australia is already working closely with the department.

Senator ADAMS—I am sure you would be.

Senator WILLIAMS—If you can provide the answer to those especially in relation to Senator Adams, of course, in rural Western Australia and me in rural and regional New South Wales.

Senator BOYCE—Professor Currow, I am sorry I was not here for all of the questioning, so if you have answered this already, please just let me know. The budget sets out some funding for you and the Institute of Health and Welfare to develop a national database and collection system on cancer.

Prof. Currow—The AIHW have been funded to look at a program, and we have two quite discrete pots of money to look at specific projects within that, Senator.

Senator BOYCE—That was primarily going to be my question, because I think the budget papers talk about this being a collaboration between Cancer Australia and the AIHW. I was wondering if you could just talk us through what the structure of that collaboration will be.

Prof. Currow—Cancer Australia is already working closely with the Australian Institute of Health and Welfare. As I discussed at estimates at the end of last year, we have already published the first prevalence and survival data directly derived, rather than estimated, jointly with the Australian Institute of Health and Welfare. We have an ongoing formalised relationship with them.

Senator BOYCE—And how is that formalised?

Prof. Currow—In a memorandum of understanding. So that has been in place and, I think, is helping to guide a very strong and fruitful relationship. The other program that we have

already completed with them was the reason for one of your questions, I think, at, again, the estimates before last, looking at non-melanoma skin cancers and some of the impacts across the health sector. So we have already established a working relationship with the Australian Institute of Health and Welfare. What we are seeking to do in this work will be to look at some intermediate outcomes for cancer. The aim will be to look at the feasibility, particularly of collecting when metastatic disease is present—that is, widespread disease from cancer—or when that becomes apparent again after an initial diagnosis of cancer.

Senator BOYCE—Can you explain that to me.

Prof. Currow—Cancer is essentially, if you will, at three levels of spread throughout the body. It can be contained locally, it may spread regionally in that area of the body, or it may spread to distant parts of the body.

Senator BOYCE—So what you are looking at is the feasibility of splitting it up into those three categories, or your data up into those three categories?

Prof. Currow—Particularly the last category, Senator, because there is a lot of work going on around the world about automatically coding for the first two of those, from existing health reports, reports from radiologists on X-rays, ultrasounds, CT scans, and reports from pathologists on the specimens they look at under the microscope. The last of those is more often a clinical diagnosis, so we need to find ways of capturing that across the system so that we can understand what happens to cancer over time in a more effective way. We will also be looking at some key outcomes to benchmark cancer services, and this is preliminary work. This is pilot work with the AIHW, but it fits within their remit and ours, and I think it provides an exciting opportunity to better understand what is happening in cancer across the community.

Senator BOYCE—I am aware of people who have been told, 'You have got a month to live,' 'You have got six months to live,' or whatever. You would be able to test those types of diagnoses, and would this information also feed into palliative care work? What else would it do?

Prof. Currow—It would certainly potentially feed into palliative care, in that we do not have a good national estimate at the moment of when cancer occurs. So if a person has been diagnosed with a bowel cancer, it is taken out at surgery and they have some subsequent chemotherapy, there is a risk that that cancer will recur in the future.

Senator BOYCE—But we have no data collection for that presently?

Prof. Currow—For that second point, if you will. And as that is often a clinical diagnosis, we cannot automatically harvest that from existing data collection. So it will help in better understanding how people are living with cancer when they start to live with cancer again, so that we can look at better consumer support across the community. And that is not just palliative care; that is across all of the issues of survivorship and of early intervention, having recognised that cancer has recurred. And if we can do that, I think we will be able to demonstrably improve cancer services for a wide range of people across the community.

Senator BOYCE—Thank you.

Senator ADAMS—Just to continue with that as far as cancer awareness with our GPs goes: as Cancer Australia, do you have GPs represented on your board?

Prof. Currow—We have a general practitioner on our advisory council and we have general practitioners on each of our advisory groups. It is a crucial part of cancer care.

Senator ADAMS—Absolutely.

Prof. Currow—And we have engaged very actively with general practitioners—with the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners. I think it would be fair to say each of our programs has specific targets in interacting more effectively between cancer services and general practitioners and ensuring that general practitioners are provided with current evidence and updating of skills as cancer changes.

Senator ADAMS—That is the key, because it is the front door where the consumer or client goes in, and I think it is just so important that GPs are kept up to speed with what is going on.

Prof. Currow—I agree totally.

Senator ADAMS—Just on the bowel cancer strategy, I know that it is a screening program, but I will ask you once again: are your consumer network coming back with any comments on that screening program?

Prof. Currow—I have had no recent comments on that. I think the issues of the screening program are an issue that should be put to the department.

Senator ADAMS—It is just, once again, the communication—I did ask the department about it yesterday—with the advertising program and moving around the rural areas, as I do. We have just had a men's health inquiry, and it is trying to get men to actually act. I know my husband got the pack and just threw his hands up and said, 'What on earth am I supposed to do with this?'

Prof. Currow—Get him to give me a call.

Senator ADAMS—These are the sorts of things. That was a typical farmer's attitude. The Lions club did a discussion on it, and I think a number of his colleagues had received packs and done nothing with them. So this is what worries me: the fact that there is a cohort there that perhaps somehow we can get to to really let them know that it is just so important. I just do not think the advertising campaign is strong enough.

Ms Halton—In fact, I was having this exact conversation the other day with the prostate cancer people who came to talk to me about it, and one of the things we have talked to them about is actually hooking them up, firstly, with what we are doing with these regional cancer centres and also to what we are doing in terms of the GP superclinics, because I think it is about finding a way to communicate some of that information and giving men, in particular, a place that they can go which might be a fraction more anonymous than the bloke they go to the pub with if they live in a regional area. There is a whole series of issues about access and knowledge and all the rest of it, so that is more than a commenced dialogue and we will do work with that issue.

Senator ADAMS—I know one of the recommendations from the men's health report was about trying to have an annual check up. I suppose I was lucky in a way that my husband was a pilot and, of course, he had to front up every two years to have a very stringent medical. These are the things, but there is just that gap, and it is really very obvious in the evidence that was received in that particular inquiry that men think that they are completely and utterly invulnerable to any of these things, whereas women tend to—

Ms Halton—We can share anecdotes about husbands here, Senator. I could start doing the anecdote about my husband. I think there is the objective evidence and then we all know, domestically, that they can all be like that; he is as bad as the rest of the blokes.

Senator ADAMS—The thing is, too, with the advertising. Breast cancer, of course, and now ovarian cancer are doing so much better with promoting the disease, and people talk about things like that now. So somehow we have got to get prostate and bowel cancer screening, especially, up. If you could ask, when you meet with the consumer group next time, just get some feedback, because the second round is starting and it is so important that those people do that follow-up if they have done the first one.

Ms Halton—Absolutely.

Senator ADAMS—Professor Currow, I remember that when you were first appointed to this position I asked you questions on consumers and you were not really quite sure what sort of beast they were. I would like to congratulate you on the way that you have involved them throughout the advisory committees, because that is really good. Thank you.

Prof. Currow—Thank you, Senator.

CHAIR—I think that is the end of the questions. Thank you, Professor. We did not get anything to you, Ms Morris, but no doubt that will happen later in the day. I do think that we should break for morning tea now rather than start the witnesses from the breast and ovarian cancer organisations.

Proceedings suspended from 10.26 am to 10.41 am

CHAIR—We will reconvene with the witnesses from the National Breast and Ovarian Cancer Centre. Good morning, Dr Zorbas. Lovely to see you.

Dr Zorbas—Good morning, Senator.

Senator ADAMS—It is very nice to see you. A number of members of our committee have visited you in Sydney. That was two years ago, so I just wondered if you could give us an overview of where the organisation is going and the achievements that you have had to date. I know it is a big ask.

CHAIR—Can you include the funding notice in your overview? I just think if you get the whole thing on the record, it would be good.

Dr Zorbas—Yes, certainly. The National Breast Cancer Centre, as it was, was established in 1995 by the Australian government, and since that time our funding continues to be primarily through the Commonwealth government. In 2001 our remit was extended to include ovarian cancer because of the successes that we had exhibited in breast cancer and breast cancer outcomes. So we work in breast and ovarian cancer, and that is what our funding

agreement is in line with, with the Commonwealth. We currently have a four-year funding agreement to 2011.

The work of the organisation continues to be defined by an evidence based approach to translating the best available research into practice. That includes information for the community that is evidence based; information in the form of guidelines and recommendations for health professionals, be they specialist, generalist or allied health; and information that supports consumer decision making, so that is taking the same information that we develop for clinicians and providing that as user friendly and appropriate language that assists consumers in determining the options that are appropriate for them, based on evidence. We also use evidence to look at the best ways to improve health service delivery and to inform policy.

We have a very strong track record that would take some time to detail. In summary, we have developed over 25 sets of clinical practice guidelines and consumer recommendations. These have significantly improved the care that women and men with breast cancer have received, and we believe we have made great changes to the way that ovarian cancer is managed and is perceived by clinicians in both the generalist and specialist fields. The information that we provide is increasingly sought by the media. We have over 250 citations in the media each year. We have a website. The website visits increase at a rate of about 17 per cent per annum and we are rated No. 2 in Google Australia. We have a suite of publications that currently number 214, and those are extensively sought after and are distributed annually. We have about a quarter of a million resources that are distributed free of charge each year. The work that we have done has made a huge difference to the way that care, not only in breast cancer but also in other cancers, has evolved, and that is because we have demonstrated that the model that we have developed in breast cancer has application beyond breast cancer and the use of that model in ovarian cancer demonstrates this.

Multidisciplinary care, psychosocial care and communication skills continue to be flagship areas that we have pioneered in Australia and they are areas that have broad application not only for those with breast or ovarian cancer. Some of our guidelines have been world firsts, and we continue to work not only to improve outcomes in terms of survival and mortality but also, importantly, to improve outcomes in terms of the psychosocial and morbidity aspects of the diseases. Our guidelines in psychosocial care, as I said, were world first, and our guidelines not only are developed, but we have a very strong plan on implementation and evaluation, so that the implementation of those guidelines and that information is informed by evidence and that evaluation cycle feeds into gaps in care that we identify through our continuous monitoring and evaluation processes in house. So we have built a very strong body of work. We have provided, I think, leadership in cancer control through our work in breast cancer. We have a number of areas of work to go forward with that we feel will not only impact considerably on breast and ovarian cancer but perhaps have application across other cancers as well.

The organisation's evidence base is really across the whole continuum of care. We take in information from risk reduction right through to palliative care, so we ensure that the whole continuum of care is addressed. Our way of working has always been, first of all, evidence based—that is paramount and non-negotiable. A partnership and collaborative approach is

also paramount to the way we have worked, and we demonstrate that through our numerous advisory groups, working groups and collaborations that are very effective on the ground.

Most important—and you have noted how important this is, Senator—is the involvement, in a real sense, of consumers, who inform and validate our work in every way. We have a very strong relationship with the consumer groups across Australia and we involve them meaningfully in every working group that we have, and we have about 30 of those active at any particular time, and in each of our advisory groups and even at board level.

Senator ADAMS—Thank you very much. That is a wonderful track record, especially in four years, nearly five.

Dr Zorbas—The work in ovarian cancer started in 2001, but we were established in 1995.

Senator ADAMS—That is very good, especially with the hits on the website like that. As far as your guidelines and the evaluation, how often do you review the guidelines?

Dr Zorbas—We have a review process. We have a research team in house, which constantly reviews the research that comes through. Each week, there would be at least 20 articles of relevance to breast or ovarian cancer which are quality evidence that we review in house. We have advisory groups who help us determine whether there is a significant body of evidence that would require review of a guideline. If that is so, that is done as that comes to light. If a guideline appears to be still current—and these are reviewed annually if there is nothing significant in the research evidence that appears earlier—then, as a matter of course, we revise those guidelines on a five-year basis. In our business plan for the coming two years, we have quite a considerable effort identified in developing topic-specific guidelines for three of our key guidelines.

Senator ADAMS—How many staff do you have working for you?

Dr Zorbas—We have approximately 30 full-time equivalent staff in the National Breast and Ovarian Cancer Centre and they have a range of expertise, which really helps us to build capacity in house. That ranges from public health research, communications, health services, epidemiology and medicine. I have probably forgotten something, but they are a broad skill base, all very highly qualified individuals, who really assist us to be able to have in-house expertise and knowledge that is built on year on year.

Senator ADAMS—The change in that time is certainly very, very encouraging. As I said, I think it was two years ago that the committee visited you, and that has happened in that short space of time. As far as ovarian cancer awareness is concerned, would you say that that has definitely improved over the time that you have been involved?

Dr Zorbas—Senator, it has been a wonderful story in terms of ovarian cancer awareness. We are very pleased with the results that I am able to report in relation to that. We had an ovarian cancer public information campaign that was launched in Ovarian Cancer Awareness Month, February 2008, and that campaign was very carefully crafted because of the very difficult communication messages around symptoms, without wanting to create alarm in the community because the symptoms are ones which we commonly experience, and yet providing enough information that would alert women to the importance of reporting those

symptoms if they were unusual or persistent. That campaign resulted in a very significant increase in women's understanding of the symptoms, and we have evaluated that.

Between October 2007, which was prior to the release of that public information campaign, and March 2008, there was an improvement in the number of women who could appreciate that an abnormal pap test did not mean that they had been tested for ovarian cancer. Sixty-one per cent of women in October believed that an abnormal pap test would be a sign of ovarian cancer, and in March 2008, after the release of our campaign, only 16 per cent of women surveyed. And this was done on an online *Women's Weekly* survey, which we have confidence in is the right demographic for the reaching of our awareness messages.

In addition to that, there was a statistically significant improvement in knowledge around the three key symptoms of ovarian cancer. The awareness of putting on weight around the middle increased from 26 per cent to 42 per cent. The awareness of feeling full or bloated increased from 47 per cent to 70 per cent, and the awareness that back pain could even be a symptom increased from 33 per cent to 61 per cent. We are quite confident that, as we were the only ones promoting these messages, those improvements were a direct result of that campaign.

Senator ADAMS—And feedback from general practitioners on that campaign?

Dr Zorbas—We worked very closely with general practice in the development of those messages and ensured that we had buy-in, because, of course, women who would potentially develop these symptoms would be going to see their general practitioner as the first port of call. With that campaign, we also ensured that general practice was adequately resourced with information to guide the way that they investigated women who would report with symptoms. We developed a guide for general practice with a format that was relevant to general practice; that is, an A4 card. It clearly identifies the symptoms and a pathway for investigation. It also clearly identifies the importance of referral to a gynaecological oncologist if there is any suspicion of ovarian cancer, because the evidence clearly defines that the outcomes for women whose care is directed by a gynaecological oncologist is improved.

We have worked very closely with general practice in developing resources, and there is also another resource that we have recently developed about appropriate referral for women with ovarian cancer, again, specific to general practice, with mention of an example of the risk of malignancy index. It is a bit technical but it actually defines quantitatively what a GP needs to know in terms of: 'This is an alarm bell that should be referred on.' But, in addition to that, we have rolled out significant educational material and worked with the divisions of general practice to get them to take up education modules that we have developed specifically in ovarian cancer, and we are working with the RACGP to develop online educational training as well in that area.

Senator ADAMS—Does anyone else have anything to add?

CHAIR—Any other questions? Thank you very much, doctor.

Senator ADAMS—I can just do one more, then.

CHAIR—Okay.

Senator ADAMS—I want to come back to breast cancer and the importance of mammography. If a patient goes through the system and a mammogram clears them of cancer but they come back later with other issues such as obscure pain and different symptoms like that, would, say, a bone scan be available to them? Have you had any feedback on that, or is there anything that you can tell me about that?

Dr Zorbas—Senator, in the first instance, in the diagnosis of early breast cancer, we have developed a number of resources and training materials and modules in relation to the symptoms and the investigation of symptoms that could be breast cancer. I think your question specifically relates to recurrence of disease. Just recently, we reviewed the evidence in relation to what is best practice in follow-up for a woman who has been diagnosed with breast cancer. The evidence does not support what we would call intensive surveillance with investigations other than mammography and/or ultrasound in the first instance.

The investigation using tests such as bone scans, CT scans or blood tests is warranted on the basis of symptoms. So if a woman who has had a primary diagnosis of breast cancer returns for follow-up or presents in between follow-up, which should happen on an annual basis, with symptoms that could be a recurrence, there is the obligation to investigate those symptoms with the thought that they may, in fact, be symptoms of recurrence—of course, they may not be—and then appropriate treatment initiated. There is no evidence, as I said, of survival or mortality benefit from doing those tests on a routine basis.

Senator ADAMS—Good. Thank you.

CHAIR—Thank you very much, Dr Zorbas. I think it is about time the committee came back to visit you, so we will make arrangements for that.

Dr Zorbas—We would love to welcome you back.

CHAIR—It was a very useful session that we had with you. Thank you.

Dr Zorbas—Thank you.

[10.58 am]

National Health and Medical Research Council

CHAIR—Our next evidence is from the National Health and Medical Research Council. Senator Williams had a number of questions, but he was called away, so he has left his questions with Senator Boyce. So we will proceed in that way.

Senator BOYCE—Good morning, Professor Anderson. Firstly, there is $340 million in your budget over the next five years for research. Could you give me a list of the organisations which you currently intend to disburse that money to, or the areas in which you intend to disburse that money?

Prof. Anderson—Thank you, Senator. Let me answer the question slightly differently, and if I am not getting it right, come back, of course. We run a number of schemes with specific objectives in mind. We fund research, we fund the next generation of people that we bring through so we have got research, and we fund some specific efforts to make sure that research turns into better clinical practice and so on. All of those schemes are openly competitive, and so researchers anywhere around Australia can apply for that. Which university or which

institute gets which amount of money just depends on how well they are going in their research, how well they apply to us, and the outcomes of our peer review panel. We do not pre-allocate, except in some small areas, where we will fund research. One of those small areas was our call last week for people to apply for research into the current swine flu epidemic. So, from time to time, we will call for specific areas. But we see our responsibility to fund research right across the health spectrum and the best ideas and the best minds.

Senator BOYCE—Ms Murnane mentioned yesterday, or it may have been Professor Bishop, the funding for projects on swine flu. What response have you had to that?

Prof. Anderson—We have had lots of inquiries, but the actual application form only went on the web by close of business yesterday.

Ms Halton—It is a little early, Senator.

Senator BOYCE—I imagine there would have been quite a few people anxious to do things.

Prof. Anderson—Yes, and also very capable. We have a very, very internationally capable set of researchers in both virology and the virus itself and also in epidemiology. So we are absolutely convinced we will have some very good researchers working with this so that by the end of the year we will know a lot more about the virus, how it affects people.

Senator BOYCE—Am I right in assuming that these would be short, sharp projects?

Prof. Anderson—Yes. Good point. And different to our normal funding. Our normal grants are three to five years. This will be up to one year, and the researchers are to report to us and to the department in six months. So short, sharp, get on with it, and very targeted.

Senator BOYCE—How much money have you set aside for this?

Prof. Anderson—We have set aside up to $7 million and we have some capability, if we have more than that in good ideas, to fund further. We already fund quite a lot in flu: off the top of my head, more than $20 million.

Senator BOYCE—Towards various projects—

Prof. Anderson—Regular.

Senator BOYCE—related to various flus and viruses?

Prof. Anderson—Sorry, I should not have said 'regular', according to the secretary; seasonal.

Ms Halton—Thank you. That is better.

Senator BOYCE—I was going to say your ordinary flu, but that is possibly just as bad?

Ms Halton—I think 'seasonal' is the accepted terminology.

Prof. Anderson—'Seasonal' seems a safer word, Senator. This includes, by the way, a very large program grant to Professor Peter Doherty who won the Nobel Prize in 1996. It is an indication of the sort of capabilities we have in this country in this area.

Senator BOYCE—Are you able to give me the priority areas that you would be interested in seeing projects for around the swine flu research?

Prof. Anderson—Yes, we can do that. And we have been relatively specific about that. We think there are two really crucial areas during our flu season—that sounds a terrible expression, too, but over the next several months, our winter. One is to understand the virus itself, what are its capabilities to turn bad or good, what is the progress of it re-assorting its genetics around that; virus biology, if I could put it that way. The second area is its effect on us as human beings—to follow the clinical course of people who have been infected to understand who is at greater risk; to model that. Who would be more vulnerable.

Senator BOYCE—Based on current evidence?

Prof. Anderson—Based on databases that we will be accumulating via the health authorities around the country. Our researchers will work with those and bring their research skills to understanding that.

Senator BOYCE—So primarily applied research?

Prof. Anderson—Yes. Certainly, the latter: applied research. And public health research, clinical research. But on the virus itself, 'applied' in the sense that we want to know some very specific things. But it will be absolutely dependent on the skills of our basic virology biologists around the country, to bring their basic skills to say, 'Based on what the world knows about viruses and about flu viruses, this is what we think will or might or might not happen'.

Senator BOYCE—And only Australian-based organisations can apply for these grants?

Prof. Anderson—No. We have said that our own researchers should work with anybody around the world about that. But under our arrangements, the money has to go to an Australian institution. So if there are researchers at the University of Melbourne or University of Sydney, they will be able to have investigators anywhere in the world on their grant but the grant will be administered through an Australian university.

Senator BOYCE—Would you anticipate that these would actually be new research projects or that people who might otherwise have been conducting research would now look for funding for that work?

Prof. Anderson—It is a good question. I am not sure I can answer until two weeks time, when the applications close. But we are hoping that as well as our established flu researchers, there will be people with virus or epidemiology skills who will say, 'I could bring my experience in a different virus or a different area to this particular issue, because I have very good models of infection' and so on. We are not restricting it. The only restriction we have, of course, is that if you are already funded for something, we are not going to double fund you for it. But other than that, we do hope to encourage some other people into this field.

Senator BOYCE—Because in some circumstances to get a new research project up in this time frame could be somewhat difficult.

Prof. Anderson—That is again a good question. One of the things about the virology research is that, versus 10 years ago, we are so far advanced now in terms of modern genomics. So people can bring their technology, which is now much more generic, to the field and should be able to start very quickly.

Senator BOYCE—Professor Currow from Cancer Australia, when he was here earlier, was discussing a NHMRC research project on cancer and data collection. Could you tell us a bit about that project, please?

Prof. Anderson—We have, I must say, terrific relationships with Cancer Australia. People, if they are applying to Cancer Australia, can also apply to us, of course, for the same research. Or they can just apply to Cancer Australia. We run the peer review system and if that cancer research, whether it is health services—

Senator BOYCE—You run the peer review system for Cancer Australia as well as for yourselves; is that correct?

Prof. Anderson—Correct. And then Cancer Australia, if people want funding from them, run the second system where they look at whether it is targeted to their priority areas. That relationship is very good.

Senator BOYCE—Are there other organisations that you undertake the peer review for?

Prof. Anderson—Yes.

Senator BOYCE—Could you give me a list?

Prof. Anderson—I can give you a full list; I do not have it with me. Since last year, the Heart Foundation, the cancer councils and for a number of the smaller charities that wish to support, say, younger researchers, younger post-docs, again we run the peer review program and sometimes co-fund with these smaller charities. We, first of all, reduce their overhead costs in terms of peer review, but also help the smaller areas get a critical—

Senator BOYCE—They simply would not have the expertise without buying it in, probably, to undertake this.

Prof. Anderson—Yes. Correct.

Senator BOYCE—I do not currently have it with me, but there was a newspaper report during the week that used the word 'research rorts'. You would be aware of this article, I take it. The tenor of it was basically that our research community was a bit of a cosy clique and did not allow for out-of-the box research. Would you like to address that report?

Prof. Anderson—Yes. I think there are two aspects there. There was the allegation that, I guess, is mainly a matter for the department of science and research, that there was some transfer of funds between universities and other organisations. I think that was the headline where 'rorts' was used. That was around the indirect costs of research. We are currently examining our policy around what we call administering institutions. It is the rules we have with universities or institutes or hospitals about how to properly look after Commonwealth funds through the NHMRC.

Senator BOYCE—How to properly monitor the use of those funds?

Prof. Anderson—Certainly in terms of reporting, and also to have rules and regulations in place. We require institutions to abide by our rules about human experimentation and animal use in research and a document we call the code for the responsible conduct of research, which is around proper research conduct. But I was referring more to just having the right

reporting mechanisms in place, because, of course, they have to account to us for every dollar. We want to make sure that we have got good policy in place about that.

The other issue that you mentioned was an article in the *Australian*. I think it came from our Nobel Prize winner in Western Australia. Barry Marshall initiated this and, of course, Barry Marshall's discovery is so wonderful that somebody got an absolute left-field idea and pursued it. It turned out to be right and it won the Nobel Prize. The idea was that ulcers were not to do with stress; they were to do with infection. Funding bodies like us are always anxious about whether we might stifle that sort of completely blue-sky research. I feel fairly proud about the NHMRC on this. We have always had the innovativeness of the idea as part of our scoring system, and that is not the case for some of our overseas sister organisations.

We also give our best researchers, through a program grant system, a lot of flexibility in following up the hot leads that come up during the grant. I certainly would not say that somebody coming to the NHRMC with a really left-field idea might not get a good peer review process through that, but it would be a judgment based on the peers. So if somebody comes with a very left-field idea it is other scientists, not the officials of the NHMRC, who will look at that. There is not a line that you can draw between ideas that are just crazy and ideas that are crazy but really smart.

Senator BOYCE—Yes. With a lot of those things, we do not know for some considerable time. Nonetheless, there is perhaps the potential for a type of groupthink to develop if you are undertaking the peer reviews of research not just for your very own substantial funding market but for other organisations as well. What are you doing to address that issue?

Prof. Anderson—That is a serious matter that I have spent a lot of time thinking about since I was appointed to this job. We have put in place quite a few things over the last couple of years to try and get around that, so that we now separate decision making through the system so there is not one group of people appointing each other to committees or appointing external reviewers.

The system is that we appoint something we call the academy—a bunch of distinguished researchers selected, amongst other things, on their reputation for integrity. They advise us on the membership of our peer review panels, and we have an independent chair who is not part of the decision-making process. We then appoint external reviewers on the advice of this academy. That is a group that can be up to many thousands of researchers around Australia. They write written reviews and it comes back to a panel. This panel, which has had no other involvement in those decisions, sits and looks at the grant, the external opinions, and makes a ranking decision between one and seven on that. And then that comes as an anonymous set of grants to our research committee that then advises our council on what to fund.

That is a long answer, but what I have tried to do is split and bring diversity to the appointment and decision-making process throughout the peer review so that the risk of being captured by a small group, and groupthink, is minimised. Of course, we also use international reviewers where we can. On the swine flu, for example, both New Zealand and Singapore have agreed to help us make the peer review decisions around that. My colleague Dr Morris has just reminded me of the other innovation I have put in, which is probably the most important one. We now have in all our peer review systems a community observer, somebody

who is not a researcher, drawn from the community. This is chaired by a layperson on our research committee. So we have independent people in each of those panels and they report directly back to us if they see people not abiding by our strict rules on how to proceed.

Senator BOYCE—Are they a permanent appointment, or it would be—

Prof. Anderson—Year by year.

Senator BOYCE—But that person would look at all the research in a particular field?

Prof. Anderson—It is usually done not field by field, but grant by grant. There will be somebody there for our Australia Fellowship Scheme and there will be another person or two for our program grants. Then there is a dozen or more people for our bigger schemes such as project grants. But they are there for the whole year, so they are there through the process.

Senator BOYCE—And one of the requirements is that they do not have professional qualifications in the area?

Prof. Anderson—It is now.

Senator BOYCE—I can see a lot of retired doctors and scientists getting involved if you are not careful.

Prof. Anderson—Yes. We were very pleased that consumer groups and others have been very interested in this. We certainly get a lot of advice from, the Consumer Health Forum on how to establish people. But you are right: it is something to guard against.

Senator BOYCE—Evidence based policy is something we have heard a lot of from the government during the estimates hearings. How does an organisation like the NHMRC absorb that line into their work?

Prof. Anderson—Good question. There are two main advisory functions of our organisation. One is the issuing of guidelines, either clinical practice guidelines or environmental health guidelines. The process there is that we run for the country some very strict criteria on how to deal with the evidence—how to rank it and how to allocate it. The first step of that is usually a rigorous review of all the literature under very strict protocols. A working party eventually turns that into guidelines—on alcohol drinking or other clinical matters which come to our council. Our staff and council have a process that insists that everything is looked at and everything is allocated in terms of its reliability as a published set of research. Of course, that can be difficult because in some areas the research is much less secure than in other places. But we have a very highly developed and, I think, admired protocol there.

On other things, such as things that are brought to us by our council—for example, fluoridation of water supplies—we would commission rigorous research and analysis of the current state of research and—

Senator BOYCE—So you have done recent research into fluoridation?

Prof. Anderson—Correct—at the request of our council. And that publication is on our website. Again, for something like fluoride we would also keep a strong survey of the research literature in case there was new research coming up.

Senator BOYCE—Thank you. What priority are you currently giving to research projects looking at the potential effects of climate change on all Australians?

Prof. Anderson—I will ask Dr Morris to answer this question. We are working with the new Department of Climate Change to fund research this year. People have already applied to us for research on the health effects.

Senator BOYCE—Have those projects been finalised,?

Prof. Anderson—No. They have been finalised from the researcher's point of view but not from our point of view. It is still under peer review.

Senator BOYCE—You have not announced them?

Prof. Anderson—They will be announced by our minister later this year. I should also point out that one of our Australia fellowships—it is our peak fellowship—is to Professor Tony McMichael at ANU. This is a big grant of $4 million over five years. Professor McMichael is heavily involved also in international policy around health effects of climate change, including with the United Nations. So we do have some stars in this area in Australia, and we are certainly expecting some good research bids to be put in this year.

Dr Morris—I can just confirm that we are working closely with the Department of Climate Change to fund research projects into various aspects of climate change, and the research priorities there were actually identified by the Department of Climate Change through a national research adaptation plan published in about October 2008.

Senator BOYCE—Thank you.

Senator SIEWERT—Thank you. I have a couple of issues I would like to talk about, but first I would like to talk about the review of the public health funding report. Could you give us an update on where you understand the report is at, and the time lines around when it was developed and when it was presented?

Prof. Anderson—Thank you, Senator. I will just remind myself of the time lines in a moment. This is a report that was commissioned by me at the recommendation of our research committee. There are four important aspects that all need support: public health, health services research, clinical research and biomedical research. Around three years ago, our research committee became concerned that the growth that they had hoped for in public health research was not as great as it should be. So I commissioned an independent committee to invite Professor Nutbeam of the University of Sydney to look at this. The work was very much helped by the Public Health Association of Australia who held consultative processes around the country.

Around the same time, I also commissioned two other independent reports: one chaired by the then head of the Canadian Institutes of Health Research and one chaired by the then head of the US National Institutes of Health. All those are very powerful and very helpful reports. Then when we received them all, I guess it occurred to the NHMRC that since we were within a year of needing to redo our strategic plan, the sensible thing was to draw those three reports and our thinking about it together into our next strategic plan. Our strategic plan requires there to be a strategy for medical research and public health research.

With those three reports and our thinking about the next triennium, we have brought them all together. We have done a lot of consultation with our committees and with our council, and I guess I will take responsibility, really, for the decision that it was best to release this report together with this overall strategy for the next triennium. I know the public health research community are very anxious to get the report; when they see it, they will be very pleased, I think, with the NHMRC's response. That has been drawn together in the strategy of health and medical research. According to our act, we need to consult with our minister on that strategy for medical research and public health research, and we are in the process of doing that.

Senator SIEWERT—As I understand it, where it is up to now, from what you have just said, is that you have presented it to the minister?

Prof. Anderson—Correct.

Senator SIEWERT—And you are waiting for the ministerial response?

Prof. Anderson—Correct.

Senator SIEWERT—When did you present it to the minister?

Prof. Anderson—We sent the minute, I think, 26 May.

Senator SIEWERT—This year?

Prof. Anderson—Correct.

Senator SIEWERT—What were the other two reports you mentioned about?

Prof. Anderson—I can send you the terms of reference, if you like?

Senator SIEWERT—That would be much appreciated.

Prof. Anderson—The so-called Bernstein committee was asked to look at our processes, especially around peer review: were we international best practice; were there things we could learn from the experience of the people on that committee. Then the Zerhouni review were asked to be more strategic, think about our general direction and give us advice on which way to go. Again, like the Nutbeam report, we have taken great ideas that came from all those three reports and incorporated them into this new draft strategy.

Senator SIEWERT—The report that was presented to the minister is the draft strategy?

Prof. Anderson—Correct. But, Senator, it also includes those three reports that I commissioned and our specific responses to each of those three reports as well. We intend to release all that for consultation over the next months.

Senator SIEWERT—So it was given to the minister on 26 May and now you are waiting for the government's response, and then it will be released?

Prof. Anderson—Correct. The minister's, I guess, response to our ideas.

Senator SIEWERT—Could you tell me how much you invested in getting the three reports done?

Prof. Anderson—I would have to take that on notice.

Senator SIEWERT—That would be appreciated. I understand you did look at also the Public Health Education and Research Program?

Prof. Anderson—No. That is a program run by the department.

Senator SIEWERT—So you did not look at the role that it has played in public health research?

Prof. Anderson—The Nutbeam report does mention what we call PHERP, but that is not a program that we run.

Senator SIEWERT—So you did not look at it, but you mentioned it. In what context?

Prof. Anderson—The Nutbeam report mentions it in the terms of the country's capacity, I suppose, in public health research.

Senator SIEWERT—I may be getting pinged out of order here but I am going to ask it anyway and they will ping me out of order. What is your opinion of the program?

Prof. Anderson—Of the PHERP program?

Senator SIEWERT—Yes.

Prof. Anderson—I prefer to answer that question when we release our report that is with the minister—

CHAIR—I think that is a fair response to that question.

Prof. Anderson—where we have clearly responded to that part of the Nutbeam report.

Senator SIEWERT—So the report does canvass that program in response to the Nutbeam—

Prof. Anderson—Correct.

Senator SIEWERT—Could you tell us who was on the independent panel that you commissioned to do the Nutbeam report?

Prof. Anderson—I will see if we have that data. Again, we will have to take it on notice. It included people with a high reputation in public health research itself.

Senator SIEWERT—If you could take it on notice, that would be appreciated. As I understand it, you commissioned three reports. Could you tell me when they were finished, and then I will ask my next question?

Prof. Anderson—The Nutbeam committee sat through the second half of 2008. The Zerhouni committee sat at the beginning of 2008 and Bernstein at the end of 2007.

Senator SIEWERT—So you had all the reports by the end of 2008. You then used them to develop your next strategy and then presented it to the minister.

Prof. Anderson—Correct. And we began to develop our strategy towards the end of 2008 and had taken it to our council two or three times and the research community two or three times.

Senator SIEWERT—Do you have any expectation of the time line of a response from the minister?

Prof. Anderson—From the research community?

Senator SIEWERT—No, from the minister.

Prof. Anderson—I do not think I should answer on behalf of the minister.

Senator SIEWERT—I was not expecting you to say anything inappropriate. I was just wondering if you had been given a time.

Prof. Anderson—No.

Senator SIEWERT—Then the idea is that, when you get it back from the minister, it goes out for consultation with the broader community.

Prof. Anderson—Yes, because we really do want to make sure we consult with the research community, as we try and make sure that over the next three years we really fund the best research across the board. We are really looking forward to the research community feedback on this plan, so they will have everything.

Senator SIEWERT—I absolutely appreciate why you would be going out to the research community, but are you going out to other stakeholders such as health consumer groups?

Prof. Anderson—Yes. Thank you for picking me up on that. As always with the NHMRC, we will not only announce publicly that we are looking for feedback but we have very extensive consultation lists of organisations, way beyond just the research community itself.

Senator SIEWERT—Thank you. I have another series of questions about something completely different. Can I go on to those?

CHAIR—You have got to 10 minutes.

Senator SIEWERT—It will be quick. Could I go on to the Naltrexone implant clinical trials? I was asking the department about these yesterday. I understand that you are looking into the clinical trials that are being undertaken on the implants.

Prof. Anderson—We have funded a clinical trial on the implants and, as in the normal course of events, received a report on that once it was finished. With, if you like, all NHMRC funded research it is a requirement that people publish their results in the scientific literature. I might ask Dr Morris to comment on that, but we do understand that there is a paper being prepared or underway for the scientific peer review literature.

Senator SIEWERT—I should correct myself, too. It was the TGA I was asking about it yesterday, sorry. Dr Morris?

Dr Morris—The NHMRC has funded five projects relating to the use of Naltrexone implants and we have been in contact with the chief investigator for that research and we understand there are a number of publications in peer review journals that are in press. We are awaiting the outcome of that process with interest.

Senator SIEWERT—So you funded the trials and out of that come peer reviewed papers, but you have not seen the papers yet?

Dr Morris—Not until they are published.

Senator SIEWERT—When did you fund the trials?

Dr Morris—It is probably best to take it on notice. There was one randomised control trial which we funded in, I think, 2004 and it finished at the end of last year.

Senator SIEWERT—Okay.

Dr Morris—That is the main one that we are waiting on the peer reviewed reports.

Senator SIEWERT—You said there was five projects. Could you take on notice what they were and how much they were and when you funded them?

Dr Morris—Yes.

Senator SIEWERT—Basically, you are waiting for the peer reviewed articles. What happens after that?

Prof. Anderson—Nothing as far as the NHMRC is concerned, unless the researchers apply for more funds, and then our peer review process would take into account what has come out of the previous research and their views of the peer review publications and so on. We do not have a role in the regulatory side.

Senator SIEWERT—Yes. You said you were expecting them shortly. Is there a time line on that?

Dr Morris—This is up to the process of journals. When you hear that an article is in press it generally means it is going to be available within four to six months.

Senator SIEWERT—And that is in press at the moment, you said?

Dr Morris—Yes.

Senator SIEWERT—Thank you.

CHAIR—Any further questions of NHMRC? Thank you very much, Professor, Dr Morris and Ms Russell. Ms Murnane being back, we will now go back to aged care. With agreement, Senator Xenophon is going to start.

[11.34 am]

Senator XENOPHON—Thank you, Chair. My first question relates to the lifting of the pension age. Has the department conducted or commissioned any analysis or research on the physical impacts on tradespeople, those who undertake manual labour, on lifting the retirement age from 65 to 67?

Ms Halton—No.

Senator XENOPHON—Maybe you could take this on notice. Firstly, is it proposed that there will be any research undertaken on that and also on how many people involved in manual labour would now face retirement at 67 instead of 65?

Ms Halton—This is probably more properly a question for Family and Community Services, not us, as we are not responsible for pensions.

Senator XENOPHON—But insofar as there could be a link with respect to issues of aged care—but I will not pursue it, Ms Halton. That is fine. Can I just ask you about funding costs, given that Australians are living longer and they are staying healthy and staying in their homes longer but that when they do eventually go into care their physical and mental needs

are greater and there is a greater demand for a high level of care. The industry claims that as need has increased the government has not adjusted funding to reflect real costs and that staffing levels have declined against need. Firstly, what information does the department have on staff-to-patient ratios? Secondly, does the department have any historical information about staff-to-patient ratios in terms of any trends in respect of that? Thirdly, what impact does—

Ms Halton—Senator, we are going to have to write this down if this is a multibarreled question.

Senator XENOPHON—I will just leave it at those two, and some you may wish to take on notice.

Ms Halton—Thank you. It is probably because our short-term memory is not what it should be. Did you get the first two barrels of that?

Mr Stuart—Yes. There is a system in place in relation to aged-care funding which does broadly reflect the level of need of each individual client. It is called the Aged Care Funding Instrument. The more high-care residents there are in an aged-care service with the more high-care needs, the more the funding flows to that particular aged-care home. So the funding model does follow need very significantly. As to staffing, the first question was about—

Senator XENOPHON—Staff-to-patient ratios and, secondly, associated with that, the trends in respect of staff-to-patient ratios.

Ms Halton—Senator, while people are turning pieces of paper, you may or may not be aware that in terms of information that is germane to funding, since the change to the system and its antecedents that Mr Stuart just mentioned, which occurred in the legislation that was passed in the late nineties, we have not funded on the basis of individual staffing members. The old funding arrangements, which went down to literally part-time clerks and dishwashers, was replaced by the kind of aggregate funding instrument that Mr Stuart just mentioned, the current one, which is the ACFI.

Senator XENOPHON—Ms Halton, whilst they are looking at that, I will just move on, given the limited time.

Ms Halton—Yes.

Senator XENOPHON—The provision of aged care has become more expensive as a result, hasn't it, with higher levels of care or higher levels of need over the years?

Mr Stuart—Undoubtedly, yes. Over the last decade the average need level of a resident has become higher. We saw under the previous resident classification scale a gradual upward drift in the classification of residents, and that was reflected in increased funding under that classification scale. By the time that the resident classification scale went out of use, nearly half of all residents were classified as either one or two on an eight-point scale, being the most needy clients, and that would have been then reflected in those homes being funded at the higher levels on the resident classification scale.

We have now moved to the Aged Care Funding Instrument, where there has been a very significant increase in the highest level of funding that is available under that instrument and also increased funding for particular kinds of residents, in particular residents with dementia

and behavioural issues, which were thought not to be adequately reflected under the previous instrument.

The level of funding in aged care rises every year quite significantly from three causes. One of those is ordinary cost indexation. Another is increase in the number of residents, which keeps going up in line with population growth. But the third is upward creep in the average level of frailty of residents. In the current financial year that led to an increase overall of a little over eight per cent on a per-client basis in the level of funding in aged care.

Senator XENOPHON—Way above the rate of inflation and the CPI?

Mr Stuart—Yes.

Senator XENOPHON—In the department's supplementary submission to the Senate inquiry, at pages 26 and 28, the department argued that revenues flowing to aged-care providers have increased faster than costs over the years from 1999 to 2008. And, as I understand it, it was attributed to greater productivity. But is it the case that the number of full-time equivalent direct care workers grew by 3.7 per cent during that period while the number of residents in care grew by close to 10 per cent? How does the department measure changes in productivity in residential or community aged care? How do you measure the quality of care, given that there has been a faster increase in the number of residents compared to the number of direct care staff?

Dr Cullen—That is a very complex question. It is certainly true that the department's analysis is that revenues grow faster than costs when you take into account the productivity improvements that providers are making. We control for quality in that analysis, because we have the accreditation system which ensures that the care delivered is of a high quality. Therefore, essentially, you know that you are producing high-quality care, so you have controlled for quality. It is also true, what you said, that there has been a faster rate of growth in the number of residents than there has been in the number of direct care staff. However, it is also important to understand that there has been a significant shift in the skill mix of those staff and that the skill mix has increased over that time. It is not just a matter of numbers there. You also have to control for the fact that there is a much greater preponderance of staff with certificate levels III and IV in the industry now and, therefore, at a higher skill level. We try to control for all of those variables when we measure the growth.

Senator XENOPHON—You are satisfied with the accreditation mechanisms? You are satisfied that care is not being compromised despite there being, on the face of it, many more residents than direct care workers in terms of the growth of the two?

Dr Cullen—I will let Ms Smith answer that. But I can provide one more piece of information there. The latest survey we did showed that there were, in full-time equivalent terms, 79,000 direct care workers in the industry, caring for around about 160,000 residents. So there is about one care worker for each two residents. You then have to take into account the fact that you are staffing over an entire cycle et cetera. But I just wanted to put those numbers in.

Ms Smith—I think we have a very mature accreditation system for aged care in this country. Homes are subject to both a normal process to assess their compliance with accreditation and then an ongoing process of unannounced visits to ensure that that quality is

being maintained over time. Ninety-two per cent of homes receive three-year accreditation, and then there is a framework to take action on any homes that have noncompliance. That is our system for ensuring that quality care is being delivered and that where problems are found, they are acted upon.

Senator XENOPHON—Is the number of unannounced visits static? Has it increased over the years?

Ms Smith—It has increased over the years. My colleagues from the accreditation agency can comment on that, but each home must receive at least one unannounced visit per year, more if necessary. That is done according to a risk profile of the likelihood of needing extra monitoring.

Senator XENOPHON—Thank you. Ms Halton, can I just go to the question of the real costs of care. Obviously, the issue of an indexation arrangement that matches the actual need is important. In this year's budget, did the government commit to an indexation for health funding that was aligned to the real cost of care in the health and hospital system?

Ms Halton—For the health and hospital system, under the COAG negotiation?

Senator XENOPHON—Yes.

Ms Halton—There is a composite index, which is quite complicated—I can get you the details of that on notice—in terms of the index that applies.

Senator XENOPHON—Thank you. The measure of indexation is a composite index?

Ms Halton—Yes.

Senator XENOPHON—But with aged care, is the indexation, the composite index, the same as for the health and hospital sector?

Ms Halton—I will have to check that. I think the elements are not strictly comparable, because what applies in the health and hospitals agreement context is an index for population growth—in other words, it is all rolled together—whereas, in fact, what occurs with aged care is that you disaggregate several of those factors. So you keep growth separate from the funding that is provided to providers. In one case we are providing aggregate funding to a state, which then passes it on to facilities; in this case we are funding direct in respect of residents.

Senator XENOPHON—Another way of putting it is that in terms of having an apples-for-apples comparison with respect to the level of indexation for the health and hospital sector as compared to the aged-care sector, are they comparable or is there a disparity between the two? And, if so, what is the disparity?

Ms Halton—It is actually hard to compare them, to be quite honest, because what you get in the health and hospitals sector all link together. It is a macrofinancing instrument to the states, an acknowledgement of population growth, ageing, issues around technology et cetera. That then is disaggregated by the state, and then provided on. In this particular case, we have an arrangement which grows places. We have an arrangement which is related to need, and then we grow that. I am happy to lay that out for you in quite some detail on notice.

Senator XENOPHON—Thank you. The Senate report into residential and community aged care has recommended that research is needed to determine the cost of care. Has the department responded to those recommendations in the Senate report? And has the department ever undertaken such a piece of research or commissioned an external organisation to undertake this work?

Mr Stuart—We are, of course, very well aware of the recommendations. They are a matter for the government to respond to in due course. The department has actually never been asked to undertake a direct cost of care costing, in my living memory, I would say.

Ms Halton—It has in my living memory, and we are the same age. But I have been doing this longer than him.

Mr Stuart—That is right. So, not over the last decade in aged care—

Ms Murnane—SAM.

Ms Halton—That's right: SAM. And before that: hostels. We are not going to go reaching back through our memories to burden you with this, Senator. In the recent past, no.

Ms Murnane—It was a long time ago. And it was heavily disputed, Senator.

Ms Halton—And it was extremely heavily disputed.

Senator XENOPHON—Perhaps I had better ask the minister. Senator McLucas, will there be a response to that recommendation in the Senate report about the research to determine the cost of care?

Senator McLucas—We will respond, of course, to all the recommendations in the report at the appropriate time. I cannot tell you what the specific response to that specific recommendation is going to be now. That is a matter for the minister.

Senator XENOPHON—Can you give me a timeline?

Senator McLucas—Faster than the previous government used to.

Senator XENOPHON—Before the double dissolution?

Senator McLucas—There is not going to be a double dissolution, not that I am aware of.

Senator CORMANN—You just thought it up, have you? We have news from Senator McLucas. For the record: there will not be a double dissolution election. This is right? You have let the cat out of the bag.

Senator XENOPHON—Can I just go to the issue of auditing and financial planning. The Senate inquiry noted that all aged-care providers are required to submit Auditor-General financial reports to the department and that these reports apply Australian accounting standards. The sector believes that the release of these reports is vital to benchmarking and future planning for the industry. Has the department released these reports since 2005-06? The information I have is that it had not, but I am just trying to confirm that.

Dr Cullen—We have never released the reports provided by aged-care providers. The reports provided by aged-care providers are often commercial-in-confidence documents. We did release summary information from those reports.

Senator XENOPHON—If I can clarify that—the summary information?

Dr Cullen—Yes. We did release that for the first two years of the conditional adjustment payment.

Senator XENOPHON—What were those years?

Dr Cullen—2004-05 and 2005-06, I believe.

Senator XENOPHON—Bu, since then, you have not released them?

Dr Cullen—That is correct, Senator. The data—

Senator XENOPHON—Can you say why?

Dr Cullen—The initial adjustment payment was introduced with a move towards ramping up the conditions that providers could meet. In particular, in the early years, providers were not required to meet all of the Australian accounting standards. Many providers struggled to meet the right standards. Many providers could not, in particular, disaggregate their data to the residential care segment so as to show what occurred in that segment as opposed to the rest of their activities. The data that was therefore produced in the early years was inconclusive at best and, therefore, the department made a judgment that it was better to work with the industry to help it increase its skill base in order to produce better reports rather than put the effort into analysing those reports. So, as I say, the conditions that providers had to meet increased over time.

It was particularly important to take that approach as providers' funding was heavily dependent upon them meeting those conditions. Therefore we put our effort into helping providers meet the conditions that were being imposed on them. We are now at a stage where the data that can be produced from those reports is of a very high quality, because all of the reports do meet all of the Australian accounting standards, including having segmented residential care data.

Senator XENOPHON—Dr Cullen, can you just clarify that: up until 2005-06, for a two-year period, summaries of those reports were being released?

Dr Cullen—Correct.

Senator XENOPHON—One of the complaints I have had is that, by not releasing that summary, it actually does not give the full picture in terms of the challenges that the sector faces.

Dr Cullen—Senator, as I tried to explain, the data being produced from those reports in the early years was so flawed, because the providers were not required to meet all of the accounting standards, that the release of the data would in no way have helped inform the debate.

Senator XENOPHON—Can I just go back—

Ms Halton—Senator, can I be clear about this. I think, as Dr Cullen has indicated, the data is certainly of a better quality now, and, in fact, we are actually having a conversation with the government about the use of that data and its potential release. So we are aware of that issue.

Senator XENOPHON—As I understand it, the Senate report pointed out that the methodological concerns of these reports have actually been addressed.

Ms Halton—Indeed.

Senator XENOPHON—Does that mean that we will now end up seeing—

Ms Halton—We are in dialogue about that issue.

Senator XENOPHON—And what is the approximate time frame?

Ms Halton—I never want to commit someone when it is not me, Senator, but, I would hope, shortly.

Senator XENOPHON—In terms of the review process, the department is reviewing, amongst other things, aged-care funding, the complaints system—I think Senator Cormann referred to that previously—and the nursing ratio. The inquiry recommended a forum led taskforce to undertake a wide-ranging review. What has happened in relation to that recommendation about the wide-ranging review, and what advice has been given about a target date for all those review processes to be completed?

Mr Stuart—You are referring to the recommendation of the recent Senate inquiry?

Senator XENOPHON—Yes.

Mr Stuart—There was a recommendation for a wide-ranging review, and that recommendation is under consideration by the government and the government will respond in due course.

Senator XENOPHON—Chair, I have got one final question. I will put some questions on notice; I think it might be more appropriate. I will go to the question of infrastructure. As I understand it, the government has introduced zero-interest loans to encourage the building of aged-care facilities in high-demand but low-profit areas, which, obviously, is welcome. But, given that interest rates have fallen significantly in recent months, that may impact on the attractiveness of the measure. Can you indicate whether any of these zero-interest loans have been handed back at all in the last six months, as a result of the lower interest rates? That is the first question. Secondly, what level of interest has been expressed in the next round of zero-interest loans, compared to the last round? And, given that interest rates have, fortunately, dropped, what other strategies are being investigated by the department to encourage the building of much needed aged-care facilities?

Mr Stuart—Senator, the question about whether there have been any handing back of loans because of falling interest rates I do not think I am in a position to answer directly at this hearing. But I would like to put some context—

Senator XENOPHON—Are you aware of any loans that have been returned?

Mr Stuart—There have been a couple returned—or, rather, we have not concluded interest agreements with some of the providers and they have indicated their wish to either wait or seek alternatives. In relation to the falling interest rates in the marketplace, that is something that has very recently been brought to my attention through some of the providers. It was perfectly defensible to have an annual rate of interest attached to these zero real interest rate loans a little while ago, when interest rates were relatively stable. Now that they have been falling quite quickly, it has been suggested to the department that we might like to update

those interest rates rather more regularly to reflect actual rates in the market, and we are very actively looking at that at the moment, Senator. That is under active consideration right now.

Senator XENOPHON—In terms of this whole issue, this crisis in aged-care accommodation, the Thornton review demonstrated that there was a lower level of return for providers who had built single-bedroom accommodation, especially when these also had an en suite. But, as baby boomers are ageing, there is even a growing demand for single-room accommodation. Is it the case that the government continues to fund rooms at 1.5 persons? Is there a disparity, then—that is, is there enough encouragement for the single-room accommodation compared to other forms of accommodation that are funded, over the reduced rates of return?

Mr Stuart—I would be happy to wrestle with that. There are a few things wrapped up in that. I just want to come back to the zero real interest loans for a moment, because I did not answer the third part of your question, which is whether the second round was as well subscribed. We are going to advertise the second round late this year. That second round has not yet been advertised. While the first round was advertised as a standalone round for zero real interest loans for specific areas with shortage, the second round will be advertised as part of the 2009-10 aged-care approvals round process, which also offers capital funding as well as zero real interest loans and community care places, and there will be both a targeting of loans and a targeting of capital funds at the same time. Where there are particularly outlying rural or remote areas that express an interest that require a combination of loan and capital funding, then we can look at that for the first time.

Senator XENOPHON—So you are looking at some additional level of funding in those high-need areas?

Mr Stuart—We are looking at being able to draw together zero real interest loans, capital funding, allocation of places, possibly community care places, in order to create viable services in rural areas. You asked about 1.5 residents per room.

Senator XENOPHON—Yes.

Mr Stuart—There is a little bit of explanation required underlying that. The government has a certification instrument which requires new buildings to have no more than, on average, 1.5 residents per room. That allows an aged-care home to be built which has as many double rooms as single rooms. We do not have any specific requirement in relation to en suites. We have a kind of ratio of people to ablutions, which makes it convenient often for providers to use en suites. But providers are also taking their own view of what the current market is for aged-care accommodation and also looking forward to what baby boomers are likely to prefer. So there is a level of building in the aged-care sector which is, I would say, above and beyond government requirement.

Senator XENOPHON—Okay. Chair, can I squeeze one more in?

CHAIR—I was wondering whether Senator Cormann had a particular follow up.

Senator CORMANN—I had a question on that point, but I did not want to be rude and to be seen as interrupting, even though Ms Halton and I had a gentleman's agreement yesterday that we could interrupt each other.

Ms Halton—We will consider whether that obtains today, Senator.

Senator CORMANN—I think that will be a standing arrangement, Ms Halton.

Ms Halton—Is it, now?

Senator CORMANN—That is right.

CHAIR—The agreement, however, was not approved by me.

Ms Halton—We will be overruled by you, chair.

CHAIR—So are we pleased to go to Senator Cormann's question?

Senator CORMANN—Just quickly on those zero interest-free loans. The department conducted a review of round 1 of those zero interest loans. Have you ever published a copy of that report?

Mr Stuart—No, a copy of the report has not been published. I think that there has been some public communication about the outcomes of that report. I remember that the minister released some information summarising the outcome.

Senator CORMANN—. But will you be releasing the report? Perhaps, take it on notice.

Mr Stuart—Yes. It was advice to government.

Senator CORMANN—I understand.

Mr Stuart—We can take it on notice.

Senator CORMANN—And if you would take on notice that if the government were of a mind not to release the report, I would like to have a statement of the public interest ground on which that refusal is based and why it is not in the public interest for that information to be released. Thank you.

Senator XENOPHON—Just finally, in terms of the funding of nursing staff, since 1997 there has been no minimum nurse ratio for aged-care providers; is that correct?

Ms Halton—Correct.

Senator XENOPHON—I know the AMA and the ANF have warned that this can put the quality of care at risk. Is there any plan to reintroduce minimum nursing ratios? And there is also the issue of what plans are there, in terms of better nursing, better funding for nurses, both in terms of the levels of staffing and the disparity in wages between the aged-care sector and nurses working in other sectors. And to that I note the Productivity Commission said it would cost about $400 million in the first year and $100 million each year after that for a catch up.

Mr Stuart—Senator, the minister has indicated her interest in looking at the issue of staffing, not just nursing, but staffing, adequacy and ratios in aged care as a part of the review of the Aged Care Funding Instrument, which is the instrument that essentially directs funding to aged care on the basis of the needs of the resident, including their medical needs and their nursing needs. The aged-care sector is probably now typified by nursing staff who are consultants, clinical consultants very often, who direct the work of other staff and those staff are increasingly well skilled. When I was in this sector a decade ago as a branch head the idea of certificate III and certificate IV in aged care were barely known. Currently, about 72 per

cent of direct care workers have a certificate III or higher and that has been a very significant sea change in aged care. So I think the discussion does need to be broader than nursing, specifically. But the minister has indicated her interest in looking at that in conjunction with the ACFI review.

Senator XENOPHON—And that will cost more money if you reintroduce ratios and there is better pay for nurses? It is axiomatic.

Mr Stuart—That is a matter for review as a part of that review. But I would say that aged-care providers are at liberty to pay their staff as they want to. The government does not determine rates. Rates are set in discussion between staff and aged-care homes.

Senator XENOPHON—Are rates not determined by the level of funding, realistically?

Mr Stuart—There are a number of components of funding, including staffing numbers, staffing mix, staffing pay, capital requirements and other expendables. It is a matter for the aged-care providers to work through. Some providers, in fact, do pay rates equivalent to or even higher than the acute care rates. In fact, some of the leading providers do so and are able to provide very good care and to innovate within the funding that the Australian government provides.

Ms Halton—And just as a matter of historical record, Senator, in fact, in the mid-nineties, when there was an arrangement in relation to the pay, there was still a disparity between acute care and aged care. So it is not a question that this has occurred since the 1997 act.

Senator XENOPHON—It has been longstanding.

Ms Halton—Yes. There was actually disparity even before this time. I just make the observation in relation to ratios. And this is clearly a matter of contest and the minister has indicated she is happy to look at some of those matters. But the reality is that the way the instruments work at the moment, the provider should have the staff of the qualification necessary to deliver the care to the individual, recognising that the needs of individuals vary quite significantly.

A lot of people make a comparison with child care. I actually think that is a very poor comparison, myself, because you know that three babies, five toddlers, will have a fairly constant need for care; it is a significant need, obviously. But in this particular case, where people's circumstances can be quite different, someone who is dementing may need a lot of actual supervision, not a lot of instrumental assistance. Someone who is bed-bound will often need quite a lot of technical nursing. So this is actually quite a complex space.

Mr Stuart—Senator, it is also not universally true that the awards for aged-care nursing are lower than awards for acute-care nursing, and Victoria would be a case in point.

Senator SIEWERT—Can I just pick up on the review. You said that, during the ACFI review, it could be taken into consideration. I am wondering if, in looking at the ongoing arrangements for the CAP, whether you have looked into it there. I understand that when the CAP was first provided one of the issues that was raised, the reason for providing it, was to look at paying some of the additional costs around workforce and making up some of those gaps. It was raised with the inquiry that we have just recently held, and I am wondering,

looking at the ongoing provision of the CAP, whether you are looking at how providers have then related it to workforce, whether it has actually made any difference.

Mr Stuart—The CAP payment was structured as an efficiency incentive, not as a staffing related payment. There has been some level of interpretation there put on that by parts of the sector that were not part of stated government policy.

Senator SIEWERT—So you have not looked at that at all in relation to the CAP and any review of the CAP?

Mr Stuart—The review of the CAP looked at costs and productivity, not specifically the issue of staffing ratios.

Senator CORMANN—Just going back to the issue of viability of aged care and the high care part of it, in your evidence to the Senate inquiry into residential and community aged care, you indicated that capital investment in the residential aged-care sector overall—and the word that you used was 'overall', so that is across low and high care and extra service, I assume—is holding up. Is it not the case that the reason you can say it is holding up is because there is a significant level of cross-subsidy from low care and extra services to high care?

Mr Stuart—Senator, I am not entirely sure exactly how to answer your question. Aged care homes make an income for a variety of levels of care and a variety of kinds of residents, and if there is cross-subsidy it is taking place within the businesses of aged-care providers rather than being a policy driven outcome.

Senator CORMANN—But there is a significant difference in the funding arrangements between low care and high care, and you will find, and I am sure you are aware, that the major concerns that have been raised by the industry relate to problems in terms of the viability of investment in high-care places. You are nodding, so I assume you are aware that that is a significant area of concern.

Mr Stuart—I am aware that that is what the providers are saying, yes.

Senator CORMANN—You are aware that that is what the providers are saying?

Mr Stuart—Yes.

Senator CORMANN—So when you say there is no problem with the level of investment in the residential aged-care sector overall, is that statement based on a significant level of cross-subsidy from low care and extra services into high care?

Mr Stuart—I do not have the specific quote in front of me, but I believe that comment would have been in relation to looking at trends in actual construction in aged care, rather than being a comment specifically to do with funding and cross-subsidisation. We would have been commenting on ABS building statistics.

Senator CORMANN—So you do not actually know how much of those buildings is going to be directed towards high care rather than low care or extra services? You made an overall statement. Your statement did not actually address the problem area, which is what I am asking you.

Dr Cullen—There are a number of ways in which you can analyse the question that you are asking. One way in which you could analyse it is you could ask: are the rates of returns which are earned in high care sufficient to allow those providers to make a reasonable return on investment?

Senator CORMANN—Do you think that it is sufficient?

Dr Cullen—The evidence I was going to give, Senator, is that the department's analysis, and not just the department's analysis, would be that the average EBITDA earned in high care is in the same order as the EBITDA earned in low care. In the top quartile, as you know, the most efficient providers, those who actually operate at an efficient level, the average EBITDA earned in high care is $15,000 per bed. The average EBITDA earned in a mixed-care home is about $15,000 per bed, and the average EBITDA earned in low care is slightly higher, at $20,000 per bed. The issue is therefore whether $15,000 per year is an adequate return on an investment of about $150,000, at a 10 per cent return on that level of investment.

Senator CORMANN—Which data are you basing that on?

Dr Cullen—This is the department's analysis of the general purpose financial reports of providers. However, I will also refer you to the Bentleys and James Underwood's data, which would show that, in the top quartile, average EBITDA earned in high care is $14,000 and the average EBITDA earned in low care is about $12,000. They actually have it the other way around.

Senator CORMANN—I will get into the Bentleys MRI survey in a minute. Are you aware of the Access Economics evaluation of capital funding in high care which essentially demonstrates that given current accommodation payments, which is $26.88 per day, the development of new high-care services is not viable as the present value of revenues is less than the present value of costs, even with constructions costs per bed as low as $138,000. Are you aware of the Access Economics report?

Dr Cullen—I am aware of that report. I am not aware that it says what you have said. My understanding of what that report says is that the average return required per day is $40 and some cents—I do not have the actual figure in front of me.

Senator CORMANN—At present, it is $26.88 per day.

Dr Cullen—No; that is, I believe, an error. Although the maximum accommodation payment or charge or supplement is $26.88, the accommodation supplement is not the only revenue which providers receive. The issue is whether, out of all the revenue providers receive after they have expended their operating expense, they have adequate left to meet a return. It is not appropriate to look at blue dollars and red dollars.

Residents pay a variety of fees. The government pays a variety of subsidies. Each of those fees and subsidies can be used either for capital or recurrent purposes. So the direct comparison between the $40 figure and the $26.88 is simply false. It is not appropriate. You are not comparing apples and oranges.

Senator CORMANN—Just to understand this whole issue of cross-subsidy between low care and high care, have you assessed to what extent there is reliance on access to bonds to cross-subsidise construction of high-care beds?

Dr Cullen—The evidence I have just given is that what we have demonstrated is that efficient providers can earn sufficient returns in high care in order to provide a reasonable return on that investment.

Senator CORMANN—Perhaps tell me, then—and you might have to take some of it notice, but if you can answer it now let me know now—what daily revenue would the average new bond received in 2007-08 generate compared with the accommodation payment in high care—that is, accommodation supplement or charge?

CHAIR—Dr Cullen, did you get that question?

Dr Cullen—I did get that question. It is a very complex question to answer, and I am not trying to be difficult. The difficulty is that it is hard to impute a value to an accommodation bond because accommodation bonds are used in different ways by different providers. They are sometimes used in a mortgage offset type of arrangement, in which case they earn an interest which is something akin to the interest charge which the provider would otherwise have been used to. Sometimes the bond is actually just put in a term deposit, where it earns a lower interest rate, so that calculation is different. However, I think it would be reasonable to say that the income that you could earn on an accommodation bond of $180,000 would in general be higher than $26.88 per day. I would be happy to make that statement.

However, I want to refer back to my earlier evidence, which is that that is not the only income which providers receive. Providers receive other income from a variety of other purposes and obviously they receive a lot more subsidy income in high care than in low care. All of those incomes can be used for either recurrent or capital purposes. I would also remind you that the $26.88 figure is increasing over the new few years to $32.38, so it is not remaining as a constant figure.

Senator CORMANN—No, of course it is not remaining as a constant. But the $26.88 figure is the right figure, isn't it?

Dr Cullen—At this moment—

Senator CORMANN—This moment, yes.

Dr Cullen—it is a description of one source of income for providers.

Senator CORMANN—You mentioned some departmental analysis which led you to believe that there was a 10 per cent return on investment. Would you be able to make that departmental analysis available to the committee?

Dr Cullen—The analysis that I was—

Mr Stuart—Senator, it was in the department's submission to the Senate inquiry, the second submission in—

Senator CORMANN—The full analysis and the methodology you used to arrive at the conclusions that you have arrived at?

Mr Stuart—I believe there was a high-level description there of the analysis.

Senator CORMANN—What I am asking for is the full analysis. I am not asking for the high-level description of the outcomes.

Ms Halton—We will take it on notice, Senator. We will have a look at what we provided and we will see what we can provide it.

Senator CORMANN—The industry and various experts obviously have got all of their surveys available for scrutiny and for peer review. So if the government has got an analysis that is completely different from what others have found, then it would be good if your methodology and analysis could be similarly subject to peer review.

Excluding extra-service residents, what is the number of high-care residents at 31 December 2008 who were low care on entry and are now high care—that is, who have rolled over into high care and the bonds were paid on entry into low care?

Dr Cullen—If you give me a moment, I will try and find that figure for you. Whilst I am finding it, I will just make the general comment that of course not all those residents will have rolled over a bond. Many of them—

Senator CORMANN—I understand that. You are pre-empting my next question. I am getting to that, but if you can stick to the question I am asking.

Dr Cullen—You mentioned bonds in your question, so I just wanted to be clear.

Senator CORMANN—I am trying to understand what is fact.

Dr Cullen—I will give you a number of figures if I can, Senator, because I would like to help you with as many facts as possible.

Senator CORMANN—It is much appreciated.

Dr Cullen—Currently, 68.6 per cent of places are occupied by high-care residents. Fifty per cent of residents enter as high care. From that, you can deduce that about 18 per cent of residents entered as low care and became high care.

Senator CORMANN—Sorry, out of the total population of high-care residents, what proportion of those started in low care and rolled over into high care as part of their progression through the system?

Dr Cullen—I cannot do the number in my head. I believe 18 divided by 68 is the number that you are looking for.

Senator CORMANN—I think you might want to take that on notice, because I do not trust that those maths are quite right. But maybe just look through the *Hansard* and see what you come up with. What was the total value of the rolled-over bonds, based on their value when rollover occurred? Some people, I understand, would not have rolled them over, but what is the total value of rolled-over bonds based on their value when rollover occurred?

Dr Cullen—I believe we may be able to answer that question from the survey of aged-care homes. I am not entirely sure that we capture the rollover flag accurately. I will look at what data we have. In general, because I would like to be as helpful as possible, the value of bonds rolled over is lower than the average bond of a new resident. Typically, when you are rolling over a bond, you have first paid the bond three years ago or so, and bonds were smaller then than they are now, so the rollover amount is smaller. But I will try and get the answer to your question on notice.

Senator CORMANN—If you can, please also give me an answer to this question: what proportion of total high-care residents on 31 December 2008 were former low-care residents who had rolled over their bond?

Dr Cullen—Perhaps I can answer that question in the following way.

Ms Halton—I would be surprised if we know that, Senator. We will see what we can find.

Senator McLucas—Simply because you just do not know who has got a bond and who has not got a bond.

Senator CORMANN—You would know who—

Ms Halton—From the survey data. We will not know universally, but we may have an estimate.

Dr Cullen—We may have an estimate. Also, Senator, I actually now recall that the secretary is quite right. I can tell you when they move homes. If you are in low care and you roll your bond over and you stay in the same home, then I would not know whether you had paid a bond in the first place or not. So I will not be able to give you that answer.

Ms Halton—No, exactly.

Senator CORMANN—So whatever you give me it will really be an underestimate is essentially what you are saying?

Dr Cullen—I will certainly try to—

Senator CORMANN—No, not because of bad intent, but because you do not have the information.

Mr Stuart—Senator, you are asking a range of specific questions in wanting to arrive at an outcome. If you were able to tell us what is the outcome you are looking for, we might be able to find a way of logically dealing with it.

Senator CORMANN—My basic premise—and I guess I am trying to find ways of ascertaining whether my basic premise is right—is that investment in high-care places is not viable and the only reason you are able to say that the overall investment is holding up is because there is a significant level of cross-subsidy from low care and extra services to high care, and I am looking at some proxy indicators that may be able to demonstrate that point. That is why I am asking some of the questions that I am asking. In the same context, I am also interested to know how many of the developments involving newly allocated places, either as new services or extensions of existing services, involve a mix of high- and low-care places or extra services, or are in some way created so that a continuum of care can be provided which would allow bonds to be tapped and rolled over into high care, so it is essentially done the same—

Ms Halton—Again, Senator, let us be careful not to conflate the thing you just said, 'they are constructed so as to enable'. There is a modest thing here called a resident and their preferences about care arrangements. I really would like to remind everyone that this is a system designed to provide care—and we are going to come to that. You have said this was a financial construct, and I would argue to you, in fact, maybe there is a financial element to it,

but the principal construct in many of these cases is actually about the care preferences of individuals, which is to age in place.

Senator CORMANN—I totally understand that there are preferences by people across Australia involved and, to be honest, I suspect that many people would have a preference to stay at home as long as they could.

Ms Halton—Undoubtedly.

Senator CORMANN—Undoubtedly. We all agree. But, for progression of care requirements we have to have a policy framework in place that will enable those services to be provided. My concern is that we have got a crisis in the context of investment in high-care places, which could well be hidden because it is all rolled up into one continuum of information from low care extra services into high care. If we do not separate some of these things out a bit, then we will continue to be able to ignore the serious problems that I believe we are facing on the high-care end. That is where I am coming from.

Ms Halton—Senator, 'crisis' is your word. We are not going to make a comment about that.

Senator CORMANN—No, fair enough.

Ms Halton—We are more than happy to try and see what data we have got. Now that we understand the issue you are going to, we will see what data we have got. But, as I suspected, and Dr Cullen has confirmed, the precise information that you are asking for we do not have, but we will look to see what we can come up with.

Senator CORMANN—Thank you very much, Ms Halton.

Mr Stuart—There are some other indicators around that question. I am just thinking that the largest trend of the last 10 years has not so much been growth of low-care bond-taking homes; the growth has been in high care and in ageing in place, as the secretary said. I think that the proportion of high-care residents in aged care has consistently grown over that 10-year period.

Senator CORMANN—Has it been growing consistent with increases in demand? We have been talking about the people handing back bed licences. We have been talking about successive aged-care approval rounds being undersubscribed. Do not tell me that the investment in high-care places is sufficient to meet the demands that are coming our way. Are you saying that it is?

Ms Halton—There is a separate dialogue we could have about what is occurring, including in places like the ACT, about the number of beds that are actually required, but—

Senator CORMANN—In the regional centre of Canberra?

Ms Halton—The regional centre of Canberra, Senator, indeed. Where is Senator Humphries when we need him?

Mr Stuart—Evidence has already been given by Dr Cullen about the capacity of high care to make a return. There have also been very substantial, real increases in funding into both low and high care, but mostly into high care, in the last five years. There has been, on my mathematics, a total of about $4.2 billion added to aged care in that time, or over a billion a

year, predominantly into high care. That includes about $1.4 billion in the 2004-05 budget immediately after the Hogan review, with the inception of the conditional adjustment payment. It went on to the current government's delivery in March 2008 of an about $1.7 billion package, of which government spending of $1.2 billion went into aged-care homes.

Senator CORMANN—So you are essentially disagreeing with the assessment.

Mr Stuart—There was a further $410 million increase in the last budget and, most recently, $728 million flow-through from the pension into residential aged care. On my maths, that makes a total of over $4.2 billion in new policy, not just growth in client numbers et cetera. This is actual new policy over that period, predominantly into high care.

Senator CORMANN—So you disagree with the assessment by Access Economics when they say that development of new high-care services is not viable?

Dr Cullen—If I can reprise the evidence that I gave earlier, what Access Economics showed is that, in their opinion, income of $40.32—I believe is their figure—is required. They then compared per day. They then compared that to the level of the accommodation supplement, which is $26.88. As we have said, that is not all the income which is available to the provider. If their conclusion that it is not sufficient is based upon that comparison, then we do disagree with that, because that is not an appropriate comparison to make.

Senator SIEWERT—What is the other income? Do you calculate that?

Dr Cullen—On average, providers receive, over the next four years, $66,000 per resident to pay for both the capital and care needs of that resident.

Senator SIEWERT—I will go back to what is blue and what is red money later; you made that comment earlier. But on a per day basis, which we were just talking about, what is the other income on a per day basis?

Dr Cullen—The other income I am talking about is all of the income the provider receives. So they receive from the resident a basic daily fee, currently set at $33.41 and set to rise by about $3 per day in September.

Senator SIEWERT—$33.41 per day?

Dr Cullen—Currently, and, because of the flow-through of the pension increases, that will increase by about $3 per day in September. So the two payments, essentially, which residents make are a basic daily fee and an accommodation payment. The Commonwealth pays a variety of subsidies through the basic subsidy, the accommodation supplement et cetera, which can vary enormously. The top ACFI payment is currently $138 per day. The revenue available to a provider, in total—and I only have the figure in my head—can vary. I said it goes up to 66 earlier, but the maximum revenue available to a provider to care for a resident, taking into account the funding provided by the government and the resident, would be in the order of 80 or so thousand dollars a year.

Senator CORMANN—Does that figure that you have mentioned, the current daily fee, include the conditional adjustment payment indexation?

Dr Cullen—It includes the conditional adjustment payment, which is an additional—

Senator CORMANN—Which is something that is going to be discontinued, is it not?

Dr Cullen—No.

Mr Stuart—No, it is not. The conditional adjustment payment has been increasing by 1.75 per cent per annum.

Senator CORMANN—You are going to discontinue the 1.75 per cent and fall back to COPO, which is, I think, two per cent annually.

Mr Stuart—The conditional adjustment payment remains available ongoing. I just want to be really clear about this, because we cannot have this got wrong around the sector.

Senator CORMANN—That is what the sector believes, because that is what they have been telling me.

Mr Stuart—The rate of conditional adjustment payment has reached 8.75 per cent of the subsidy pool and will now continue at that level ongoing. That level of CAP is still worth $2.4 billion to the sector in additional revenue over the coming four years.

Senator CORMANN—So you are saying that indexation is not stopping?

Mr Stuart—The continuing increases in the conditional adjustment payment are not going to continue, but the conditional adjustment payment itself is continuing at a value of 8.75 per cent of the subsidy pool.

Senator CORMANN—But what does that mean, in effect, year on year?

Mr Stuart—Year on year, that means that, whatever payments you get in the care pool through the Aged Care Funding Instrument, you are now going to get 8.75 per cent more than you would have otherwise got, and that will continue in to the future. In the forward estimates, that is worth $2.4 billion over those four years in additional subsidy payments to the aged-care sector.

Senator CORMANN—If what you are saying is right, you might really want to go out of your way to get that message across to the industry, because I have had a number of members of the industry tell me that they now expect to get only two per cent year on year by virtue of COPO being the only indexation of care costs. And they, of course, contrasted that with the 7.3 per cent per annum in the national healthcare agreement for public hospital funding. Obviously, I am supportive of the 7.3 per cent, but there is a level of concern across the industry that indexation is moving significantly less forward than what it has been in the past, only accentuating the problem. So, if what you are saying is right, please get out there and spread the word.

Mr Stuart—There are two things I would say. One is that we know there have been comparisons drawn between health sector increases and aged-care increases. The methodological difficulty is that the health care increases generally include within them increases in frailty and in client numbers, which are separately accounted for in the aged-care sector. And so, on an apple-for-apple comparison, the per-resident growth in funding in to this current financial year, including indexation, client growth and frailty growth, was actually eight per cent. I am sorry; I included resident growth. Including only frailty growth and indexation, it was eight per cent.

Senator CORMANN—So you are saying there is going to be indexation of eight per cent moving forward?

Mr Stuart—I am trying very hard to be clear. The health indices very often contain within them a range of factors—three or sometimes four factors, in fact—including indexation of costs, increases in the number of patients, increases in the average frailty of patients and sometimes also technology. That is all wrapped up in these percentages of seven per cent and so on. In the aged-care sector we separate those things out because some of them are paid through the subsidy pool and some of them are declared through indexation. The equivalent number for aged care for the current financial year is that there was an eight per cent increase on a per-resident basis in total funding, taking into account frailty increase, indexation and new policy. And the total increase, including increase in client numbers, was above 10 per cent.

Senator CORMANN—Dr Cullen, you mentioned a figure of $60,000 before.

Dr Cullen—$66,000.

Senator CORMANN—Can you give us a breakdown on what is making up that figure?

Dr Cullen—Certainly. That is the average yearly payment over the next four years, and that consists of $45,000 in government subsidy and $21,000 on average per year in resident fees.

Senator CORMANN—At one of our previous estimates, and also during the Senate inquiry, there was some discussion about the findings of the Grant Thornton Aged Care Survey. Essentially, your argument was that they were in conflict with other major studies by Stewart, Brown & Company and James Underwood. The principal argument was in relation to their conclusions on the viability of modern single-bed facilities and all shared-room services. Essentially, the argument is that what you call the more efficient services comes down to, maybe, the shared-room services, and that there is a real viability problem around modern single-bed facilities. Are you aware that, following your appearance at the inquiry, the authors of the reports that you mentioned presented the inquiry with a joint statement confirming their consistent view that modern high-care facilities are not viable and that all facilities with shared rooms perform financially much better? Are you aware of that statement?

Dr Cullen—I would like to say two things there.

Mr Stuart—We are aware of the statement.

Senator CORMANN—Do you agree with the statement? Do you agree with the proposition then, given that all of those three surveys come to the conclusion that modern high-care facilities are not viable and that all facilities with shared rooms perform financially much better? Given that all three of those surveys seem to indicate the same evidence, do you now agree with that statement?

Mr Stuart—I think I ought to give David Cullen the opportunity to disentangle this a little bit.

CHAIR—Dr Cullen, what I would suggest, because this is a core aspect, is that we come back at 1.45.

Senator CORMANN—And give you some time to do some homework.

CHAIR—We are going to keep going into this area. I think aged care is probably the core issue of today, so my proposal is that we come back at 1.45, we go straight into aged care again for 45 minutes and then we go through the program after that. But we will come back to your answer. You know what that question is. I think, Senator Cormann, you have more questions on aged care, and Senator Williams does as well. My proposal is that we will have at least 45 minutes after lunch on aged care.

Ms Halton—Are we going back after this break to program 10, which we did not get to?

CHAIR—Yes, we are going back to the program area.

Ms Halton—Thank you. That is very useful. Can I also just say, Senator Boyce, that one of my officers is a bit concerned that she may have misled you yesterday when we talked about the procedures for FOI. She mentioned about someone 'clearing'. We just need to be clear. She did not mislead you. I am overegging it and I apologise, but I want to be sure that we are accurate. In the process for clearing an FOI, a decision maker is a decision maker. We have a checklist to make sure all the procedures around an FOI have been observed, that legal advice has been taken, that documents—

Senator BOYCE—This is in relation to who decides?

Ms Halton—Correct.

Senator BOYCE—Okay.

Ms Halton—So there is no second-guessing the decision maker, but there is someone who certifies that the process has followed all of our internal requirements.

Senator BOYCE—It is an internal audit, so to speak, of—

Ms Halton—the requirements, not the decision.

Senator BOYCE—the decision-making process?

Ms Halton—Correct. I just wanted to be clear about that.

Senator BOYCE—All right. Good.

CHAIR—So we will break now until 1.45 pm.

Proceedings suspended from 12.38 pm to 1.45 pm

CHAIR—We will now reconvene and we are going back into program 4, aged care and population ageing. Senator Cormann, you have the call. You were midstream when I stopped you.

Senator CORMANN—Yes. Well, I think I had asked the question of—

CHAIR—You had a question to ask of Dr Cullen.

Senator CORMANN—I think the question was quasi given on notice, given that officers were allowed to think about the answer.

CHAIR—Dr Cullen, were you able to get an answer for that one, or do you wish to take it on notice?

Mr Stuart—I wanted to give David the opportunity to respond on the question. I cannot immediately recall what it was.

Senator CORMANN—I am happy to remind you of the question. Essentially, a statement has been made through the Grant Thornton Aged Care Survey that modern high-care facilities are not viable, and that all the facilities with shared rooms perform much better financially. When this has been raised before, either in estimates or during the senate inquiry, the response was, 'Well, this is inconsistent and in conflict with other major studies.' Since then, the other major studies or the authors of the other major studies that were mentioned have signed a joint statement of researchers, which was provided to the Senate inquiry into residential and community aged care, confirming that modern single-room high-care services made very poor or negative returns on average. These returns are far below the returns achieved in all the shared-room high-care services.

In our opinion, modern single-room high-care services, other than those with extra services approvals, are not viable on the current funding and regulatory arrangements. Given that this statement was signed by Grant Thornton, James Underwood & Associates, and Stewart Brown Business Solutions—Max Hopkins; they are the authors who were previously mentioned—does the department now agree with the proposition that modern single-room high-care services are not viable on the current funding and regulatory arrangements?

Dr Cullen—I was confused by your question earlier because I thought you had indicated that I had already commented on that, and I could not find anywhere in the record where I had made a comment on that particular issue.

Senator CORMANN—I raised that particular issue in Senate estimates, if not the last one, the one before. When I raised the Grant Thornton survey you said that the other surveys showed something different. That these three organisations found it necessary to present a joint statement of this nature to the senate inquiry would indicate that they felt that you essentially tried to separate out two of the organisations in terms of their conclusions from what the Grant Thornton survey found. Are you saying that everybody agrees that modern single-room high-care services are not viable?

Mr Stuart—No, Senator, we do not agree with that statement. But, clearly, we would agree that, on average, a single-room with an en suite costs more to build than a shared facility. That stands to reason on average.

Senator CORMANN—If I could just go back to Dr Cullen. Are you saying that you have never given evidence—

Dr Cullen—I have given evidence that the three surveys disagree.

Senator CORMANN—that the findings of the Grant Thornton Aged Care Survey were in conflict with other major studies by Stewart Brown and James Underwood.

Dr Cullen—Absolutely I have given that evidence. I have given consistent evidence to this, that the levels of obiter—the average and top quartile results found in the three surveys—vary differently from each other. The evidence that I have given about the three surveys not being in accordance with each other has been about the results which they say providers are capable of achieving.

Senator CORMANN—So what are you saying? Are you concerned about the findings in the Grant Thornton Aged Care Survey, which I know is supported by James Underwood and Associates, and Max Hopkins from Stewart Brown Business Solutions?

Dr Cullen—As Mr Stuart has said, if what they are saying, as I think they do say, is that it costs more to build the single bed en suites than it does to build double- and single-room mixed accommodations, then, I would agree that on average, that is correct.

Senator CORMANN—So you agree that modern single-bed high-care facilities are not currently viable?

Dr Cullen—No, Senator, that is not what I said at all. What I said was that I would agree—

Senator CORMANN—You think it is lower returns, but you think that is still high enough for them to be sufficiently profitable in your judgment? Help me. I am trying to understand what you are saying. Is that what you are saying?

Dr Cullen—I think the analysis that we had would indicate that efficient homes of whatever construction in high care can earn a sufficient return on their investment.

Senator CORMANN—So what does that mean? I do not understand what you are saying. Maybe I am not smart enough.

Dr Cullen—I think I might be agreeing that there is a different level of return earned, but that the level of return earned by efficient providers of homes who have chosen to build to a very high specification may still be sufficient.

Senator CORMANN—And who are those efficient providers? What is the category of efficient providers? It is all of the facilities with shared rooms, isn't it?

Mr Stuart—This is one of the issues about the Grant Thornton survey, which comes to their definition of what is a multi-bed service, which we have given evidence about before. What I would say, Senator, is this: there is a high degree of variability across the sector in a wide range of factors, including how they are building and what they are building and what cost that is. We provided a piece of evidence to the Senate inquiry, which was newly public work from the department, that showed the breakdown from the survey data that we have of what it costs to build aged-care services.

The mean was $150,000 a bed, which is well short of some of the industry claims. But there were single-bed-with-en suite facilities in the $130,000 to $140,000 per bed range, as well as significantly higher. So there are people building quite a different range of facilities at quite a range of costs, and I think generalising about the industry as a whole is unhelpful, and what David Cullen has been doing is pointing out that in both high care and in low care, efficient providers are making adequate returns.

Senator CORMANN—I am going to get to the adequate returns in a minute, but you did raise those questions regarding the definitions used in the Grant Thornton survey for multi-bed facilities in the Senate inquiry. and you were stating with absolute certainty that it included facilities with just a few single bedrooms. Are you aware that Grant Thornton has submitted supplementary evidence confirming that single-bed facilities were defined as those with more than 70 per cent single beds? I am advised that you declined their invitation to discuss the trends and parameters of the survey.

Dr Cullen—We are aware that they, subsequent to discussions—I attended a briefing that they gave on the results of their survey at which they did not in any way make clear what they meant by a single-bed service. I am aware that after that—and I went away from that—

Senator CORMANN—The parliamentary submission on the public record—

CHAIR—Sorry, Mr Cormann—

Senator CORMANN—May I please—

CHAIR—Dr Cullen?

Dr Cullen—Long before that inquiry I went to a briefing by them.

Senator CORMANN—Long before the inquiry.

Dr Cullen—I went away from that briefing with a clear understanding that what they meant by single-bed facilities was single-bed facilities. I now understand that I was wrong. In the evidence that I gave, I stated what my true belief was at that stage. I now accept that they have clarified that. I do not accept—and there is no record of this within the department—that any offer was made by Grant Thornton to the department to clarify the materials in their survey.

Senator CORMANN—So if Grant Thornton wants to discuss the trends and parameters of their survey with the department, you will make yourself available to do that?

Mr Stuart—We would be happy to do that, Senator.

Senator CORMANN—I am very, very pleased to hear it. I now want to go back to the issue that we talked about this morning: the complaints investigation scheme. I started asking this question before you had to leave for your meeting. The minister said in the *Four Corners* interview on Monday night that a review would be heard into the complaints investigation scheme. Can you tell us when that review was announced, what its terms of reference are and what the closing date is for that review?

Ms Smith—Senator, I think you mean the complaints investigation scheme.

Senator CORMANN—Yes, indeed.

Ms Smith—Certainly the minister was clear in her interview that was shown on *Four Corners* that she was interested in looking at the operation of the complaints investigation scheme. That scheme is a relatively new one. It has been in place for a couple of years now.

Senator CORMANN—Two years?

Ms Smith—It started on 1 May 2007, so just on two years. At the end of this financial year we will have two full years of data so, yes, the minister has indicated her interest in having a look at that area.

Senator CORMANN—Indicated her interest or made an announcement that there would be a review? Or was the announcement on *Four Corners* on Monday night?

Ms Smith—I think the minister demonstrated her interest in looking at the scheme.

Senator CORMANN—So she has not yet made—

Ms Smith—Just as she has shown an interest in looking at other aspects of the quality framework.

Senator CORMANN—So what you are saying is—

Ms Halton—She has not formally announced it.

Ms Smith—There is no formal review that has been initiated at this point.

Senator CORMANN—So she has not formally announced the review, there has not been a formal initiation of the review. The first that you heard of the review was on the *Four Corners* interview, was it?

Ms Halton—No, that is not true.

Senator CORMANN—Okay, so when did you first hear about it?

Ms Halton—We would have to take that date on notice.

Senator CORMANN—You want to take that date on notice?

Ms Halton—Yes, I will because I do not—

Ms Smith—No, I do not recall a specific date.

Senator CORMANN—So have you been asked to provide some draft terms of reference for the review of the complaints investigation scheme?

Ms Smith—We obviously provide advice to the minister on a range of issues. We have been asked to provide some preliminary thoughts to the minister; she is considering those.

Senator CORMANN—When were you asked to provide those preliminary thoughts?

Ms Smith—I will have to take that on notice.

Senator CORMANN—You can take the exact date on notice, but was it before or after the *Four Corners* interview?

Ms Smith—It was before.

Senator CORMANN—A week, a day?

Ms Halton—We will have to take that on notice, Senator.

Senator CORMANN—Can you just define the role of the complaints investigation scheme for us?

Ms Halton—In talking to you about what the CIS is, what I am going to ask Ms Smith to do—I apologise if this; for some people this is going over old ground—is to remind the committee, and therefore place on the record, what the CIS replaced.

Senator CORMANN—Yes, I am happy. That is fine.

Ms Halton—Yes, thank you.

Ms Smith—The complaints investigation scheme was introduced by the previous government in May 2007. It was developed in response to the perceived inadequacies of the former Aged Care Complaints Resolution Scheme and its capacity to deal with a range of concerns about the care provided in Commonwealth funded aged-care services. There were a couple of key deficiencies with the previous scheme. Officers who were working within it had

a limited capacity to access premises and review a home's records and really get to the bottom of what was happening when allegations of concern were made. The other thing that was a key feature of the old scheme was that it was based on alternative dispute resolution methodology. That methodology is quite appropriate in some situations, particularly where there might have been a misunderstanding or communication breakdown between a family and an approved provider, but it became apparent during the life of the CRS that it was quite inappropriate in a number of situations. I have actually met with families of residents who were the subjects of assault and who made their concerns known under the former scheme. Those families found it incredibly distressing, when there were allegations of assault, to be put in a situation where they were trying to resolve a dispute between themselves and the provider. What they were looking for was an investigative model which could get to the bottom of what actually occurred and take corrective action.

So those were the sort of issues that led to the introduction of the new scheme which, as I said, came in on 1 May 2007 with powers to investigate any concerns that related to an approved provider's responsibilities under the Aged Care Act. The complaints investigation scheme was also accompanied by compulsory reporting of assaults from 1 July 2007 and these were all initiatives of the former government. What currently happens is that it is operationally delivered through the state and territory offices of the department. We have an intake function: people can either ring in with a concern or complaint or they can lodge that online. We have a group of staff within the intake who can assess the seriousness of the complaint, the urgency, whether a care recipient is at risk or not and escalate it to senior managers and investigators for action.

The scheme has legislation under which it operates. It has a detailed procedures manual for staff. Our staff also undergo training in investigation methods. We do deal with quite a significant volume of contacts every year. The report on the operation of the Aged Care Act, which was released in late 2008, gave the figures for the first full year of operation of the scheme. We had total contacts in that year of 11,323, of which 7,496 were investigated by the department. What we do find is some of the calls that come into the scheme do not relate to an approved provider's responsibilities under the act. It could be, for example, someone who is concerned about a guardianship matter or something that the department has no capacity to investigate. In those situations we refer them on to the appropriate authority. But we did investigate almost 7,500 cases in 2007-08.

Senator CORMANN—How many staff does the complaints investigation scheme employ?

Ms Smith—The most recent figures we have is that we have 156 officers nation-wide who are directly employed as investigators, and they are employed in our state and territory offices. We also have managers who support that work and we have program support and policy advice provided by additional staff in central office.

Senator CORMANN—On notice, can you perhaps provide us with a breakdown of the public service employment levels of the complaints investigation scheme staff?

Ms Smith—Sure.

Senator CORMANN—Does the CSA employ any medical professionals?

Ms Smith—We do have quite a number of registered nurses who work in the scheme.

Senator CORMANN—Any doctors?

Ms Smith—Not to my knowledge, but we do have access to medical practitioners within the department if we need to check issues.

Senator CORMANN—And the budget of the financial years 2007-08, 2008-09, 2009-10 for the scheme?

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

Senator CORMANN—Yes, that is fine. While you are taking that on notice, perhaps you could also provide us with a month by month breakdown of the number of complaints received by the scheme in 2008 if that is okay.

Ms Smith—2008-09?

Senator CORMANN—The calendar year 2008.

Ms Smith—Just to set it in context, the cases that are being dealt with by the scheme, of the 7,500 investigated cases, the department identified 930 breaches and we issued 214 notices of required action.

Senator CORMANN—So you have got how many complaints and how many were serious breaches?

Ms Smith—We investigated virtually 7,500 cases and we identified 930 breaches.

Senator CORMANN—Can you give us a breakdown on the nature of the complaints? When you say 'breaches', what are some of the themes coming through?

Ms Smith—The report on the operation of the Aged Care Act does give percentages of the type of issues raised, not surprisingly health and personal care is a fairly significant proportion.

Senator CORMANN—Yes, can you give us a list of the proportions and the types of issues.

Ms Smith—I can give you that on notice, Senator.

Senator CORMANN—So does the department believe, and perhaps this is a question for Ms Halton, the CIS is the most efficient and useful way of resolving complaints? Is it better than what was there before? Is it as well as we can do?

Ms Halton—I have been through several versions of the approach to monitoring complaints in my experience with aged care, as has Ms Murnane. I do believe this is better than the last scheme. There have been some issues in respect of bedding down this scheme and, as I said to you earlier today, I am more than happy to talk you through what some of those issues are. As Ms Smith mentioned, in a number of cases that approach to alternative dispute resolution, which is really the kind of approach that the previous scheme was founded on, was found wanting and therefore a change was warranted. So compared to the other versions we have had in my rather lengthy history with aged care, this is the best that we have seen.

Senator CORMANN—So how much do you invest in advertising the CIS?

Ms Smith—There was quite a significant communication campaign when the scheme first came into operation, and I would have to take on notice the level of dollar investment in that communication activity. We also do a range of routine advertising in terms of the availability of the number through things like the White Pages and other such means. We have a variety of posters and brochures which are displayed in aged-care homes.

Senator CORMANN—You have mentioned online advertising; you have mentioned brochures and posters. Can you give us a bit of a comprehensive overview, perhaps also on notice, of the sorts of mediums you use to advertise the scheme? Why do you think there has been a threefold increase in the number of complaints lodged with the CIS?

Ms Smith—Firstly, there has not been a threefold increase. I think you might be referring to a statistic from the weekend papers.

Senator CORMANN—Yes, I am. I take the media at their word until you prove them otherwise.

Ms Halton—Senator, you could get yourself into a lot of trouble that way.

Senator CORMANN—I have to cop it on my end, so you have to join us in it. Isn't that right, Senator?

CHAIR—That is absolutely right.

Senator CORMANN—But I give you the opportunity to correct the record.

Ms Smith—There is certainly an increase in contacts between the old complaints resolution scheme and the new complaints investigation scheme, and we were expecting that to happen. Through moving to a new model with greater publicity about its existence, we were expecting the volume to increase. The old complaints resolution scheme had what were called 'complaints' and then it had what were called 'information calls', and 'complaints' were substantiated complaints that could be the subject of alternative dispute resolution. So there had to actually be a care recipient or a legal representative of that care recipient to progress a substantiated complaint. Anyone else who rang in with an issue of concern—for example, a staff member—could not take forward a substantiated complaint. That was recorded as an information call.

If you combine complaints and information calls, there has been a doubling of contacts between the last year of the complaints resolution scheme and the first year of the complaints investigation scheme. I think that what the weekend media did was to compare 'contacts' under the new scheme with 'complaints' under the old scheme. What we can now do with the new complaints investigation scheme is take on board concerns from a wider range of people, such as staff members and interested parties. So you might go into a home to visit your relative, and you express concern about another resident; you can actually make a complaint under the new scheme. You could not under the old scheme.

Senator CORMANN—Yes.

Ms Smith—So it is a doubling rather than a tripling, but it was always anticipated that by changing to a new model which was more accessible we would get more people prepared to come forward and have their concerns looked at.

Senator CORMANN—Who makes the decision of which complaints will be investigated?

Ms Smith—As I said before, we get a number of contacts. The things that we can investigate have to relate to an approved provider's responsibilities under the Aged Care Act. So, obviously, we cannot investigate things that are not within scope. We turn down very few complaints that come within scope of investigation. One of the grounds on which we might not investigate is if the same matter had previously been looked at; we cannot keep relitigating the same issue. But the very vast majority of concerns that relate to an approved provider's responsibilities are looked at.

Senator CORMANN—When you say 'the very vast majority', are we talking about 60, 70, 80, 90, 95 or 99 per cent?

Ms Smith—I will have to get the exact proportion for you.

Senator CORMANN—I am trying to get a sense today, then you can give us the exact proportion. Is it just over half? Is it nearly full?

Ms Smith—If it is within scope of the scheme to investigate, I would imagine that it is almost 100 per cent.

Senator CORMANN—Almost 100 per cent?

Ms Smith—But it has to be within scope.

Senator CORMANN—Yes. So what is the Public Service employment level of the people who make those decisions as to whether it is within scope and is going to be investigated?

Ms Smith—The intake function is probably managed at a different level in some of our state and territory offices—the smaller offices would have one manager who is responsible for a greater range of things within the scheme—but generally our first line of managers would be at the executive level 1 position.

Senator CORMANN—What are the criteria? You mentioned in scope and out of scope. Essentially, the criteria are the act—or have you got some departmental operational guidelines?

Ms Smith—There is the act, and then there are the investigation principles, which sit under the act.

Senator CORMANN—Yes.

Ms Smith—The key criterion to enable an issue to be investigated is that it falls within an approved provider's responsibilities under the Aged Care Act.

Senator CORMANN—What other sorts of criteria for determinations do you utilise?

Ms Smith—The key criterion, as I said, is that it relates to an approved provider responsibility under the Aged Care Act, and then within that relative priority is decided. We split cases into 'critical', 'major' and 'minor.'

Senator CORMANN—On what basis? That is what I am trying to get at.

Ms Smith—Level of risk to the resident.

Senator CORMANN—How do you determine 'level of risk to the resident'? What are the things that you are looking for?

Ms Smith—We have procedures and criteria, and I can answer that on notice for you.

Senator CORMANN—Thank you; that would be great. That probably means that we can go through it quicker. How many investigators do you employ?

Ms Smith—I think we just answered that, Senator.

Senator CORMANN—I thought you answered on how many people are working for the CIS; I do not think that you answered on how many investigators.

Ms Smith—We had 156 officers in direct investigative roles at our last point of checking.

Senator CORMANN—So what you are saying is that all of the people employed by the CIS are investigators?

Ms Smith—We have people who are directly employed to investigate cases, and then we have managers who guide and supervise their work.

Senator CORMANN—Talk me through this again. What is the total number?

Ms Smith—We had 156 officers nationwide, at our last point of checking, who are investigating cases.

Senator CORMANN—And on top of that?

Ms Smith—They sit within a management structure of people who are guiding and monitoring their work.

Senator CORMANN—And the people in the management structure are not part of the CIS; they are part of the department?

Ms Smith—They are part of the CIS, but they are not directly employed as investigators.

Senator CORMANN—How many are the ones who are in the structural part of the CIS and not employed as investigators?

Ms Smith—That is what I said I would need to take on notice.

Senator CORMANN—Are we talking about five, 10, 20, 30 or 50—roughly? I am not looking for an exact number right now; I am happy to get that on notice.

Ms Smith—I think we would be talking about 20, probably.

Senator CORMANN—I am looking for a rough guesstimate. Is there a maximum number of investigations an investigator can carry out at any one time?

Ms Smith—We certainly try and maintain a reasonable caseload for all our investigators, but we do not have a magic number, no.

Senator CORMANN—So you do not have a magic number. Do all of those 156 investigators have a comprehensive knowledge of the Aged Care Act?

Ms Smith—That is part of their training.

Senator CORMANN—So the answer is yes?

Ms Smith—They have training in the Aged Care Act. They do modules of the Certificate IV in Government (Investigation). They are also provided with training in basic administrative law, clinical decision making and CIS procedures, including how to use the national database that we have to monitor our caseload. We also have access to a legal team in our central office who are able to provide more specialist advice if there is any lack of clarity about the act.

Senator CORMANN—And you are confident that all 156 investigators are able to determine what is in scope and out of scope, based on what is in the act and what is in your rules and regulations?

Ms Smith—I think we have a very good framework under which they are operating, and I think we also have a very good framework for officers who may be uncertain to seek advice from more senior officers.

Senator CORMANN—And there are consistent standards across Australia on the way those 156 investigators go about their business?

Ms Smith—Clearly any bureaucratic structure that operates with state and territory offices has to put a lot of effort into ensuring that there is nationally consistent operation. We have a variety of mechanisms to achieve that. Key to the process is that we have a team of people in central office who are providing national policy advice and national program support. We have a national legal team who provide legal advice across the scheme. We also have regular get-togethers with state and territory managers, assistant state managers and also the CIS program managers to make sure that we are sharing experience and doing things consistently.

Senator CORMANN—Presumably, those 156 investigators are not all on the same public service employment level—are they? There would be junior and senior people.

Ms Smith—We have people generally at the APS6 and EL1 level, but we also have some people who have registered nursing qualifications as well who are employed under what is called a Commonwealth Nursing Officer classification.

Senator CORMANN—The person that would be taking the initial complaint on the phone: what public service employment level would they be at?

Ms Smith—Generally, at the APS5 or APS6 level.

Senator CORMANN—Decisions made by the Aged Care Commissioner; are they reviewable by the Administrative Appeals Tribunal?

Ms Smith—Not to my knowledge. She actually does not make an enforceable decision. She makes a recommendation to the department. They are not reviewable.

Senator CORMANN—Do the investigators have any form of medical training?

Ms Smith—I do not believe we have any medical professionals in the scheme but, as I indicated before, we do have quite a significant proportion of registered nurses and we have access to medical advice from departmental doctors when required.

Senator CORMANN—So the people who take the initial complaint or those 156 investigators, presumably they could not keep running—how many nurses have you got?

Ms Smith—Twenty-six per cent.

Senator CORMANN—Twenty-six per cent of them are nurses?

Ms Smith—Yes.

Senator CORMANN—So whenever there is a medical issue at stake would the matter automatically referred to those 26 nurses?

Ms Smith—Obviously, we allocate cases depending on the nature of the issue. Where there is a complaint that involves clinical issues we seek to ensure that there are nurses as part of the investigation team. We also have access in Canberra to a senior nurse adviser who provides quite a significant amount of clinical advice to investigators working in a scheme.

Senator CORMANN—How many appeals have gone before the Aged Care Commissioner?

Ms Smith—You recall that in 2007-08 we dealt with almost 7½ thousand cases. Reviews by the Aged Care Commissioner were only requested in relation to 134 individual decisions of the scheme, so that is only—

Senator CORMANN—Sorry. Can I just interrupt you there because before you have been at pains to explain how the 7,000 figure was the broad figure of contacts and that you only investigated or that there were only breaches of—how many of them did you investigate?

Ms Smith—No. What I said was that we had 11,323 contacts.

Senator CORMANN—Yes.

Ms Smith—We investigated almost 7½ thousand cases and reviews by the Aged Care Commissioner were only requested in relation to 134 individual decisions.

Senator CORMANN—How many of the decisions made by the commissioner has the department held up in full?

Ms Smith—Sorry. Could you just repeat the end of it?

Senator CORMANN—How many of the decisions or recommendations made by the Aged Care Commissioner has the department upheld in full?

Ms Smith—In the 2007-08 year there were 90 completed reviews of individual decisions, and in 46 of those reviews the Aged Care Commissioner agreed with the department's original decision. In 27 reviews the Aged Care Commissioner recommended that the department's decision be varied, and in 17 reviews that the department's decision be set aside and there were only 10 cases out of that where the department did not agree with the Aged Care Commissioner's recommendation.

Senator CORMANN—On what basis did you not agree with the Aged Care Commissioner's recommendations?

Ms Smith—Without going into each of the individual cases—

Senator CORMANN—Give us a theme.

Ms Smith—I think there are probably some occasions where the department and the Aged Care Commissioner have a different legal interpretation of the legislation, and then there would be a number of other cases where a different weight has been placed on the evidence so

there is a different clinical judgment about whether the approved provider has or has not breached responsibility.

Senator CORMANN—Who in the department is the decision maker when it comes to making a decision on overturning a recommendation or judgment of the Aged Care Commissioner?

Ms Smith—We have a process where, once a decision has been reviewed by the Aged Care Commissioner and her office comes back with a recommendation, it is considered by a delegate who was not involved in the original decision making and who is at a more senior level from the original decision maker. What we have done as a process improvement is ensure that there is a level of senior scrutiny of any occasion on which we believe we may have a difference of view with the Aged Care Commissioner.

The process is that there is always a discussion with the commissioner and her office to ensure that we have a comprehensive understanding of the reasoning behind her recommendations. Where the issue involves a clinical matter we seek the view of our senior clinical adviser in Canberra and we also obtain legal advice if there are legal questions. All of those disagreements under our procedures are also brought to my attention and I have to be satisfied that there is sufficient evidence not to accept her recommendation.

Senator CORMANN—Are you saying that you are the ultimate decision maker?

Ms Smith—No.

Ms Halton—No, certainly not.

Ms Smith—I have to be satisfied that an appropriate process has been followed.

Ms Halton—I would like to put this on the record. Ms Smith talked about process improvement. I indicated at the beginning of this that we acknowledge that this is a not very mature, in terms of length of time in operation, scheme. And, as a result of our experience in its operation, particularly in the early days, there were a number of things we identified, in terms of how the scheme was first rolled out, that were probably not working as effectively, and therefore as carefully thought through in terms of oversight and scrutiny, as they might. This particular process improvement was precisely in response to one such concern. So this was introduced—how long after the scheme operated, can you remember?

Ms Smith—It was probably in early 2008, I think.

Ms Halton—Yes, so we had a period of six to nine months at the beginning of the scheme operating where this was identified as a weakness in the scheme, in terms of ensuring that there was appropriate oversight of that consideration of the commissioner's decision and, as a consequence of that internal review of those processes, this is the arrangement that has been put in place.

Senator CORMANN—Now that you have changed the arrangement because a concern was identified, what is the public service employment level of the person who is the decision maker? You having been satisfied that the process was followed, what is the public service employment level of the decision maker who makes a decision on whether or not to overturn a recommendation from the Aged Care Commissioner?

Ms Smith—It would vary from state to state, simply because—

Senator CORMANN—Why is that?

Ms Smith—Simply because in the bigger states there is such a volume of decisions that it is sometimes decided at a slightly less senior level than in the smaller states.

Senator CORMANN—Can you define 'less senior level'?

Ms Smith—The original decision would be made by an EL1 in most state offices. The review decision would be made by an EL2 in most state offices but can also be made by a state manager in some state offices.

Ms Halton—Who may be an SES officer.

Ms Smith—Who may be an SES band 1.

Senator CORMANN—Yes. But you say, given the volumes involved—I mean, as you were going through the numbers, only a very small proportion go to the Aged Care Commissioner. Then you have been at pains to say that only a small proportion of those reviews that come back from the Aged Care Commissioner you actually disagree with. So it is not something that, listening to you, happens on a daily basis. Why—

Ms Halton—There is a separate issue to be considered here, and that is actually having people with sufficient expertise in the matters concerned to actually take that decision.

Senator CORMANN—Yes, and I think that is the point. Yes.

Ms Halton—Yes. Our state offices are not enormous and, therefore, it is a question of finding exactly—as Ms Smith has said—a delegate who has delegated power under the act who was not the original decision maker. In other words, to be very clear, that was not the original decision maker.

Senator CORMANN—Could I just go back to my question before in terms of the Administrative Appeals Tribunal. Somebody came and gave you quick advice to say no, the decisions were not reviewable by the Administrative—

Ms Halton—The commissioner's recommendations.

Senator CORMANN—Yes, they were not reviewable. And, presumably, are your decisions as a consequence—

Ms Smith—Under the complaints investigation scheme, neither the original decision nor the reconsidered decision are reviewable decisions either.

Senator CORMANN—Why is that? Can somebody explain that to me? Presumably, they are administrative decisions. They are decisions made by the administrative arm of government, so I am just trying to understand why they are not reviewable.

Ms Smith—Senator, my understanding of why that is the case is that the complaints investigation scheme is set up to achieve a remedy for an individual. So you are someone who has got a concern about how a particular resident is being looked after in an aged-care facility, and the concern is that you get a timely and quick resolution of your concerns.

Senator CORMANN—So they are not administrative decisions? They are just you trying to sort it out.

Ms Halton—You then, if you are not happy, go to the Ombudsman.

Ms Smith—You can go to the Aged Care Commissioner or, if you are still not happy after you have gone to the Aged Care Commissioner, you can go to the Commonwealth Ombudsman.

Senator CORMANN—So you can run around from ombudsman to commissioner to ombudsman.

Ms Murnane—If I could just say one thing here.

Senator CORMANN—Yes, please.

Ms Murnane—If, when the investigator visits the home, the investigator sees signs of systemic issues that worry them, they then refer the issue over to Compliance, and a number of things could happen then, including, and most probably, a review audit by the Aged Care Standards and Accreditation Agency, which could result in a variety of sanctions by the department—and those sanctions are reviewable. That is the distinction we are making: the distinction between investigating a complaint, which undoubtedly is very important to the individual, and investigating if something truly egregious is found, either on an individual basis or on a systemic basis in the home. Then there is traffic between the complaints scheme and the compliance scheme. That then goes through a full process which is reviewable.

Senator CORMANN—Just going back to the Ombudsman, we can go from the Aged Care Commissioner to the Ombudsman. Are the Ombudsman's findings appealable to the Administrative Appeals Tribunal? If you are not happy with the outcome after the interaction between the Aged Care Commissioner and the department, Ms Halton said that we could go to the Ombudsman. Once the Ombudsman makes the decision, where do we go then? We are not talking about sanctions; we are talking about complaints that are not reviewable. I am not asking about sanctions.

Ms Smith—I have just been reminded by my colleague that it is open to either party, either an approved provider or the complainant, to go to the Federal Court through the Administrative Decisions (Judicial Review) Act if they are unhappy with the individual decision.

Senator CORMANN—That is a pretty complex process compared to the more straightforward process of the Administrative Appeals Tribunal, isn't it?

Ms Halton—You might want to take some other advice from other people about that matter, Senator. The bottom line is that what we are trying to do here is operate a scheme which is available and is quick to the extent that is possible for people. I think you would find there would be different views about whether the AAT would actually deliver that same kind of outcome. It is a matter of opinion, but certainly that is not what I have heard people say in the past.

Senator CORMANN—What Public Service employment level is the commissioner?

Ms Halton—She is a statutory appointee.

Senator CORMANN—What would be the equivalent Public Service employment level?

Ms Halton—This is not an equivalent Public Service level. It is a statutory—

Ms Smith—There is a Remuneration Tribunal determination in respect of the Aged Care Commissioner.

Senator CORMANN—But would it be a more senior or a more junior position than those of the people that make decisions overturning the—

Ms Smith—The Aged Care Commissioner, in terms of reviews of individual decisions, also has a process of delegation within her office. My understanding is that the people within her office who look at the reviews of individual decisions are also at the EL1 level. So they are comparable to the level of the people in the department.

Senator CORMANN—But, ultimately, she is the decision maker, isn't she?

Ms Smith—No. In relation to reviews of individual decisions, she has actually delegated her decision making to EL1 people in her office.

Senator CORMANN—The minister, on Monday night, on *Four Corners*, said:

… we've previously committed to looking at the issue of the staffing mix through our Aged Care funding review that's underway at the moment.

Can you let us know, Ms Halton or Parliamentary Secretary McLucas, what funding review is the minister referring to, when was it announced and when is the closing date?

Mr Stuart—We gave some evidence a little earlier in the hearing that the minister was referring to the review of the aged-care funding instrument which she wants to use in part to look at this issue about staffing.

Senator CORMANN—I was asking questions before about the review into the CIS. I might have been out the room. Was that with another senator, was it?

Mr Stuart—Yes.

Senator CORMANN—It was not with me, perhaps.

Mr Stuart—But we are not talking about a CIS review here. We are talking about the ACFI review.

Senator CORMANN—I am talking about the review of aged-care funding arrangements.

Ms Halton—Yes.

Mr Stuart—That is right.

Senator CORMANN—So it is underway, is it? When was it announced?

Mr Stuart—The minister has been talking about her intention to do this for a while.

Senator CORMANN—So it has not been announced yet? The answer is yes?

Mr Stuart—No. I am smiling because it is a little bit more complicated than that.

Senator CORMANN—Why is it complicated?

Senator SIEWERT—It's aged care; it's always complicated!

Ms Halton—Thank you, Senator Siewert; you are absolutely right.

Senator CORMANN—It is no wonder the industry is getting confused!

Mr Stuart—Please bear with me.

Senator CORMANN—I will bear with you. Please explain to me why it is complicated.

Mr Stuart—There is an 18-month review of the ACFI which has been a government commitment for some time.

Senator CORMANN—But has it been announced?

Mr Stuart—It was committed to when the legislation was passed in March 2008.

Senator SIEWERT—And it was in the inquiry.

Mr Stuart—The department has been embarking on data collection and gathering of evidence and information, including independent analysis by Access Economics, over the entire course of the year.

Senator CORMANN—But the minister said it was underway.

Ms Smith—Senator Cormann, it is underway.

Mr Stuart—Data gathering has commenced. The process of consulting on and then putting forward the final terms of reference has not yet been undertaken, and that will be done in due course.

Senator CORMANN—So it is underway. And your definition of 'underway' is that you are collecting data; is that right? What else, other than collecting data, are you doing at present?

Mr Stuart—We have an ACFI steering committee with the industry that meets regularly, which is reviewing aspects of the ACFI all the time. We are gathering evidence from that as well as from analysis through Access Economics.

Senator CORMANN—Is there a time line for that? Have you got a closing date? Have you got a deadline?

Mr Stuart—There will be a more formal commencement of the consulting stage of the review, with terms of reference in about September. The commitment was to commence this review at the 18-month point, after the implementation of the ACFI.

Senator CORMANN—We are going back here over some ground that I touched on before but more specifically, because I am now going through some of the statements of the minister on *Four Corners*. The minister said:

… what I can tell you is that this is a very viable sector and we look at a whole host of different surveys that are out there as well.

Can the department please provide details of the surveys that demonstrate the viability of the sector?

Mr Stuart—Just bear with us. We are finding our place.

Senator CORMANN—I am happy to bear with you, as long as you give me an answer at the end!

Mr Stuart—Senator, one of the things that we did in response to the Senate inquiry was to do a comparison of each of the major data sources in relation to the financial viability of the sector—that is available in the public arena—and set that out in a table. That table was included in our second submission to the Senate inquiry and is therefore in the public arena.

My memory is that we also attached it to an answer to a question on notice, which I am just looking for.

Senator CORMANN—This is a question that does go to attitude and culture. It seems like you are spending a lot of time and we are having a lot of debate where you are trying to prove that all these people out there who are saying there is a problem with the viability of the sector are wrong and that you are right. You seem to be utilising a whole lot of resources to prove your point and, every now and then, after it has been clearly demonstrated and three organisations come together and make a joint statement, we get a comment today, 'Sorry, I got that wrong. I now realise I got it wrong.' People really have to prove to the nth degree that what they are saying is actually right and that there is an issue with the residential high-care sector. Would it not be better if we had an attitude where you would actually work with the industry to understand why they are saying what they are saying, rather than to continuously try to put up this wall, 'You are wrong because of these reasons'?

Ms Halton—Well, Senator, I actually have not heard anyone say, 'You are wrong for the following reasons.'

Senator CORMANN—I am getting that impression and I think that I am about to get the same.

CHAIR—Senator, this is the last time I am going to say this: please let the witnesses finish. You have been trying, but that was a clear example where Ms Halton was speaking and you came in.

Senator CORMANN—And I know you do not agree with our little private arrangement.

CHAIR—No, I do not.

Ms Halton—Senator, as I have indicated, as long as I have known, there is always a contest inside aged care about what constitutes viability and the financing in the sector. This is not an attitude issue. We have an obligation to understand these numbers as well as anyone else, and I have to say we are very open to that discussion and, indeed, I think we have already had the office say they are very happy to talk to the people you have been talking about. No problem with that at all.

Senator CORMANN—And I will ask you questions about it next time.

Ms Halton—That is fine. The thing you have got to understand is that we also get this level of scrutiny from our central agency colleagues. So the bottom line here is: it is not just a question of us saying, 'Yes, that sounds like a reasonable case, we will just go put it to government.' We actually have to all understand these numbers in a very methodical and detailed way. What the officers are trying to do, very genuinely, is understand those matters. The bottom line is they are very happy to talk to people outside if they have a view which is grounded in evidence, but, in the interim, we also have to analyse that evidence and, because we do have to discuss this with out central agency colleagues, be very clear about what that evidence says.

Senator CORMANN—So now that we have had our friendly conversation, have you had enough time to find the information?

Mr Stuart—I have, Senator.

Senator CORMANN—Thank you.

Mr Stuart—I can refer you to an answer to a question at additional estimates from 25 February. It is question 155 from that hearing, *Hansard* page CA77, in answer to Senator Boyce, where we were asked to provide a summary of the key data sources publicly available in the sector, including Bentleys MRI, Stewart Brown & Co. and Grant Thornton, which we did both in the form of a table and in text, looking at both the average for all services and the top quartile data on a per bed basis.

Senator CORMANN—This is where we are starting to go around in circles, because we have spoken about all these surveys and that all of them find that there are serious problems; in fact, that modern high-care places are not viable unless they are in old, shared accommodation. So are you saying that the things that you have just listed, these are the surveys that the minister is basing her statement on that everything is well; that it is a very viable sector and you look at a whole host of different surveys. They are the surveys you are talking about?

Mr Stuart—Yes, I believe so, Senator. Senator, in this table that I have referred you to, there is a comparison of data sources. Bentleys MRI/James Underwood, has found, from 2006-07 to 2007-08, an average increase in EBITDA per bed of 18 per cent between those years. Stewart Brown found an increase of nine per cent and Grant Thornton found a decrease of nine percent. For the top quartile, Bentleys MRI found an increase of 10 per cent; Stewart Brown an increase of 20 per cent and that data is not published by Grant Thornton. So we have done, I think, quite a comprehensive survey of the information that is available.

Senator CORMANN—The only new survey that I have heard you mention and we have not yet discussed today is the Bentleys MRI. Can you confirm that they have not released a report on their findings for 2008?

Dr Cullen—That is correct, Senator, but they have released—

Senator CORMANN—Thank you.

Dr Cullen—Sorry, Senator, if I can finish my sentence. They have released the unit record data to everyone for people to make their own analysis. Indeed, we also have the unit record data from Stewart Brown, and the figures that we have given here are the department's analysis of the unit records which those surveys collect.

Senator CORMANN—So are you saying that the Bentleys MRI survey for 2008 presents an improvement in returns for operators, where the Grant Thornton survey presented a decline in returns between 2007 and 2008.

Dr Cullen—Both the Bentleys and the Stewart Brown surveys show an improvement, whereas the Grant Thornton shows a decline.

Senator CORMANN—I have already indicated to you that all of the surveys you have just mentioned have signed off in a joint statement.

Dr Cullen—But that statement was not about the question—

Senator CORMANN—No, the joint statement was about the fact that they all endorse a proposition that the high-care sector is currently not viable. I have agreed with the chair that I

am going to ask two or three quick more questions and then pass onto somebody else. Minister Elliott announced $14.4 million for palliative care in the 2009-10 budget and then issued a second media release on 27 May for what appears to be a further $14.4 million allocation to palliative care. Neither amount we were able to find in the forward estimates. Could the department please explain if, in fact, there are two allocations in this year's budget of $14.4 million?

Mr Stuart—At the risk of saying 'it ain't simple'—

Ms Halton—At least he is consistent, Senator.

Mr Stuart—I can help you with that, Senator. The first $14.4 million, there is a measures description in the budget papers, but the measures description shows an amount of zero.

Senator CORMANN—Why is that?

Mr Stuart—I will explain this slowly.

Senator CORMANN—Please.

Ms Halton—You are allowed to take objection to that, Senator, 'explain this slowly'. That suggests he thinks you are not quick on the uptake.

Senator CORMANN—I am quite happy for him to think I am dumb, as long as he explains it slowly! As long as I get an answer, I am quite happy—

Ms Halton—No, he does not think you are dumb. I promise you that.

Mr Stuart—I have been explaining this to a range of other people in the sector recently, Senator, and it seems to require a little bit of effort. It is complicated. The $14.4 million which was in the budget was formerly a part of the healthcare agreements, but which was expended by the Commonwealth as a Commonwealth own-purpose outlay. Since we now give all funding under the healthcare agreement to the states, it required a decision of budget for that funding to be ongoingly available to the department to expand on palliative care. So there was a decision for the $14.4 million to be available ongoing for palliative care expenditure by the department, but the numbers in the budget measures show a zero, because those figures were formerly a part of the healthcare agreements and were, therefore, in the healthcare agreement forward estimates.

Senator CORMANN—So the bottom line is: it is an accounting trick, measure, issue?

Mr Stuart—I think it is a little bit more significant than that, because the government decision meant the ongoing availability of that funding specifically for palliative care initiatives from the Commonwealth. In terms of the money, it is a movement of the funds from one place to another.

Senator CORMANN—Are we talking about $14.4 million or $28.8 million?

Mr Stuart—We are talking about, on that particular initiative, $14.4 million.

Senator CORMANN—So there is one lot of $14.4 million and, even though it shows zero, it is somewhere, but it has been announced twice?

Mr Stuart—The more recent announcement added up to $14.4 million purely by chance. It bears no direct relationship to the other decision. There was a package of measures under a

range of palliative care programs that the minister announced in a press release. So it is not all that money, but it is not all other money either. It is a range of funding sources.

Senator CORMANN—So you are saying it is repackaging, in part, from a range of other funding sources?

Mr Stuart—The minister has announced a range of expenditures on palliative care that just happen to also add up to $14.4 million.

Senator CORMANN—Just coincidentally?

Mr Stuart—Yes, absolutely. Some of which are drawn from the budget measure and some of which come from other funding sources on palliative care available to—

Senator CORMANN—That is an incredible coincidence, isn't it?

Mr Stuart—I am afraid so.

Ms Halton—So the best way to think of this is: one is an allocation and the other is expenditure—of commitments, of projects.

Senator SIEWERT—But there are not two lots of $14.4 million. There is a bit more than $14.4 million, which is the new initiative, plus some from the department.

Senator CORMANN—And to conclude on that question: how much are we talking about? So it is not $14.4 million; it is a bit more. But it is not $28.8 million; it is significantly less. How much are we talking about once you put it all into one lump?

Mr Stuart—There is, overall, a significantly greater amount of funding available for palliative care—

Senator CORMANN—I am not asking overall. I am talking about these two issues: the one announced by the minister on budget night and the one that was announced on 27 May. Regarding those two amounts that she has announced, I understand there is some overlap there and I take your word for it that the zero is really $14.4 million. I understand what you are saying, but how much does that $28.8 million out of those two releases represent as a bottom line figure?

Mr Stuart—Concerning the initiatives announced in the press release by the minister, some of that funding would have been drawn from the $14.4 million and some of it would have been drawn from other funding sources on palliative care. There is a total over five years of $114 million available to the Australian government for specific palliative care initiates. Some of that is the $14.4 million in the budget measures, and—

Senator CORMANN—You have got to laugh, don't you?

Mr Stuart—It would be nice if life was simple, but sometimes ain't.

Senator CORMANN—So can you please—

CHAIR—Senator, I am coming in on this. Mr Stuart, would you please itemise the expenditure on palliative care over the out years? Could you show where it is, item by item, allocation by allocation? Table that, and then if we have any further questions we will follow up with you.

Mr Stuart—Thank you very much, Chair. I would be very happy to do that.

CHAIR—Are you almost through, Senator Cormann?

Senator CORMANN—That question just now would have been my next question.

CHAIR—That is good; I got in early.

Senator CORMANN—And my final question is: could the department also please provide a list of organisations and their principals that have or will receive money under this program and the amounts of money these organisations will receive? And I am happy to put everything else on notice.

Senator SIEWERT—Can I just ask another question on palliative care? Have you done any benchmarking of the cost of provision of palliative care?

Mr Stuart—We have just been having a brief discussion, and we are not aware of any collection on the cost of delivery. The Commonwealth is working with state and territory governments to develop indicators in relation to palliative care, but we are not aware of that encompassing cost efficiency.

Senator SIEWERT—Thank you. Perhaps if you could take it on notice to double-check if there is, that would be appreciated.

Mr Stuart—Yes, we are happy to do that.

Senator SIEWERT—And I also appreciate the fact that you are going to be giving us a detailed list of the initiatives and various funding sources for palliative care. I am just wondering, do the various initiatives provide potential funding for people providing community care? So will funding sources be available for providers of residential care but also community care?

Mr Stuart—Yes, Senator. The core responsibility for funding palliative care lies with state and territory governments, and so they fund the operation of palliative care and the provision of palliative care. The Commonwealth contributes by undertaking various practice improvement initiatives and paying for national data collection and things of that kind, and some of our money goes towards community based palliative care which is not for the aged, as well as that for the aged in both residential and community care settings.

Senator SIEWERT—Yes, I appreciate that it is not just about aged care. Thank you. I want to go, please, to, firstly, some of the questions on notice that you answered as part of the inquiry. This relates to a couple of questions that I asked. One of those was around the number of non-government organisations in the top quartile. At the time I think we had a dialogue around who was in the top quartile and I was assured that, yes, there were some non-government providers in that top quartile. Then you took on notice to have a look at that further, and—I have just closed my computer, so I have not got it in front of me—but the answer to the question was along the lines of: you cannot give me that detail because you do not have that level of detail. So I am wondering how you can tell me that there were non-government organisations in the top quartile if you have not got the information available to tell me who they were. I can find the exact question, I think, if that is going to be of use.

Dr Cullen—As we said in the answer to the question on notice, we do not have the data as to whether someone is a not-for-profit organisation or a for-profit organisation for the two public surveys, so we were not able to answer your question with respect to those surveys.

Senator SIEWERT—I can check the *Hansard*; I do not have the *Hansard* in front of me. I am pretty clear in my recollection that you said, 'Yes, there were not-for-profit providers in that top quartile.'

Dr Cullen—I did say that.

Senator SIEWERT—Yes. So how can you say that if you do not have the detail?

Dr Cullen—I have the detail for the general purpose financial report, which is the dataset which the department owns.

Senator SIEWERT—Which is different to the other datasets, is it?

Dr Cullen—Correct. The Stewart, Brown and the Bentleys datasets are collected by survey. Ours is a complete collection of all of the general purpose financial reports.

Senator SIEWERT—So when we have these discussions about who is and is not in the top quartile and the various surveys, you are bouncing between a number of datasets?

Dr Cullen—Unless otherwise identified, my statements are from the full dataset, which is the general purpose financial statement.

Senator SIEWERT—And that general purpose financial statement you used to then work out who is in the top quartile?

Dr Cullen—I did.

Senator SIEWERT—Are you able to provide us with that data?

Dr Cullen—That data is one of the bases of the CAP review, and the minister is currently considering the release of the CAP review and its data.

Senator SIEWERT—I find this quite frustrating when we are told—

Mr Stuart—I will take on notice the question about the breakdown of that data according to our auspice of the organisation, and we will see if we can get an answer for you.

Senator SIEWERT—That would be appreciated, because we are assured that there are not-for-profits in that top quartile but we are given no evidence with which to substantiate that claim.

Mr Stuart—We are happy to take that on notice, Senator.

Senator SIEWERT—Thank you. I learn in estimates to be a lot more detailed, and the answer to this question has in fact taught me to be very specific in what I ask for. When I asked for the breakdown of the last ACAR round, for the number of places that were available and the number of requests, you answered the question but not in a helpful manner. I got the number of places that you released and I got the actual number of applications for those places, which conveniently did not tell me the number of beds. So in actual fact it provided me with no ability to analyse how many beds were applied for against how many you released, and I am pretty certain you would have known what I was after.

Senator McLucas—Are you asking a question?

Senator SIEWERT—Now I am being more specific. I want exactly the number of places that were applied for versus the number of places that were available. I realise that you need

to take that on notice, because you have given it in each state against each region, as I asked, but it is impossible for me to work it out. It says, for example, there were three applications for 360 beds, but of course it is impossible for me to analyse what the unmet need was because three applications could have been for three beds or 100 beds.

Mr Stuart—I have some data in front of me.

Senator SIEWERT—Are you able to table that now? I am not going to go through each state for each region because it will take us half an hour to get that data.

Mr Stuart—By region?

Senator SIEWERT—Yes. What you gave me was a list for each state against metro and against each region, so it is a long list. For WA, for example, there is Perth and then there is the south-west, Goldfields et cetera.

Mr Stuart—I only have a state breakdown, not a region breakdown in front of me.

Senator SIEWERT—I am specifically interested in the regional breakdown. As I said, you did give me a partial answer, and I can tell you the exact question number if you want.

Mr Stuart—I have got it here in front of me. I am happy to take that on notice.

Senator SIEWERT—You understand what I am getting at, don't you?

Mr Stuart—I do understand.

Senator SIEWERT—Thank you. I would appreciate it if you could supply that.

Senator McLucas—Senator Siewert, just in defence of the officers, I have to say this—and I think you acknowledged that you are going to be able to frame your questions a lot more specifically. The officer cannot predict what you are wanting. I just said as an aside to Senator Cormann, when he was concurring with you, I think, that I used to sit over there, and I sat over there for a long time, and I think it is only reasonable that we frame our questions very specifically because the officer honestly cannot predict what you are getting at.

Senator SIEWERT—Minister, I do take your point, but that ask was in the context of some very rigorous discussion that we were holding during that inquiry.

Senator McLucas—Yes.

Senator SIEWERT—It was fairly obvious where I was coming from, in fact, where we were all coming from in that questioning. I do accept it and I do learn and I will get more specific.

Senator McLucas—I am not trying to make a political point. I am just trying to defend the officers.

Senator CORMANN—Senator, you have just mentioned our little interchange. I just want to remind again—and I do concur with Senator Siewert—that it is overall an issue of attitude. At the end of the day we are all in this together. We are here to make a positive difference and we are here to make some improvements to what is an important industry. We want to feel that we are working on this together and that people in the department, when they clearly know what we are trying to get at, rather than defend a position at any cost will actually assist

us in trying to get to the bottom of things so that, for the benefit of everybody, we can make improvements moving forward.

I did make those comments at the beginning of this session and I do hope that the government and the secretary are going to reflect on them. Because you sat on this side for five years, as you mentioned, I am sure that you understand perfectly what I have just talked about. This is really about achieving the best possible outcomes, and unless we start actually sharing information on these important things more freely we are not going to get there.

Senator McLucas—Senator, I do have to respond to that, and this is really important. I take your point that we are all trying to work in an area that is very complex, that does have a point of difference between some of the major players, and I think the discussion this afternoon has underlined that. But the officers of the department, like you and I, care about frail, older, vulnerable Australians—

Senator CORMANN—I accept that.

Senator McLucas—and they work very closely in this sector, and to refer to them in the way you did earlier I think was erroneous. I think it was unfair.

Senator CORMANN—I do not take a step back at all from what I said earlier. I think that—

Senator McLucas—I am very disappointed in that.

Senator CORMANN—We should not have a defensive attitude when it comes to these things. We should have—

Senator McLucas—I do not know—

Senator BOYCE—Minister, could I—

CHAIR—Would both of you please end this discussion.

Senator BOYCE—Minister, could I just—

CHAIR—No.

Senator BOYCE—I think that—

CHAIR—I am sorry, Senator Boyce, I have said no.

Senator BOYCE—This is just silly argy-bargy, Chair

CHAIR—Senator Boyce, this discussion has ceased. I think the political discussion has been held and I think people have had their chance to put their points on the record. Senator Siewert, you are in the middle of questions.

Senator SIEWERT—Yes. Thank you. I have only got one more question about a question on notice. It is the question around the exchange of beds for community care packages. You gave me what I asked for—so I am not having a go—in terms of the number of beds that were exchanged from 2006 to April 2009 as a total, which was, from memory, around 297. I am wondering if it is possible to give me that breakdown per year and per state. Is that possible?

Mr Stuart—Yes, we can do that—on notice, obviously.

Senator SIEWERT—Yes. This next question stems from my confusion, and we touched on it earlier, and that is: what extra income are providers are able to—claim is the wrong word—use from the pension increase? Could we just clarify that, please?

Mr Stuart—The headline figures are a total of $724 million over four years in income that will flow through to aged-care providers as a consequence of the pension increase. We will explain how that works.

Senator SIEWERT—Yes, if you could, because I think that is where there is some confusion out there—and here, but out there as well.

Dr Cullen—Certainly. I think I can encapsulate it in one set of numbers. The pension is going up by $32.49 a week. Of that increase, $10.09 remains with the resident and $20.40 is additional revenue which flows to the provider. There are some transitional and other sort of protections for certain residents et cetera, but for a newly entering resident who received the pension increase then, in respect of that resident, the provider will receive $20.40 extra a week.

Senator SIEWERT—Of the increase in the base rate?

Dr Cullen—Correct.

Senator SIEWERT—So what was the comment about it being capped, that aged-care providers would not be able to access the increase? Was that false information that was circulating?

Dr Cullen—I am not sure. I do not know what the comment was.

Senator McLucas—I might be able to help here. Previously—and I will make sure I get the figures right for you—a residential aged-care facility could charge up to 85 per cent. What we have done is not kept that 85 per cent of the total with the $32.44, or whatever it is—it is not 85 per cent of that total.

Senator SIEWERT—Which is why it has gone down to 84.

Ms Halton—Exactly.

Senator McLucas—That is right.

Senator SIEWERT—So now it is always going to be—

Senator McLucas—It is on the basis of Mr Stuart's figures of actuals.

Senator SIEWERT—So now it is always going to be 84.

Ms Halton—Correct. Essentially what happens is that ratio then is maintained. So the increase, which is an extraordinary increase, has been shared between the provider and the pensioner, and on the basis of that share we have recalculated the overall proportion that we would charge of that total amount the provider can charge. It is 84. Off it goes.

Senator SIEWERT—This is for a single pensioner because that significant increase is for a single pensioner. What happens if you are part of a couple that goes in?

Dr Cullen—Couples who live in residential aged-care homes are treated as couples separated due to illness and they each receive a pension equivalent to the—

Senator SIEWERT—Then they will go back—so that provision still—

Dr Cullen—That is correct, so they receive the single pension increase, yes.

Senator SIEWERT—Thank you. Should I ask here about HACC?

Mr Stuart—Yes.

Senator SIEWERT—Could you just give us a brief update about where we are up to with the state-Commonwealth negotiations on HACC? You are looking blank.

Mr Stuart—I am not looking blank.

Senator SIEWERT—Sorry, I thought I was asking the wrong—

Mr Stuart—No. COAG is yet to consider the issue of home and community care. Officials have done some work over the course of the past year and it remains to take that work to COAG itself, so space will need to be found for that in due course on the COAG agenda.

Senator SIEWERT—How soon do you think that is—

Ms Halton—That is very difficult to predict. Essentially, the work is not yet complete and the COAG agenda and the timing of COAG obviously are not in our control.

Senator SIEWERT—Yes.

Ms Halton—I would hope later this year, but please do not take that as meaning it is in any sense likely. We just do not know.

Senator SIEWERT—The changes, anyway, would not flow until the next funding—

Ms Halton—Even that is not certain so—

Senator SIEWERT—round of HACC.

Ms Halton—Let us be clear: you cannot make any major change in that space quickly. Everyone would have to think their way through timetables etcetera. Work is not yet complete. It will go to COAG, I am quite confident of that. We will keep you posted.

Senator SIEWERT—I have had, as I have said before, and I continue to have a number of representations from community groups that are concerned about not quite knowing what is going on. There are rumours circulating around the decreased number of programs et cetera, so there is a bit of nervousness out there.

Ms Halton—Yes, I understand.

Senator SIEWERT—The sooner it can be resolved, the better. Is the government planning to review, or is it reviewing, the day respite programs?

Mr Tracey-Patte—I am not aware of any review of the day respite programs themselves. Certainly, there is some consideration at the moment of how the parliamentary inquiry into better support for carers might feed in to the respite space, but I am not aware of any particular focus on day respite.

Mr Stuart—Senator, you may be recalling, I think, that there is an election commitment to streamline respite care. Now that the inquiry has reported, we are considering and advising on how that reflects in that area and how that work can be taken forward.

Senator SIEWERT—What do you think the time frame will be for that?

Mr Stuart—The government has three months usually to respond to a parliamentary inquiry. There were over 50 recommendations. It is being coordinated through FaHCSIA. We are contributing to that and we are, internally, considering that report and how it can be used to reflect on how we deliver on the election commitment, if I can put it that way.

Senator SIEWERT—Thank you. At the time last year when the last lot of changes were made to the aged-care legislation—I cannot remember the date—there was some talk of change to the aged-care principles. Is that progressing? And, if it is, what time lines are you thinking about?

Mr Stuart—There were changes made to legislation on aged-care assessment teams and aspects of regulation. That legislative change was accompanied shortly afterwards by changes to principles that were consequent on that change. That happened late last year.

Senator SIEWERT—Are there any further changes?

Mr Stuart—The next round of changes to the aged-care legislation will be the pension measures, because they need to be reflected in aged care, and after that it is a matter for the minister and the government to consider whether there is the prospect for further change.

Senator SIEWERT—But there will not be any change to the aged-care principles with the next round, the pension rounds?

Mr Stuart—There will be changes to the principles consequent on the pension changes in order to give effect to the government's decision on pensions.

Senator SIEWERT—But not outside those parameters?

Mr Stuart—No.

Senator SIEWERT—Thank you. I have got a lot more questions, but I will put them on notice, before the chair smites me!

Ms Halton—Very precisely on notice.

CHAIR—Senator Adams, I know you have some questions. I can give you 10 minutes.

Senator ADAMS—Aged-care allocation rounds: have questions been asked on that?

CHAIR—We have not started on that.

Senator ADAMS—In the 2007 election the current government undertook to review the aged-care allocation round process and the formula underpinning the three types of service delivery. Have you had questions on that yet?

Mr Stuart—On the review of the allocation process?

Senator ADAMS—That is correct.

Mr Stuart—No.

Senator ADAMS—Sorry. Because I had to go somewhere else, I was not sure. Has this review begun?

Mr Stuart—The department has been undertaking a range of activity in that space. There has not been a formal announcement of a formal review. But there have been very substantial

amounts of work going on, including our assistance to the ANAO that has recently produced a report on the approvals round process. We have also been finalising a review that was commenced under the former government, under RSM Bird Cameron, which made a number of recommendations to improve the efficiency and transparency of the aged-care approvals round. Those have all been responded to and many of them now implemented. There are a couple of specific things that were in the election commitment that have not yet been completed and we are liaising further and consulting with the sector on those things.

Senator ADAMS—Has the RSM Bird Cameron review been made public at all or is that just an internal document for the department?

Mr Stuart—It has only very recently been signed off by the reference group that was appointed by the then minister to oversee it. It is currently under consideration for release, hopefully, shortly.

Senator ADAMS—Shortly: how soon? We are getting very used to 'shortly' but we are not quite sure what the actual definition of 'shortly' is.

Mr Stuart—Subject to consideration by government, Senator.

Senator ADAMS—Thank you, Mr Stuart. How does the department determine the components of the formula as it is currently constructed?

Mr Stuart—For the allocation of aged-care places?

Senator ADAMS—Yes.

Mr Stuart—There are three parts to an aged-care approvals process. The first part we call the level 1 and it is really what determines what level of places are made available and where. I will ask Bernadette to talk through broadly how that works.

Ms Walker—As Mr Stuart was just saying, we have an overall ratio of 113 aged-care places per 1,000 people aged 70 and over. What we aim for is 88 of those places to be residential operational places and the remaining 25 to be operational community care places. The goal is to reach all of them by June 2011, and that is what we aim for, generally speaking. Once we have those numbers generated each year to put out through the aged-care approvals round, in order to meet that goal, we put those numbers on a state basis to aged-care planning and advisory committees who help us generate what might be available on a regional basis, depending on need.

Senator ADAMS—Having sat on one of those committees for a number of years, I am fully aware of that process. Thanks. I am from Western Australia and I have just got a few questions applicable to Western Australia. Given that there are only 530 residential care places applied for out of the 1,208 offered as available in the 2008-09 ACAR round for WA, what steps is the Department of Health and Ageing taking to ensure that there are adequate places for Western Australia's ageing population?

Mr Stuart—Senator, we are doing two things, one in relation to the current round and one in relation to the future. In relation to the current round—and it remains to be announced, so this is a process we are currently still working through—where there are fewer applications for residential care places than were made available, we are looking to make more community care places available at the request of the minister. She has asked us to look very hard at

making more community care packages available and, in particular, more EACH packages available, which are a higher level of care at home. That is in relation to the current round. Of course, we are using capital funds to the maximum available extent to provide incentives in that round also for places to be put where we really need them.

In relation to the next aged-care round, there will be zero real interest loans and capital available as well as residential places and community care places available. They will obviously be, again, targeted to areas that are then areas of need. We are looking to combinations of loans and capital funding to really provide the incentive for providers in the most difficult areas.

Senator ADAMS—I think, as I have mentioned before, with Western Australia, with the land being at such a high price and hard to come by, what is happening, of course, is that the providers are moving further out into the suburbs. But we really are going to be desperate for aged-care places. The EACH packages have coped so far, but a person gets to the stage where, really, they have to be in residential aged care. So it is of concern to a number of the providers that were hoping to be able to acquire these beds but have not been able to, because of the profit margin; the bottom line is just not there for them. Therefore there needs to be an incentive put out there. Somehow we have to come up with something that will entice people to actually build more facilities—and, once more, with the ageing population, with the baby boomers, that is quite a frightening scenario.

Mr Stuart—There will be substantial growth required.

Senator ADAMS—Therefore, what you are saying is that there is going to be more opportunity for capital funding to be available or loans.

Mr Stuart—Loans and capital funding, and we are of course looking very hard at the targeting of that.

Senator ADAMS—Something else that is becoming a problem are the regulatory and compliance costs over the past five years. Is the Department of Health and Aging able to provide an account of additional costs imposed upon aged-care providers to cover this increase? Can anyone help me with that?

Mr Stuart—When we put forward the most recent package of legislative changes last year, there was a process of looking very hard at regulation as a part of that and we identified a number of reductions in regulation as well as increases in regulation in that package. So what we were trying to do was to be as neutral as possible about regulation in that package. For example, there were a number of areas where regulation actually reduced, including when ACAT assessments were required and also in relation to capacity for transfer and sale of not yet fully completed aged-care buildings. From memory, we were also trying to clarify what were the requirements in relation to separate wings and floors of facilities which were formally caught up within the act but which may have been for separate kinds of businesses. In that legislation we took those outside the act to give providers an opportunity to carry on mental health or disability or other kinds of rehab and other kinds of businesses without being inadvertently caught by the Aged Care Act. So there is a balance in what we are trying to do of regulation and regulation reduction.

Senator ADAMS—Regarding, the aged-care workforce, what steps is the federal government taking to ensure that, despite the rapidly aging population and aged-care workforce, older Australians will continue to receive quality care from highly skilled aged-care nursing staff into the future?

Ms Halton—Senator, I might just make an overarching statement in relation to the workforce issue. You probably know that all health ministers recently agreed to the National Registration and Accreditation Scheme and that we are in the process of setting up Health Workforce Australia. These are really significant moves right across the health and ageing workforce in terms of ensuring that we have enough of the various kinds of skilled staff that we need right across health and aged care but also that we streamline and ensure that if we do have staff we need to move across state boundaries et cetera we can apply the same standard and we can be really clear about quality and safety. So there is a particular series of issues obviously in respect of the aged care domain, but I think that that broader COAG initiative which is now being really given some flesh on the bones is going to make quite a significant difference. It is certainly something we are very welcoming of.

Senator ADAMS—It is like breaking down the state borders. Perhaps they could follow the same pattern for the Patient Assisted Travel Scheme. I could not resist that!

Ms Halton—Good on you, Senator.

Senator ADAMS—We are all aware that aged-care nurses are getting paid considerably less than our public health sector nurses, so what can we do to try and fix that solution up?

Ms Smith—We cannot comment on the wage issue—I think that would be Mr Stuart's area—but we can certainly outline for you the range of workforce programs that we run, both in terms of our nursing section of the workforce and also the personal care workers. As Mr Stuart and Dr Cullen outlined earlier, one of the welcome developments of the last 10 years has been an increase in upskilling of the personal care workforce. My colleague Ms Nicholls might just quickly outline for you the programs.

Senator ADAMS—Good. thank you very much.

Ms Nicholls—We run a range of workforce training programs to support aged-care workers in the sector. This ranges from support programs for registered nurses right down to personal care workers. If I work from the top down, we have the Bringing Nurses Back into the Workforce measure, which is designed to encourage registered nurses who have been out of the workforce for some time back into the aged-care sector.

Senator ADAMS—How popular is that program? Have you had good results from it?

Ms Nicholls—The uptake has been slower than we would have wanted, but there has been a steady increase over the last four or five months in the uptake.

Senator BOYCE—What are the official numbers of the intake?

Ms Nicholls—As at the end of May, we had had 68 nurses who had returned and been assessed as eligible for the bonus. We have another four applications currently being processed.

Senator ADAMS—That is nationally?

Ms Nicholls—That is nationally for aged care. We have just embarked—

Ms Smith—We have also started a promotional campaign to increase uptake of the measure.

Senator ADAMS—Okay.

Ms Nicholls—In terms of aged-care scholarships, under the Aged Care Nursing Scholarship Scheme funding is provided up to $10,000 per year for a maximum of $30,000 per applicant for undergraduate scholarships. We have postgraduate continuing education scholarships which are valued up to $15,000 per applicant for residential aged care and we have postgraduate scholarships for community care nurses as well.

Senator ADAMS—Right, so what has the uptake been on those scholarships?

Ms Nicholls—Since the scholarships inception we have offered 2,459 scholarships, of which 1,736 are undergraduate scholarships and 723 are either postgraduate or continuing education scholarships. That is since 2002.

Senator ADAMS—And how many people have taken up those scholarships? Is that what has gone out? Is that what you mean by 'offered'?

Ms Nicholls—That is correct. I would have to check what the completion rates are because those are the numbers that have been offered.

Senator ADAMS—Could you give that to us on notice, please?

Ms Nicholls—Yes, I could.

Senator ADAMS—Thank you.

Ms Nicholls—In terms of supporting the upskilling of personal care workers, in the residential care area we have the Better Skills for Better Care Program. That provides funding for certificate III and certificate IV level courses and includes certificate IV enrolled nurse courses and diploma nursing courses.

Senator ADAMS—And has that been popular?

Ms Nicholls—That is very popular. That is always oversubscribed. The most recent round, which we are just finalising, will roll out more than another 5,000 training places in that area. We will also have the Support for Aged Care Training Program. That program is particularly targeting rural and remote services—those services that are in receipt of the viability supplement. Funds are available to upgrade the skills of personal care workers. In addition to funding the courses—certificate III and certificate IV—there are short courses and enrolled nursing courses. In recognition of the additional difficulties and costs for those services in accessing training, we also provide funding for student travel and accommodation and to support some backfilling of staff.

Senator ADAMS—That is good.

Ms Nicholls—And in addition to supporting the community aged-care workforce, we also have the Community Aged Care Workforce Development Program, which is designed to upskill personal care workers in the community care sector. Again we look at certificate III and certificate IV level courses for them.

Senator ADAMS—Thank you very much.

CHAIR—Senator Boyce has a couple of questions to finish off this section. For the agency, Senator Williams had questions which he has put on notice because he has been called to another committee, so we will not be calling the agency. My deepest apologies to the group.

Senator BOYCE—Sorry, I do have a couple of questions for the agency.

CHAIR—Do you have questions for aged care or the agency, Senator Boyce?

Senator BOYCE—Both.

CHAIR—Yes, I said you had three questions.

Senator BOYCE—I am happy to put my accreditation ones on notice then.

CHAIR—With Senator Williams. Again, my apologies to the agency. We will finish up the section with aged care and then we will complete outcome 4, then we will go to afternoon tea and come back to mop up outcome 10. Senator Boyce.

Senator BOYCE—Thank you. I would just like to refer you, Mr Stuart, to questions on notice E09-152 and E09-179, which set out the places, the bed allocations that had been provisionally allocated but were 'aged', in that that they had not been taken up. We had nearly 10,000 provisionally allocated aged-care places that were more than two years old, working through to nearly 400 that were more than five years old. Either on notice or if you are able to tell me, could you give me the same figures again with a state breakdown on a year-by-year basis, as in: more than 12 months old, more than two years old, more than three years old, until we run out of years, so to speak.

Mr Stuart—We could do that as at the last stocktake so as to match that 9,694 number that we provided you.

Senator BOYCE—When was the last stocktake?

Mr Stuart—30 June 2008. We are not far from a new one.

Senator BOYCE—I would be happy to wait till July or August to get these figures if we were to use—

Mr Stuart—The 2009 data.

Senator BOYCE—the 2009 data. That would be good. On the same basis, I have to ask you: is Evans Head still the winner—and I use the term very loosely—in terms of being the longest outstanding not-built home in Australia?

Mr Stuart—It is one of two. There is—

Ms Halton—This one is unique, however, Senator. In fact, Senator McLucas and I were actually discussing a question she asked when she was on that side of the table about this particular facility.

Senator McLucas—Can I say my favourite words?

Ms Halton—You can say your favourite words.

Senator McLucas—Unexploded ordnance.

Senator BOYCE—I beg your pardon?

Senator McLucas—Unexploded ordnance.

Ms Halton—She asked a question about unexploded ordnance and she was reminding me that my response to her was, 'Have you got your headline now, Senator?'

Senator BOYCE—I am told that that is right, yes.

Senator CORMANN—So you were sceptical then, too, about our true motivations.

Ms Halton—There was something a bit theatrical—

Senator CORMANN—We are just humble seekers of the truth.

Ms Halton—The theatrical nature of unexploded ordnance did strike one, Senator.

Senator BOYCE—Nevertheless, a cleanup has apparently recently been redone on the site under the auspices of Minister Fitzgibbon—former Minister Fitzgibbon, I should say.

Mr Stuart—The defence department is contributing to the site cleanup costs and that has commenced. As you know, this one is high on my watch list, and I wrote to—

Ms Halton—There is the military metaphor again—he can't resist!

Mr Stuart—I wrote to the provider, the council and the defence department earlier this year about progress, and they have written back with various assurances about funding availability and time frames.

Senator BOYCE—Is this the first time they have given you assurances, Mr Stuart?

Mr Stuart—No, we have had assurances before, Senator, all given in good faith. We are previously on the record—

Senator BOYCE—Perhaps if their faith is good, it is their performance that is not quite so good.

Mr Stuart—There have been various attempts that have been met with difficulty. The allocation would have been withdrawn some time ago if we were not convinced that, against sometimes interesting odds, they have continued to try to push forward with this one.

Senator BOYCE—Thank you.

CHAIR—Thank you very much to the officers. It has been a very long session. We will now have a break and come back to the other elements of outcome 10.

Proceedings suspended from 3.29 pm to 3.45 pm

CHAIR—We are going to go back into the departmental side of outcome 10. We will have no questions on 10.5, as palliative care questions were asked under another outcome, and anything else will be put on notice. We will go through item by item, beginning with 10.1, which is chronic disease, and I know Senator Siewert has a question on that, and then we will go to other senators on the items.

Senator SIEWERT—Thank you. I wanted to go to the question that I asked in the wrong place yesterday around MS and funding for MS research and treatment. I am asking in the right spot now.

Ms Morris—You are, Senator.

Senator SIEWERT—Do you fund research on MS?

Ms Morris—Senator, the department proper does not fund research on MS, but there is funding for MS through the National Health and Medical Research Council.

Senator SIEWERT—I should have asked them.

Ms Morris—Most medical research would be funded through them. It is rare to find research specific funding in departmental programs.

Senator SIEWERT—Thank you. I will put it on notice for them. That is fine. Thank you.

CHAIR—Are there any other questions on 10.1: Chronic disease?

Senator ADAMS—I would like to ask some questions on the chemotherapy drugs under the PBS.

Ms Morris—That will be outcome whatever pharmaceuticals is, I am sorry, Senator.

CHAIR—That is outcome 2.

Senator ADAMS—All right.

CHAIR—Are there any other questions on 10.1?

Senator BARNETT—Can I just ask, does this cover cancer centres and funding for cancer—

Ms Morris—The regional cancer centres?

Senator BARNETT—Yes.

Ms Morris—Yes, Senator. They are funded through the Health and Hospital Fund, which is also covered under this outcome. The chronic disease area together with Cancer Australia will be responsible for looking at them.

Senator ADAMS—We have already talked about that.

Senator CORMANN—We had a bit of discussion about that, because there is only one location specified, the 'regional centre of Canberra'.

CHAIR—What was your question, Senator Barnett?

Senator BARNETT—I am specifically interested in the funding for Cancer Council Tasmania for the accommodation centre at the LGH?

Ms Morris—LGH?

Senator BARNETT—Adjacent to the Launceston General Hospital.

Mr Coburn—Senator, as we were discussing yesterday, it is physically located with, but not part of, the Launceston General Hospital revamp which is being done under the HHF. The projects you are talking about, I think, are covered under outcome 3. That is in relation to the patient accommodation and radiation oncology at Launceston.

Senator BARNETT—Yes, but there are two parts. There is outcome 3, which is the $7.7 million for the Launceston General Hospital linear accelerator for the Holman Clinic. I understand that is outcome 3. I am asking about the accommodation services, and the funding

for that, that has been built to support the cancer patients and is being provided to Cancer Council of Tasmania.

Mr Coburn—Yes, that is also under outcome 3. It is not through the Health and Hospitals Fund.

Senator BARNETT—Thank you.

CHAIR—Make a note, Senator Barnett. Any other questions under 10.1? We will move on to 10.2: E-health implementation? I know there are some on that.

Senator BOYCE—I have got some questions on that. I was just wanting to have yet another update on where this is at. The health ministers all endorsed, I understand, a national e-health strategy which had been developed by Deloitte in December 2008. What funds have been put aside for the implementation of the national e-health strategy now?

Ms Morris—Senator, the national e-health strategy is endorsed by all Australian governments and each individual government will commit money to it. Within the Commonwealth government, we have some ongoing funding which we will commit to parts of the strategy. That is in the forward estimates. But any major investment will be a decision of COAG.

Senator BOYCE—How much is currently in the forward estimates?

Ms Morris—In our forward estimates for e-health—

Senator BOYCE—I must have missed that figure.

Ms Morris—it is $51 million, exclusive of the money we are putting in to fund NEHTA, which was $108 million over three years.

Senator BOYCE—$51 million, exclusive of the money for—

Ms Morris—Of the money that the Commonwealth is committing as its share of NEHTAs forward funding, which was, I think, from memory, $108 million over three years, Senator.

Senator BOYCE—The $51 million is over the forward estimates?

Ms Morris—Yes, Senator, but any agreed joint investment will be a decision of COAG.

Senator BOYCE—There have been a number of submissions recently, following on from a supplementary paper from the National Hospital and Health Reform Commission paper on e-health, suggesting that the approach that is being taken is deeply flawed. Would you like to respond to that?

Ms Halton—Can you be precise, Senator? A number of papers from whom?

Senator BOYCE—Submissions, I thought, that followed the release of the supplementary paper.

Ms Halton—Submissions to the commission?

Senator BOYCE—Yes.

Ms Morris—I cannot comment on those, Senator. I am sorry, I have not seen them.

Senator BOYCE—Would you not, in the normal course of things, see it?

Ms Halton—No, Senator.

Senator BOYCE—Okay. Is it possible for you to make inquiries around that?

Ms Halton—Anything that is provided to the Health and Hospitals Reform Commission is a matter for them to consider and then they are going to put out their report.

Senator BOYCE—Yes. Perhaps you could talk me through. They put out their report, and then what happens?

Ms Halton—The government will consider it. So we are expecting their report at the end of this financial year, and I think we discussed that yesterday, in terms of the printing timetable et cetera. So quite when it will be released, I am not sure, but certainly early in the new financial year is my expectation. I did say yesterday that I do not know what is going to be in the final report, but we did know that in the interim report they went to this issue, not necessarily in a great deal of detail, and I would be surprised if there were not something in the final report that went to this issue as well.

Senator BOYCE—I have had approaches from a number of players in the medical software industry who have expressed their annoyance and concern that they are being asked to modify software for NEHTA, but not having any reimbursement of costs around that modification. Have those concerns been brought to your attention?

Ms Halton—I am not aware of the precise request and from whom it has come, Senator, so I would not want to make a comment. You are suggesting that someone from the department has asked them to modify software?

Senator BOYCE—I am suggesting that as part of an implementation of NEHTA—and I am sorry, I do not actually know who would have asked them to modify the software. I can find that out.

Ms Halton—Yes. What that would probably be, without knowing the precise detail but just taking a wild guess, there are a series of NEHTA standards which will form the basis of connectivity nationally. In purchasing, when, now, governments purchase, that includes us but also others, we are all saying that anything we purchase should be compliant with NEHTA standards. Obviously, over a period, we all know the software changes and we all know that as more technology becomes a feature of the healthcare sector, it is our expectation that that software will be NEHTA compliant. So whilst I cannot talk about the particular case—

Senator BOYCE—Have people been given a period of grace for this or is it—

Ms Halton—There is no formal requirement for anyone to go back and upgrade their software. Being honest about it, my expectation would be that for anybody who is in the market at the moment, if they wish to stay current and commercially attractive, it would be in their interest to make sure that their software is NEHTA-compliant because that connectivity will increasingly be part of our healthcare sector.

Senator BOYCE—Nevertheless, would they have any indication from government—I suppose, we will do this a bit more broadly than a department—as to whether the purchase of their software might be ongoing? Could I just put it in these terms: if I am going to do some expensive upgrades to my software, I would like to have some sort of certainty that someone is intending to purchase it. Would that be a—

Ms Halton—Can I turn it around the other way?

Senator BOYCE—You could.

Ms Halton—The question of purchase is a matter for the purchaser; that is not us. The thing that we can be confident of is that all Australian governments are committed to an electronic health sector and that the NEHTA standards will categorically form part of that, and therefore an investment in compliance with NEHTA standards is not a wasted investment.

Senator BOYCE—No. I take your point. You spoke yesterday about some sentinel GP practices; was that the term you used?

Ms Halton—That is correct.

Senator BOYCE—There are—and this was in the context of the swine flu—GPs who are using online reporting already. Can you tell me a bit more about that?

Ms Halton—In fact, I was resisting describing to you sentinel chickens yesterday, and I am going to resist the urge as well today. 'Sentinel' means some—

Senator BOYCE—I think Thursday Island specialises in sentinel goats.

Ms Halton—Yes, there are sentinel things around the northern parts of Australia.

Ms Morris—Sentinel pigs.

Senator BOYCE—Pigs, are they?

Ms Halton—And we used to have sentinel chickens.

Senator BOYCE—I am glad we are using GPs now instead!

Ms Halton—We may want to rephrase that! The GPs who are performing that data-gathering sentinel function—I do not quite know what the verb is of that—are connected into what is called NetEpi. NetEpi is the approach to gathering which I think Ms Halbert was outlining for you. It is that epidemiological information in respect of the prevalence of whatever is the particular issue we are interested in.

Senator BOYCE—Sorry. I understood her to be telling me that we were actually piloting e-health for some GPs.

Ms Halton—No, she was describing—

Senator BOYCE—I was quite excited about the advance that we appeared to have made on that basis. When can we expect to see that?

Ms Halton—Sentinel GPs?

Senator BOYCE—With the new meaning that we have just given it.

Ms Halton—Yes, good question. There are a number of steps that are being taken by NEHTA which go to what we call those foundation elements. We have talked about this in the past.

Senator BOYCE—We have.

Ms Halton—NEHTA is working towards a rollout of those features by the end of this year.

Senator BOYCE—This calendar year?

Ms Halton—Yes. What I would be happy to do for you, Senator, because it is probably best that we get this absolutely accurate, is take your question on notice and give you an indication of what work NEHTA is due to complete and to implement this year.

Senator BOYCE—A chronology would be good.

Ms Halton—Yes. I am happy to do that.

Ms Morris—I would add that there are networks where e-health is being used by GPs and local hospitals and a variety of other health providers, but, in the absence of the national foundations that NEHTA is doing, those connections just are not scalable to bigger areas.

Senator BOYCE—NEHTA will eventually take us, one hopes, to e-prescribing; is that correct?

Ms Morris—Yes.

Senator BOYCE—I understand that there is already some private group e-prescribing happening.

Ms Halton—Correct.

Senator BOYCE—Can you tell me about that and can you tell me how it is going to interact with NEHTA, or not, as the case may be?

Ms Morris—I do not think I can answer your question as asked. What I can say is that we commissioned a consultancy last year from KPMG to look at e-prescribing. That consultancy outlined a few areas where the government needed to give more consideration to some things. We have just issued a tender for a second piece of work to be done.

Ms Halton—But there is work going on in the pharmaceutical benefit space by the guild and commercial interests who are looking at that whole electronic transmission of scripts to pharmacy. That work is proceeding and, in fact, I had a briefing on that from key representatives fairly recently. They absolutely understand that what they are offering is a proprietary product. Some people may choose not to use theirs; they might use other things in due course. But the crucial thing is that they understand that, particularly with the NEHTA standards, and with this more connected world, it will be important that, as it evolves, their software and that process is able to be part of the whole electronic health record process.

Senator BOYCE—Let us hope that understanding holds.

Ms Halton—Let us also be clear that actually anything that does not eventually articulate, in my view, will not actually remain robust in this environment because, overwhelmingly, consumers tell us that they actually want an electronic health record and they want the convenience of all that that implies. Physicians will want that as well, and it actually means that anything that does not articulate well will not have an ongoing use.

Senator BOYCE—They will fall out of use?

Ms Halton—I think that is right.

Senator BOYCE—I am sorry, Ms Morris; you were talking about a second piece of research that was—

Ms Morris—It is a follow up consultancy to the one that was undertaken last year.

Senator BOYCE—Is that again with KPMG?

Ms Morris—It is out for tender now.

Senator BOYCE—What will the purpose of that second round be?

Ms Morris—I will just need to check some notes here. I do not want to make it up. I have just been pointed to the right paragraph. We want a consultant to review the options for governance and ownership of e-prescribing systems, which is very relevant to the point Ms Halton was just making, and for the stewardship—

Senator BOYCE—The Pharmacy Guild can answer that for you, Ms Morris.

Ms Morris—There will be several answers, I think, yes. And they will review the options for the stewardship of medicines transaction data.

Senator BOYCE—When were the NEHTA standards that you have referred to finalised?

Ms Morris—There is an ongoing process of developing and finalising them.

Ms Halton—They are being promulgated.

Ms Morris—There is no one standard. There is a set of standards for a range of things, and they are being rolled out sequentially.

Senator BOYCE—But, again, this comes back to that question of software developers feeling that they have not got certainty about what they should be developing. Has that question been brought to you?

Ms Morris—I suspect the questions that have been brought to you are in the context of the PIP e-health incentive. And, yes, there was concern at the beginning, but NEHTA and the department have worked very closely with the software industry, have had several meetings with them and have extended the time frame for the part of the process that they were most concerned about. I have not actually heard anything for probably four to six weeks.

Senator BOYCE—Four to six weeks?

Ms Morris—For the last four to six weeks. There was initially some concern as it was a new incentive and there were deadlines looming, but there has been a lot of discussion with software manufacturers and my understanding is that outstanding issues have been resolved with them.

Senator BOYCE—What happened four to six weeks ago that resolved those issues?

Ms Morris—I may not have the time frame exactly right.

Senator BOYCE—No, but about that period.

Ms Morris—Two things happened. One was that we sat down with NEHTA and talked to software developers about what their issues were and tried to work them through and resolve them, which is the sensible thing to do when there seems to be an issue. And the other was that the time frame for compliance was extended slightly. I do not have the exact details with me. The person that can talk to this will be here under outcome 5, Primary care. That is also my area but I just do not have the details with me to give you more information, I am sorry.

Senator BOYCE—I shall attempt to remember to re-ask that question when we get to outcome 5.

Ms Morris—If not, we are very happy to give you something on notice.

Senator BOYCE—I have two questions to go in the area. One was that point raised yesterday, which was discussed during our period talking about H1N1 with the Healthcare and Hospitals Association, saying that our surveillance in a pandemic and in the current situation would have been more accurate and more timely if we had an e-health system in place. What is your view on that, Ms Morris?

Ms Halton—Well, it is not really a question for Ms Morris.

Senator BOYCE—Ms Halton.

Ms Halton—The bottom line is there are several things that go to the gathering of data in respect of a pandemic. If you are in pandemic and you are concerned about a particular virus, what you may or may not have is information in the electronic health records—so there is one—which goes to the particular diagnosis as quickly, sometimes, as you may be able to get it from laboratories. I think it is a fair point that an electronic health record, universally deployed, will enable you to monitor population health issues much better than is the case currently.

Senator BOYCE—Obviously, that GP to—

Ms Halton—No two ways about it.

Senator BOYCE—report to the state health department would be—

Ms Halton—Yes. There are no two ways about it. So, looking at mass, population-wide issues, including, actually, the progression of seasonal flu, which I think we have all agreed with Senator Cormann is not regular—he isn't listening; he is playing with his computer.

Senator CORMANN—I am listening very carefully to everything you say, Ms Halton. Believe you me.

Ms Halton—A man who can multitask! I am extremely impressed. There is no doubt that the electronic health record, universally deployed, provides not just individual benefit; it provides population-wide benefit. We are very clear about that. In pandemic, I think, at one level it is an academic argument whether it would be quicker using an electronic health record or using the kind of sentinel arrangements we have talked about. To be honest, we do not know the answer to that question, because we do not have a universal deployment here. What we have at the moment, I think, is actually a good and effective system. If their general point is electronic health will improve the monitoring of population-wide health issues as a general rule, I absolutely agree. I would not want to be categorical about whether it would be better in pandemic or worse, because what we do have at the moment, I think, is effective.

Senator BOYCE—A program that many GPs use, called Medical Director—do you know of Medical Director?

Ms Halton—Yes.

Senator BOYCE—There have been concerns raised about the price hike on that program recently, which has been said to be caused by the need to conform to the NEHTA standards. Have you had discussions about this program or with the program developers?

Ms Morris—No, I have not.

Senator BOYCE—Were you aware that there was concern out there about the cost increase of this program?

Ms Morris—It certainly has not been raised with the department by any of the GP groups.

Senator BOYCE—Do we have an agency that is responsible for the oversight of NEHTA's implementation of this program? Who oversights it? The department, or—

Ms Halton—The board, actually. NEHTA is a company, and it is owned by all Australian governments, and the board—

Senator BOYCE—Who is the responsible minister? Does it have a shareholding minister?

Ms Halton—No, it is actually owned equally by all the Australian governments. So the board comprises the chief executives of the Commonwealth, state and territory health departments, and it has an independent chair and an independent member as well.

Senator BOYCE—Thank you.

CHAIR—Let's move on to 10.3: Health information.

Senator CORMANN—Where do I ask them a question on expenditure for activity based funding? Which part of 10.1 is that? Because I was told at the beginning—

Ms Halton—It is 'Acute care'. We actually did cover that briefly. In fact Senator Boyce asked something about that. It is Acute care. ABF.

Senator CORMANN—I was asking at the beginning, in the opening, during the corporate section I was referred to outcome 10.

Ms Halton—No, not for this. It was Acute care for this. There were a number of specific questions.

Senator CORMANN—I have missed it, have I?

CHAIR—What is the question, Senator Cormann?

Senator CORMANN—Essentially, I was interested to understand why it is taking until 2011-12 for the expenditure to kick in, and what is going to be happening in the meantime.

Ms Halton—What page are you on, Senator?

Senator CORMANN—It is page 32 of Budget Paper No. 3. Sorry, I have been patiently waiting.

Ms Halton—I will just have a look for that.

CHAIR—The officers are looking for that area. What we will do is keep moving through 10. At the end of 10, before we move on to the next one, we will see whether we have got an answer.

Ms Halton—Senator Cormann, page what?

Senator CORMANN—Page 32 of Budget Paper No. 3.

[4.11 pm]

CHAIR—10.3: Health information. Do we have any questions in that area? 10.4: International policy engagement? 10.6: Research capacity? Senator Barnett?

Senator BARNETT—Diabetes research. I have some questions surrounding the cuts of some $31.8 million to diabetes research and the PBS 'Support for diabetes—remove duplication in research effort'. That is what it is headed. Department of Health and Ageing, 2009-10, a cut of $7.7 million; 2010-11, $7.9 million; and then 2011-12, $8 million; 2012-13, $8.2 million. Are we in the right spot? Have we got the officials here?

Ms Morris—What would you like to know?

Senator BARNETT—The document says:

This measure established a research program into islet cell transplantation to treat Type 1 diabetes and promoted the Lift for Life program to control Type 2 diabetes.

I am interested in the heading: it is a 'removing of duplication'. Can you describe how a cut of $31.8 million is removing duplication, when it is a net cut to diabetes research.

Ms Morris—This measure had two specific, time-limited projects in it. One was the International Diabetes Institute, which is now Baker IDI, which was funded to roll out a strength training program for older people with type 2 diabetes.

Senator BARNETT—All right. So we are talking about the Lift for Life program?

Ms Morris—That is Lift for Life. This project has now been completed. They were funded to do something specific; they have delivered, so that is done. The other part of the measure—

Senator BARNETT—Are we going to focus on that for a minute? Is any of the funding in this so-called duplication of research cut allocated to the Lift for Life program?

Ms Morris—It was all rolled up in the one outcome. So there was ongoing money—

Senator BARNETT—Over those four-year periods, what had the government allocated to the Lift for Life program?

Ms Morris—To Lift for Life? It has been completed at a cost of $2.018 million.

Senator BARNETT—Right. I remember it well, because it was launched at my Healthy Lifestyle Forum in Launceston in June 2004.

Ms Halton—I remember that.

Senator BARNETT—And you were there, Ms Halton. It went very well. It was a great day. So that is why there is some disappointment about this. IDI, and now Baker IDI, have a very good reputation. When you say 'completed', that means that the work has been undertaken adequately and to the satisfaction of the department?

Ms Morris—Yes.

Senator BARNETT—So you are happy with their work?

Ms Morris—As far as I understand it, yes.

Senator BARNETT—All right. So far, the $2.018 million has been expended.

Ms Morris—That is right.

Senator BARNETT—Out of the $31.8 million, how much of that money over that four-year period was allocated or dedicated to the Lift for Life program, if any?

Ms Morris—I cannot answer that with what I have in front of me; but I can take it on notice.

Senator BARNETT—How is it possible you cannot answer that? I am sorry; it is just puzzling.

Ms Morris—I just do not have the figures in front of me, Senator.

Senator BARNETT—But you would agree that out of that $31.8 million—

Ms Morris—If I understand your question correctly, what you are trying to get to is, out of the whole measure for the program, how much had actually originally been allocated to Lift for Life? I will see if any of the officers behind me can help. There is a lot of head shaking back there.

Senator BARNETT—While they are looking at it, let us keep going—

Ms Morris—Yes, that is fine, Senator.

Senator BARNETT—because the other half or the major portion—

Ms Morris—I am not trying to obfuscate. I just do not actually have it, Senator.

Senator BARNETT—No. It would be really good. Why don't we go to the major part of it, which relates to the islet cell transplantation research. When does that contract conclude—the initial contract?

Ms Morris—The program is expected to continue through until October 2011 and will be funded until then.

Senator BARNETT—How much funding have they been granted and how much will they receive in the period to October 2011?

Ms Morris—The amount that they will get for the whole project is $30.08 million.

Senator BARNETT—Is that in accordance with the expectation from the announcement of that program? It was a $30 million research program; is that correct? And when did it commence?

Ms Morris—My understanding is that JDRF understand that is the amount that they are getting for it and are not expecting funding beyond that period.

Senator BARNETT—When was it announced? Do you have that date with you?

Ms Morris—No, I do not. You've got it, Ms Huxtable?

Ms Huxtable—The advice that I have is that it was announced in the 2005-06 budget, Senator.

Senator BARNETT—It was certainly announced with much fanfare, because I remember being there and applauding the decision at the time. So that is some $30.08 million which will conclude in October 2011?

Ms Morris—Yes.

Ms Huxtable—That is correct.

Senator BARNETT—Is any of that $30.08 million in this part of the $31.8 million that has been cut or is that—

Ms Morris—No.

Senator BARNETT—over and above that?

Ms Huxtable—No, Senator.

Senator BARNETT—So there is going to be no cut to the $30.08 million. That is locked in.

Ms Morris—Yes.

Ms Huxtable—That is correct.

Senator BARNETT—Can somebody please explain to me how you come up with $31.8 million being cut, because—

Ms Morris—Senator, it is my—

Senator BARNETT—if you are trying to remove a duplication research effort, it has got to be somewhere else. So where is the duplication?

Ms Morris—I will try to explain, Senator. My understanding is that when this program was announced—and three or four years in this type of research is a long time—there were very high expectations of the potential of islet cell research for people with type 1 diabetes. It has turned out that that potential has not been realised. It has got some application in terms of treating people with type 1 diabetes, but in the interim other forms of research and treatment for people with type 1 diabetes have been shown to be more successful; these have been funded through the NHMRC.

Senator BARNETT—Can you identify them, please.

Ms Morris—Because I am not a clinician, it is not at the front of my brain; I am sorry, Senator.

Senator BARNETT—Is it in front of anybody's—on their pad or briefing papers?

Ms Morris—I am just getting advice, Senator.

Senator BARNETT—It is not related to the NHMRC. This relates to the $31.8 million. It is in the budget papers and that is what we are trying to ascertain.

Ms Morris—Yes. I think, Senator, I would prefer to take this on notice.

Senator BARNETT—All right.

Ms Morris—These are quite difficult and complex medical issues, and I am a bureaucrat. I do not think I can do them justice.

Senator BARNETT—Yes. What you are saying is we have got $31.8 million—that is in the forward estimates—that is going to be cut. That was, up until the budget, allocated to and identified for diabetes research, specifically islet cell transplantation. Is that correct?

Ms Morris—That is right, Senator.

Senator BARNETT—We are seeing a dedicated cut of $30.8 million to islet cell transplantation diabetes type 1 research over the forward estimates to 2012-13. Correct? Is that a yes?

Ms Morris—Yes, Senator.

Senator BARNETT—Thank you. You are saying you are removing duplication. Are you saying to this committee that that money will be expended in other areas of diabetes research, and you can put that on the record to commit the government to that? Or are you saying, no, this is a matter for the NHMRC and they will determine that on a case-by-case basis, on a merit basis, as they usually do, and the diabetes community will just hope for the best that they will get $30-odd million in diabetes research over those four years? Is that a fair analysis? Would you agree with that?

Ms Morris—The money has not been reallocated, which, I think, is what the first part of your suggested premise was. The NHMRC—

Senator BARNETT—It is not my premise, with respect; it is the government's premise. They are saying it is removing duplication in research effort. It is not my premise. This is the government's document, its budget document. I can ask it another way: is there a guarantee that $30.08 million will otherwise be expended on diabetes research over that four-year period?

Ms Morris—I cannot give you a guarantee on that, Senator—

Senator BARNETT—No, I—

Ms Morris—but I can tell you that the NHMRC spends more than that already on diabetes research over that same period, over the previous three and four years. And I am happy to give you those figures on notice.

Senator BARNETT—That is appreciated. Sorry, Ms Huxtable, did you want to jump in there?

Ms Huxtable—I was going to make a very similar point.

Senator BARNETT—That is all well and good, but we have a government that has, in writing, confirmed there will be a cut to type 1 diabetes research, and there are 140,000-plus kids and adults with type 1 diabetes in Australia, and you are sending a message to them today and in these budget documents that they are not important. That is the message that comes through from a $30 million cut without any guarantee that that money will otherwise be expended on type 1 diabetes research. We well know that the NHMRC researches a whole range of things and it is all done on a case-by-case basis and on a merit basis, with which I do not have a problem.

CHAIR—Senator, you have made your point. Is there a question to the end of that?

Senator BARNETT—I am interested in Senator McLucas's response, if you would care to respond to that observation, Parliamentary Secretary. I would really like you to respond to it.

Senator McLucas—It is an observation, I think, that is not founded. I think you and I agree that the government's commitment to preventative health—and I recognise this is type 1

diabetes and that is a different question—but I think Ms Morris did actually try and explain to you, and has offered to take on notice, the medical explanation for why certain research that was being conducted is in fact duplicated and is in fact complete. You want to make a statement; that is fine. That is what politics is about. That is okay, but—

Senator BARNETT—It is not about politics. It is actually about people with type 1 diabetes, and there are 140,000—

Senator McLucas—Yes, I got it the first time.

Senator BARNETT—of them, and their families, all around Australia.

Senator McLucas—But I think Ms Morris has, in fact, tried to answer your question in a factual way. You can make a political point; that is fine.

Senator BARNETT—Let me just ask one final question.

Senator McLucas—But I also want to refer you to the material that you will get from Ms Morris that looks at the breadth of work that the NHMRC does fund.

Senator BARNETT—Yes. That is what my final question relates to. Ms Morris, thanks for taking that on notice. You will provide a list of the research NHMRC undertakes which supports the diabetes community—I presume type 1 and type 2—but what you cannot guarantee is that their funding for type 1 diabetes research will not necessarily increase by $30.08 million over that four-year period. Correct?

Senator McLucas—Of course she cannot. It is a merit based—

Senator BARNETT—Indeed.

Senator McLucas—competitive round.

Senator BARNETT—Indeed. So we have seen a cut of $30 million. I am happy with that, chair. I am very disappointed with the outcome and—

Senator McLucas—And I am disappointed that you have not taken the answers that Ms Morris has given you.

Senator BARNETT—I have taken them. I am looking forward to reading the response on notice.

Senator McLucas—Be disappointed after you get the answers. Give her the benefit of the doubt.

Senator BARNETT—I have received the answers and I am aware of that. I am looking forward to receiving further answers, so thank you.

Senator CROSSIN—Senator McLucas, you are saying it is not accurate to predict the level of funding that will be given to this sort of research in forward years, because the NHMRC is a merit based assessment, which means that the government is at arm's length from what projects get assessed and what projects get funded. Is that correct?

Senator McLucas—There are sometimes priority areas that governments will set. We have had the NHMRC here earlier, and I am not competent to be able to go through those priority areas. There are also the fellowships that they award, but they are also a competitive process.

But in essence you are right; government does not interfere or become involved in any of the assessment processes of the various rounds of research grants through the NHMRC.

Senator CROSSIN—So it would be inaccurate to come to the conclusion that there has been a $30 million cut, because the process is at arm's length and it is assessed and awarded by research peers within that area; is that right?

Senator McLucas—It is, but I think, in fairness to Senator Barnett's question, this is a different type of program. But we are just making the point that medical research funding is by and large done through the NHMRC.

Senator CROSSIN—Thank you.

[4.27 pm]

CHAIR—Any further questions on 10.6: Research capacity? No? 10.7: Health infrastructure.

Senator CORMANN—Yes. I just have a little question in my capacity as a senator for Western Australia, and that is that, if I refer you to Budget Paper No. 3 again, on page 36, regarding the National Partnership for Health Infrastructure, there are a whole series of projects that are funded under that program and there is zero allocated to the great state of Western Australia. Is there a reason for that?

Ms Halton—There are a range of initiatives at various times, Senator. They all have different histories, and you will see this in a very similar way in terms of things that have come out of the Health and Hospitals Fund. So these are particular projects that have come about based on timetables when things are ready to roll et cetera. So I do not think there is a particular reason why on this occasion Western Australia does not feature here.

Senator CORMANN—But this is a forward estimates budget. This is not just on this occasion. We are talking for the period 2008 to the period 2012-13. So we are talking five years. We are talking the financial year that is just finishing and the four financial years of the forward estimates.

Ms Halton—Senator, can I just point you to a tiny historical fact?

Senator CORMANN—Yes.

Ms Halton—A number of these projects were actually announced by the former government.

Senator CORMANN—Yes.

Ms Halton—So these are initiatives, in a significant number of cases, of the former government, and what you are actually seeing here is the end of the payments in respect of those projects.

Senator CORMANN—So this is not actually a program that is continuing to be rolled out and developed moving forward. Are you saying that the explanation is that this is the tail end of a program that was—

Ms Halton—Some of these are. We will give you a more complete briefing if you like about the antecedents of these. But by looking at them I can tell you right now where they came from, because I recall a number of these from previous years.

Senator CORMANN—So the funding in 2010-12 for the Cairns integrated cancer centre is a decision of the previous government?

Ms Halton—I cannot tell you about that one specifically. I suspect it might be, actually, but I would have to take some advice on this. But for example, Olivia Newton-John Cancer Centre is; I know that for sure. These have got various histories.

Senator CORMANN—Yes. But you cannot blame me for asking the question when, as a senator for Western Australia, I look through those budget papers and see funding going everywhere except to the great state of Western Australia over a five-year period.

Ms Halton—Indeed.

Senator CORMANN—Does not look very good, does it, given that it is called the national partnership for health infrastructure?

Ms Halton—Yes. As I said, you will see a number of these kinds of things over the period. Sometimes one state will be hit—

Senator CORMANN—But I do not like seeing them. That is—

Ms Halton—You have done your bit by making the point about Western Australia. We have noted that.

Senator McLucas—Can I assist?

Senator CORMANN—As long as you admit there is some—yes, please.

Senator McLucas—I point you to the section on hospital infrastructure and other projects of national significance, where—

Senator CORMANN—I know that there is the odd one there.

Senator McLucas—the new rehabilitation unit at Fiona Stanley Hospital is $255.7 million; the Midland Health Campus at Midland, Western Australia, $108.1 million; the Kimberley renal services in Kimberley, $8.6 million; and the replacement paediatrics unit at the Broome Hospital, value $7.9 million.

Senator CORMANN—Which is part of a totally different program, and the rest of Australia is getting a share—

Senator McLucas—Ms Halton has explained why that is in Budget Paper No. 2—

Ms Halton—Yes.

Senator McLucas—and why, if you are looking at this budget, you should look at the PBS. It is a different way of presenting the material. These are old programs that are continuing.

Senator CORMANN—These are your government's budget statements from this year. Why do you have a statement in here about National Partnership for Health Infrastructure

which, as you say, now does not include all of the National Partnership for Health Infrastructure investment? Is that what you are saying?

Ms Halton—No, because the HHF is not actually a partnership payment. Because we have got these different structures, you will see some things are listed some place and some things listed elsewhere. You are right; that means that if you look in one place you will not get a complete view. So you need to look in a couple of places to get a complete view.

Senator CORMANN—Yes, but Senator McLucas has just quoted in isolation what is allocated to Western Australia without putting it into the context of the total funding allocation for a particular program. So I cannot on the spot—

Senator McLucas—I will give you that.

Senator CORMANN—What is the proportion that Western Australia is getting out of the total funding allocation that you just mentioned?

Senator McLucas—I will find out.

Senator CORMANN—Can you give us a percentage of how much funding out of that particular program that you just mentioned goes to Western Australia?

Senator McLucas—We will take it on notice. I just cannot do the maths as quickly as you would like.

Senator CORMANN—No, that is okay. I am happy for you to take it on notice.

Ms Halton—I can tell you that the projects that Senator McLucas has read out were very consistent—in fact I think 100 per cent consistent—with the priorities of the Western Australian state government in terms of the operation of their system.

Senator CORMANN—As long as you make sure that the needs of the people of Western Australia from a health infrastructure point of view are top of your mind when you look at national health issues.

Ms Halton—We are acutely aware of the needs of Western Australia.

Senator CORMANN—I am very pleased to hear it.

Ms Halton—Given that you have taken us to BP3, I will just go back to that question in relation to activity based funding.

Senator CORMANN—Yes, please.

Ms Halton—I am reminded on reflection that what happens with this is that because this is the Commonwealth funding there is a state component to this as well, and we did make a payment in 2008-09—

Senator CORMANN—Yes, and then there is two years of nothing.

Ms Halton—So there was a down payment made in 2008-09. There is some state money that is rolled out in respect of these things in any event. We are currently working with the states on the whole structure of coding all the technical details. It will take us some time before we actually physically roll this out. So this is the profile that was agreed with the states in terms of what would be required in respect of this program.

Senator CORMANN—Okay.

Senator WILLIAMS—I refer to the $27 million in the budget for the Narrabri Hospital in Northern New South Wales. I would imagine that also requires a—

Ms Halton—Where are you reading from, Senator, just so we can be clear.

Senator WILLIAMS—It is one of those things I noticed in the budget, so I do not have the page here.

Ms Halton—We need to know where it comes from. Here are the people.

Senator WILLIAMS—The health infrastructure crew!

Ms Halton—No. It is where the initiative is listed in the budget, but the health people can no doubt—

Senator BOYCE—We are joking.

Ms Halton—I think I know where Narrabri is.

Ms Powell—There was funding for the Narrabri District Health Service through the Health and Hospitals Fund. It received $27 million through that project to establish an integrated district health service.

Senator WILLIAMS—That requires funding from the New South Wales government as well to get the project underway, does it?

Mr Coburn—Hang on a second and we can tell you what the government contribution is.

Ms Powell—While Mr Coburn is getting that I will go back to the question that Senator Cormann raised before about the proportion for Western Australia. I can let you know that $454.3 million was allocated through the Health and Hospitals Fund.

Senator CORMANN—To Western Australia.

Ms Powell—To Western Australian projects.

Senator CORMANN—So that—

Ms Powell—In addition there are a range of national projects such as the regional cancer centre that obviously Western Australia could expect funding for at some point.

Senator CORMANN—But we do not know where yet.

Ms Powell—For the regional cancer centres, no, not yet.

Senator CORMANN—Except for Canberra.

Ms Powell—That is right. And that was out of a total of $3.2 billion.

Ms Halton—This is becoming, Senator, an obsession.

Senator CORMANN—I am just intrigued—

Ms Halton—Senator Humphries, I just want you to know that your colleague over here is moderately obsessed by Canberra, the regional centre.

Senator CORMANN—I cannot believe that there is a magnificent program like this and you are not able to point to any location except the national capital, and you describe it as a regional centre.

CHAIR—We actually had that discussion yesterday. Senator Williams, your question.

Mr Coburn—Senator, the New South Wales government is contributing $14.69 million to this project.

Senator WILLIAMS—And they have ticked off on the project?

Mr Coburn—Yes. They were the applicant.

Senator WILLIAMS—When is that project due to start? Have you any idea? I know it is well and truly needed, and has been for many years.

Mr Coburn—We only have a very rough idea of when the projects would commence. I do not believe that—

Ms Halton—We are expecting some expenditure in 2009-10, in the forthcoming financial year. But what that will comprise in terms of actual sod turning, concrete laying et cetera, I do not think we could tell you. But we do expect the project will commence in 2009-10.

Mr Coburn—We are in the process right now of working out with the various applicants to the fund exactly when the various projects will commence.

Senator WILLIAMS—The reason for my question was that I noticed on budget night the $27 million for the Narrabri hospital in Griffith, and I could not work that out—whether there was going to be a new hospital in Griffith or in Narrabri. But it is very pleasing news that that project is underway and hopefully will be completed in the next couple of years.

Mr Coburn—Yes. It is currently expected to be finished in 2011-12.

Senator WILLIAMS—Wonderful. Thanks, Chair.

CHAIR—Thank you. As there are no further questions on 10.7, Health infrastructure, we have completed program 10. Did we get the answer to Senator Cormann's earlier question that people were going away and looking into PBS papers for?

Ms Halton—I did that.

CHAIR—That means we have completed outcome 10.

[4.38 pm]

CHAIR—We now move to outcome 11, Mental health. Senator Williams is going to start.

Senator WILLIAMS—Are you aware of the increase in mental health issues in country Australia, obviously brought about by drought, lean times, higher costs et cetera? Have you seen an indication of increase in that?

Prof. Calder—Senator, we have an overarching view of the demand for mental health services through a range of services, particularly call services and telephone call lines, which you would be aware of. We also have the Better Access measure. At this point in time, there is no particular indication of an increase in the Better Access measure. There is some informal information from call services as to the extent of the increase in calls largely relating to

practical matters of how to cope in financially difficult circumstances. I will ask Ms Krestensen to give you some more information.

Mrs Krestensen—Just to clarify, Senator, you are after information about whether there has been additional demand for services in rural areas?

Senator WILLIAMS—Yes. Were there any statistics of increase in serious mental health problems in rural areas?

Mrs Krestensen—We have got no evidence of an increase in serious mental health problems in rural areas. The program that I manage, which provides services including to rural areas, is the ATAPS, Access to Allied Psychological Services program. We certainly are reallocating some of the funds from that program from inner metropolitan areas to outer rural areas because of workforce issues—basically to accommodate the fact that there are a greater number of private practitioners in city areas, inner metropolitan areas, and there have been some underspends in some of those programs because of the availability of the Better Access medical items. So we have been reallocating some funds to rural areas to accommodate the extra demand for our ATAPS services, but we have not seen any evidence of an overall increase in demand for services or an increase in mental health problems in the community.

The drought measure we have got in place, which has just been continued through the recent drought measure, is providing some support to people in those rural areas that are impacted by the long-term impact of the drought, both in terms of community outreach and also in providing, I guess, broad-based counselling referral to the other range of services they need. The indication that we are getting from the various reviews of the drought measure and the feedback we have had on it is that people appreciate the outreach support, and I think they feel that there is an ongoing need for substantial mental health services in those areas. But there has not been any indication of any recent increase in demand for those services.

Senator WILLIAMS—Do you have any modelling, any statistics or anything, or do you do any research in that very field assessing the volume of serious mental health problems in regional areas, rural areas? Is it all grouped under the one banner?

Mrs Krestensen—Senator, I might defer to Professor Whiteford on this question, because he is most able to comment on the results of the recent survey of mental health and wellbeing and the extent to which that may have picked up any increase in the severity of problems or the nature of problems.

Senator WILLIAMS—Wonderful.

Prof. Whiteford—The answer, Senator, is no, there is no routine population survey of mental health problems in Australia. There is a survey carried out by the ABS which was done first in 1997, then repeated in 2007. There was no overall change in the prevalence of mental disorders in Australia in that survey.

Senator WILLIAMS—Could I just go back to suicides. Has there been any increase in suicides over the last five years? Do you have statistics on that for rural and regional areas?

Prof. Calder—Yes, we do, Senator. We have national statistics on suicide. Ms Krestensen is getting o the figures. There is some work being done also on the quality of those statistics.

Mrs Krestensen—Senator, we know that there was a very slight increase in the total number of suicides from the ABS causes of death report in March, which reported on suicides in 2007. It is noted that there were 1,881 suicides in 2007, which was an increase of 82 over and above the 2006 figures. The sector and the experts with whom we regularly speak in the suicide area are assuring us that, while, of course, we are all concerned about the increase in figures, it represents, I guess, an issue of data in that it represents an increase in the number of suicides counted as opposed to possibly the number of suicides, because there has been improvement over the last couple of years in the way in which data is counted in terms of suicides. The ABS causes of death report itself had a section which talked—I think in paragraphs 77 and 78—about the fact that more cases were being closed and that improvements were being made in the counting of suicides. Nevertheless, there has been a small increase in suicides, which was the first question you asked. You asked about rural suicides. There were 9.5 suicides per 100,000 people in capital cities compared to 11.2 suicides in urban areas and 12.5 suicides per 100,000 people in rural areas. So it is fair to say that there continues to be a high rate of suicide in rural areas.

Senator WILLIAMS—Higher than the national average, obviously.

Mrs Krestensen—Higher than the national average.

Senator WILLIAMS—This is a serious problem. Of those 1,881 suicides—unfortunate incidents—in 2007, do you know what percentage were men?

Mrs Krestensen—Seventy-eight per cent of those suicides were men.

Senator WILLIAMS—Looking ahead at addressing this very serious problem, what steps have you put in place to try and prevent these sorts of things? Almost four in five suicides are male. We have got 12.85 per cent in rural areas, the highest in Australia. What are the plans, if I could call them that, for those in the future, to see how we can reduce this?

Mrs Krestensen—We take suicide prevention very seriously. The Suicide Prevention Strategy is committed to addressing particularly a focus on high-risk groups, including men and people in rural areas. The work plan that we have, the National Suicide Prevention Strategy work plan for the current financial year, states or acknowledges that a high proportion of people who suicided were men and identifies men as a continuing priority group for support under the National Suicide Prevention Strategy. It identifies a range of strategies which we are taking forward because they have worked well in the past. For example, we have projects which are aimed at men working in particular industries where we know there is a high rate of suicide. We have got projects including the OzHelp Foundation and the IncoLink projects, which engage with building and construction industry apprentices—who are predominantly male—to facilitate better early intervention and mental health promotion activities amongst those people. And we have also got funding for Men's Shed activities, which promote connectivity as a form of protective factor against suicide.

We have also got a training package which is being developed by a network of accredited community based organisations for clients of the Child Support Agency. There is a great deal of concern amongst the Australian Suicide Prevention Advisory Council about the high rate of suicide in newly separated men, so working with the Child Support Agency is looking at better training to encourage help-seeking in relation to family relationship difficulties but also

to promote the capacity of professionals to identify somebody who might be struggling. And we are also working with the Family Court of Australia in a broader mental health support project which has similar aims.

Senator WILLIAMS—I just want to touch on the Men's Sheds there, as there has just been one established in my home town over the last 12 months. The federal government provides funding to assist in those sorts of projects?

Mrs Krestensen—It does indeed. That is right. An example I can provide is one that we fund in the Mount Druitt area of New South Wales, through the Men's Health Information and Resource Centre. They were funded through the previous broader community grants processes where they won their funding through a competitive approach. They are one of a range of things that we fund to support networking and connection of men. Another example that is not a Men's Shed but has a similar objective is the Toowoomba Older Men's Network, which supports older men around Toowoomba who are disconnected and isolated and potentially lonely, and creates a social network for them. It has been a very effective project as well.

Senator WILLIAMS—Just on the Men's Sheds, I know that they had a meeting at Wilcannia. About 46 men came along for the meeting and are interested in a Men's Shed. It might pay for your department to have a good look at Wilcannia. The average age of a man in Wilcannia is 36 years. It is a sad place. I have been travelling through it for some 30 years, and it is an area in New South Wales that really does need some attention. I do suggest you have a look at that area. Perhaps it needs some sort of industry. The problems of, simply, alcohol, lack of exercise, obviously little to do in life, boredom et cetera are really serious. Not only Wilcannia but other rural communities in New South Wales and, I am sure, around Australia have similar problems. The HASI home support has been allocated to some regional towns; are there plans to expand this?

Prof. Calder—That is really a question for FaHCSIA. They handle the housing program.

Senator WILLIAMS—All right. Are mental health services for the elderly being expanded?

Prof. Calder—No. There are a range of activities in the area of older people and mental health services, particularly psychogeriatric services, because of the complication of those people who develop dementia, and that is not a mental illness. I might ask Professor Whiteford to elaborate on that, but there is work done in the aged-care program on this, and there are a number of projects. Ms Hart, I think, is ready to add to it.

Ms Hart—Yes, thank you. There are, of course, a number of mainstream programs under which older people can access services to assist with mental health problems they might have, through the Medicare funded better access measure—which may be a suitable one for consultations and support provided, triggered by the general practitioner with the support of a range of allied mental health services. But also, particularly in rural and remote areas, we have a program, Mental Health Services in Rural and Remote Areas, that supports about 50 services.

They are focused in areas where we know that there are is not the same supply of general practitioners as there would be in metropolitan areas. That program provides about $60

million over the next four years and included some additional funds of $6.7 million in the recent budget. It supports mental health workers, from psychologists through to social workers and nurses, to provide mental health to people in rural and remote locations, including the general population, but older people as well.

Senator WILLIAMS—And just a final question: what has been put in place to ensure that the mental health needs of our young people are being addressed and nurtured?

Prof. Calder—There is a National Mental Health Youth Foundation that has been in place now for almost four years. That has as its primary vehicle the headspace program, which has 30 sites across Australia that are in development and established. Do you want further information about anything in particular, Senator?

Senator WILLIAMS—No. I will just add that I suppose in this field it is very hard to gauge success. How do you measure success? I see the parliamentary secretary is nodding her head there. It is not like you gauge success by building a building or painting a fence or putting in a new bitumen road. I suppose there is no way to actually gauge success but to be there when people are in times of need and when they are in these situations.

Prof. Calder—Senator, you are correct; that is one of the reasons that the headspace model is a dispersed model across Australia, targeting communities of particularly high-youth populations or high areas of need, to endeavour to provide that service on the ground where they are needed.

Senator WILLIAMS—I do hope what comes out of today is the highlighted point about suicides in rural areas—that is that where the highest number are in Australia—and they are alarming rates. I mean, suicide is bad enough and almost 80 percent are male. I think that highlights where the government really has to focus on some very real issues there.

Senator SIEWERT—I want to headspaces and look at funding. I am sure you will have heard the *PM* report on Monday, 1 June about the mid-North Coast of New South Wales project and the concerns there about funding. So could you take us through funding. Could you tell us if there have in fact been any funding cuts and if those services on the mid-North Coast of New South Wales are in fact going to get funding?

Prof. Calder—The funding arrangement for headspace is that there is a funding agreement between the government and the headspace providers, which are in fact a consortium. That project has the responsibility for establishing services across Australia, with a target of 30. The funding arrangements with those services, called CYSS or community youth support services, are arrangements put in place by headspace. Having said that, the funding agreement was for four financial years but in fact, because of the start-up delays with headspace and then the long delays in developing the community youth support services themselves, it was delivered mostly over about 2½ to three years. That funding was particularly targeted to those community youth support services, and that was $34 million over the four years. But it has been delivered in a shorter time frame, and the manner in which that has been delivered has been managed by headspace.

Senator SIEWERT—How much money is now available from the government for headspace?

Prof. Calder—The same level of funding per annum as has previously been available.

Senator SIEWERT—And how much is that?

Prof. Calder—$34 million over four years.

Mrs Krestensen—$35.6 million over the next three years has recently been announced.

Senator SIEWERT—I am sorry?

Prof. Calder—Minister Roxon has recently announced three years of funding at $35.6 million.

Senator SIEWERT—For the next three years?

Prof. Calder—Yes.

Senator SIEWERT—Okay. And that money then goes to headspace?

Prof. Calder—Yes.

Senator SIEWERT—And headspace decide how to allocate it; is that correct?

Prof. Calder—Yes, that is correct.

Senator SIEWERT—So I presume you are aware of the comments that were on *PM* the other day?

Prof. Calder—We are aware of them.

Senator SIEWERT—What would be the reason for them perhaps not knowing their funding or being uncertain about their funding future?

Prof. Calder—I think the issue is quite possibly one of communication. The arrangement with headspace has been in a position where we have been moving to a new funding agreement. It has relied on the headspace consortium establishing an independent company with whom the new funding agreement is to be established, so there has been some delay and that, I am sure, has led to some anxieties further out in the community. There is a commitment. Minister Roxon has announced that commitment and the certainty is there.

Senator SIEWERT—I understood the minister had announced some further funding in December. I thought it was a bit different funding—

Prof. Calder—Minister Roxon, late last year, announced a commitment to headspace. She announced the intention of moving to support the establishment of an independent company with which to take out the future funding agreement.

Senator SIEWERT—The problem here is the company has not been established yet. Is that—

Prof. Calder—It is in the process and it is due to be established fairly shortly.

Senator SIEWERT—When will the funding be handed over, because—

Prof. Calder—The funding agreement will be taken out with that company as soon as it is established. It may be necessary to vary the current funding agreement for a short period of time to cover that.

Senator SIEWERT—That is where I was getting to. Come 1 July—and it is the 4th today—it sounds like it is unlikely that the company will be in place and the money handed over by the next financial year.

Prof. Calder—Quite possibly, but, as I said, there would be a deed of variation taken out to continue it, given the minister's commitment to the establishment of a board for that new company. Already, in fact, the minister has been working with headspace around the appointments to that board.

Mrs Krestensen—I will just add that, because we are concerned to ensure continuity of service provision and to give a clear signal about that continuity, we provided already this week a draft deed of variation to headspace for at least three months to ensure continuity whilst we are getting the new company set up.

Senator SIEWERT—That then covers the funding for all the existing—I thought I heard somebody say that you would like 30 services provided—

Prof. Calder—There are 30 services established.

Senator SIEWERT—There are already?

Prof. Calder—Yes.

Senator SIEWERT—That was the aim and you have achieved the aim. So the extra funding will be available and the variation to the agreement will cover those 30 while the process of putting in place the company is undertaken—

Mrs Krestensen—That is correct.

Senator SIEWERT—or completed, I should say.

Mrs Krestensen—That is correct. Like the previous agreement, we give funding to headspace central to administer grants to those 30 sites over the three-month period.

Senator SIEWERT—Will that be at the level of funding that they already have or that they expect to continue their services at? In other words, there will not be a cut in funding.

Prof. Calder—It will be at the level of funding to headspace for those services that has been in place for the past several years.

Senator HUMPHRIES—We were told this time last year in budget estimates about a substantial cut to mental health services in terms of the announcement made by Prime Minister Howard in 2006, and the forward estimates for that mental health initiative which was originally $1.9 billion, I think, amounted to about $290 billion over four or five years. A number of those cuts went through at that last budget estimates. We were told that the reason for that cut was not because of any lack of commitment to implement improvements in mental health in Australia but because a number of the programs were underutilised and that there were workforce shortages which prevented some of these programs actually being delivered. Can you give me advice at this stage about the state of the mental health workforce? Are the projections of people taking up study or moving into the mental health workforce what they were at this time last year? If not then what do we anticipate to be the likely level of the health workforce foundation on which initiatives of this kind might be built?

Prof. Calder—A number of things have been put in place to address that issue. There is a Mental Health Workforce Advisory Committee that—

Senator HUMPHRIES—Before you go on, Professor Calder, I am not interested in what the inputs are. I am interested in what the outcomes are. Are we actually trending up? Are there more people appearing on the horizon to provide these services? Are we still expecting that major shortage that we were talking about last year to be there? What is actually happening rather than what you are trying to make happen?

Prof. Calder—Without having numbers to give you, because I do not have them with me, I can say that there is evidence that there is an increasing interest in psychology courses and increasing numbers of applicants for those courses. There is an increasing rate of take-up of clinical psychology training and qualifications by the established psychology field, so there is certainly that evidence. There is work being done in the mental health nursing space, but I do not have those numbers and I do not even have anecdotal information, I am afraid. We could take that on notice, but in this budget there has been a rearrangement of scholarships to ensure that more can be achieved with the funding available and that includes targeting areas and professions that are in shortage.

Senator HUMPHRIES—Let me ask about a particular area that we discussed last time, and that was mental health nurses. We were told that there were at that time about 120 mental health nurses who were taking advantage of or who had signed up to the Mental Health Nurse Incentive Program. The aim had originally been to recruit about 160 nurses to that program. At this point in time how many nurses are there in that program?

Prof. Calder—I am just scrambling, I am sorry. I am four weeks out of date.

Ms Hart—I may be able to assist. As at 29 May this year there were 466 organisations participating in the Mental Health Nurse Incentive Program, which provides $56.8 million over five years. I am just looking to see if we have got information on the number of nurses in that program. I will just check with one of my colleagues. I am advised that 410 nurses are currently engaged under the initiative.

Senator HUMPHRIES—What Mr Smyth told us last year—I assume he is not with this area of the department any more—was that the projections the department then had for the incentive program was that you expected that by 2011-12 you would be looking at about 160-odd nurses engaged in that measure. That was on a full-time equivalent basis, paying about $115,000 per nurse. It sounds as if you have had much better take up than you originally expected. You are nodding, Professor Calder. The figure for last year for this program was $49.45 million. Ms Hart, did you say $56 million is the size of the program now?

Ms Hart—The amount allocated for the program is $56.8 million over a five-year period, from 2006-07.

Senator HUMPHRIES—The original amount allocated to that program, of course, was $191 million. Based on the figures that were provided to us last year, I would assume that you would be in a position to restore some of the funding that was displaced in last year's budget on the basis that there was not enough take-up. You are now getting, according to the figures you have given us, much better take-up than you were anticipating when last year's budget

was framed. So are we going to see a large proportion of that $191 million restored to the incentive program?

Prof. Calder—The commitment in the budget measure last year was to monitor these arrangements and to respond to demand as appropriate. At the present time this is a pleasing increase in uptake, but it still falls a long way short of the intended uptake and so it will continually be monitored.

Senator HUMPHRIES—What was the intended uptake originally?

Prof. Calder—I do not have those figures with me but it was significant.

Senator HUMPHRIES—Again, I am a little confused because we were told that the estimated uptake under the budget last year was going to be 160-odd, full-time equivalent, nurses by 2011-12. If you have got 410 in the program now, as of 2008-09, you are obviously tracking well above what you anticipated needing to spend. Has the average amount per nurse come down? We were told it was $115,000 per nurse. Has that figure come down? Is that why we now have more nurses for less money?

Prof. Calder—We have just decided Professor Whiteford has more up-to-date information.

Senator HUMPHRIES—Okay.

Prof. Whiteford—I think the 410 are not full-time equivalents. That is the total number of nurses. Most nurses in this program are only part time.

Senator HUMPHRIES—Okay.

Prof. Whiteford—So we are not yet at the full-time equivalent numbers that were estimated.

Senator HUMPHRIES—So what are the full-time equivalent number of nurses in the program at the moment?

Prof. Whiteford—I will have to check that but it was 300 and something, Senator—in the 300s.

Senator HUMPHRIES—Three hundred and something.

Prof. Whiteford—FTE. I will take it on notice.

Senator HUMPHRIES—But even that is double what we were told last year was the estimate for 2011-12, so by 2008-09 you have got twice as many nurses in the program as you expected to have, as of what you told us this time last year.

Prof. Calder—As Professor Whiteford says, by headcount not by hours worked.

Senator HUMPHRIES—No, he is talking about full-time equivalent now. You have got over 300 nurses in the program full-time equivalent as of now.

Prof. Whiteford—No.

Senator HUMPHRIES—So what are you telling us about the number of nurses in the program?

Prof. Whiteford—That was the original aim of the program, I thought the question was.

Senator HUMPHRIES—Okay.

Prof. Whiteford—Most nurses are not full time, so the full-time equivalent number is the figure originally given.

Senator HUMPHRIES—What was the original estimate of the number of full-time equivalent nurses that you wanted in the program?

Prof. Whiteford—I will take that on notice, Senator. I cannot be sure because I am going from memory; I do not have the figures of that in front of me.

Senator HUMPHRIES—Okay, but obviously I need those figures. We were told last year, and I am quoting Mr Smyth:

> The government has stated that, should the demand be there to increase the size of the program, those figures will be revised.

It looks as if the demand is there; it is coming back. Are we going to see some of that original $191 million restored to the program? The members of the then opposition, now government, were very keen to support it when it was announced, and the money was cut because supposedly there was not the demand there for the program. It is now coming back. Is the money going to be put back?

Prof. Calder—As I said the commitment in the last budget was to monitor such programs for demand, so undoubtedly that will be monitored. It is currently tracking within budget for the year so there is no issue at this point in time.

Senator HUMPHRIES—Okay. Could I have, please, what was originally envisaged to be the full-time equivalent number of nurses in this program over the five years? What is the actual number of nurses—and I would like each of these figures in full-time equivalent and actual number—in the program at the moment and how many you anticipate to be in the program over the out years as well? And how many dollars are attached to those projections?

Prof. Calder—I will take that on notice.

Senator HUMPHRIES—As I read the PBS, there is a reduction in the budget for mental health services of more than $4 million—about $4½ million—in the coming year over last year. Am I reading them correctly?

Prof. Calder—I might have to ask for advice on that.

Senator HUMPHRIES—I am looking at table 11.2.

Prof. Calder—I cannot comment on that at the moment. I will have to take that on notice. It definitely is a $4 million difference.

Senator HUMPHRIES—If you could please. There is a much more explicit cut in the budget measures—

Ms Halton—Senator, it is the healthcare agreements. You know how we have had the transfer of the funding in terms of where it is appropriated, if you look at that that is what you will see there.

Senator HUMPHRIES—Okay.

Ms Halton—So it is not actually a reduction; it is just that it has been transferred to the other portfolio.

Senator HUMPHRIES—The other portfolio being Treasury.

Yes.

Ms Huxtable—Senator, in the paragraph before table 11.2 it says something along those lines.

Senator HUMPHRIES—Yes, but it does not explain what the apples versus apples difference is.

Ms Huxtable—It does not mention the actual figure but it does note that.

Ms Halton—There will not be a reduction in the other place.

Senator HUMPHRIES—That is good to know. What, then, about the measure referred to on page 286 of Budget Paper No. 2 which refers to a saving of $20 million over four years? I might just commend whoever has drafted this for a masterful piece of obscure description. This reads like an increase in funding but it is actually a $20 million reduction in funding:

This measure will provide savings of $20 million over four years as less funding over the forward estimates will be required reflecting the revised focus on key priorities.

So what key priorities are being focused on and from where precisely will that money be taken?

Ms Hart—I think the program that you are referring to and the savings measure relate to an initiative called Leadership in Mental Health Reform. It is funding that supports a range of activities. The $20 million over the four-year period is a reduction on the forward estimates, as you point out. The funds support some work around data standards and the development of key performance indicators and measures, support for national peak bodies which represent consumer and carer input and also national population surveys.

Senator HUMPHRIES—I want to ask about those things you have mentioned, but the $66.6 million over four years which was previously indicated in Leadership in Mental Health Reform presumably was in the 2008-09 budget? In other words, what was this $5 million being cut from?

Prof. Calder—It was over four years.

Senator HUMPHRIES—Yes.

Prof. Calder—In relation to the previous healthcare agreements arrangement.

Senator HUMPHRIES—Okay, but what was it being cut from. You say that the Leadership in Mental Health Reform provision was $66.6 million over four years, so where is that?

Senator McLucas—Which page is this?

Senator HUMPHRIES—I am looking at page 286 of Budget Paper No. 2.

Prof. Calder—It is a Commonwealth allocation for activities in the mental health leadership arena.

Senator HUMPHRIES—Yes, but where did that appear? Was it announced in the 2008-09 budget?

Prof. Calder—No, it has been ongoing through the period of the healthcare agreements.

Senator HUMPHRIES—Right. So these are payments to states, are they?

Prof. Calder—No, it is a Commonwealth allocation for Commonwealth leadership in the mental health area, in conjunction with, if you like, the healthcare agreements arrangements, particularly in the areas that Ms Hart has referred to.

Senator HUMPHRIES—But this is described as a cut. I quote:

Provision of $66.6 million over four years was previously included in the forward estimates.

When was it included in the forward estimates?

Prof. Calder—It has been in the forward estimates for a number of years, each year forward. So it has been reduced for—

Senator HUMPHRIES—Was this a Howard government initiative?

Prof. Calder—I think it possibly was.

Senator HUMPHRIES—I suppose it must have been if it was pre—

Prof. Calder—I think it was possibly the previous government. It has been in place for some years.

Senator HUMPHRIES—Okay. But you said before it was a four year initiative, didn't you, Senator McLucas?

Ms Hart—I did. I may have been talking about the four years of the forward estimates for the program that the cut relates to.

Senator HUMPHRIES—It is four years of cuts, so presumably it must have been a longer period of original allocation. I am just trying to find out what exactly this $20 million cut applies to. Could somebody take that on notice and describe to me what program has been cut by $20 million, please? That is what we are here for—to find out what is going on in the budget, I am not getting much of a picture of that at the moment.

Prof. Calder—We can give you further detail, but it is an allocation to the Commonwealth for Commonwealth activities which are largely national. It supports the national survey that Professor Whiteford has referred to. It supports the national data development and data collections. It supports the national mental health annual report.

Senator HUMPHRIES—So what exactly are we losing by cutting $20 million?

Prof. Calder—It had a degree of flexibility built into it and those areas of priority work will be sustained within this allocation.

Senator HUMPHRIES—So are you saying no-one will notice the $20 million disappearing? No people out there getting services will see any difference?

Prof. Calder—It does not relate to service delivery.

Senator HUMPHRIES—You mentioned national peak bodies before. How are they affected by this cut?

Prof. Calder—As I said, the priorities already in the allocation application will be sustained. It may mean that some new things will not be done, but—

Senator HUMPHRIES—New things that have already been announced?

Prof. Calder—No.

Senator HUMPHRIES—I look forward to some further description of what is going on there. You say in the PBS that there will be 'integrated and expanded support provided to individuals with persisting psychological symptoms as a result of trauma and loss' arising from the Victorian bushfires. Is that an as-required or a demand driven service?

Mrs Krestensen—That is a reference to the government's bushfire mental health response package, which was announced on 23 February by Minister Roxon and Minister Macklin. There is $7.5 million towards psychological services, phone based counselling, specialised education and training for mental health providers, and capacity building for those communities impacted by the fires. So there is a commitment in the PBS to implementing that over the year up to June 2010.

Senator HUMPHRIES—Is that specific amount referred to in Budget Paper No. 2?

Mrs Krestensen—The budget papers allude to the new funding. The $7.5 million comprises new funding of $3 million and reallocation of existing funds of $4.5 million to achieve that total of $7.5 million.

Senator HUMPHRIES—Is that the $4.5 million we were missing before in the budget papers? We said there was $4.5 million being transferred to Treasury. Is that the $4.5 million?

Prof. Calder—No.

Mrs Krestensen—No, I do not think so. It is $4.5 million this financial year which we are allocating from within existing programs which relate to telephone counselling, psychological services and so forth. We are giving priority to those programs to support these groups of people. So it is $3 million of new funding which is included in the budget papers and $4.5 million of existing funding.

Ms Halton—Actually, Senator, I might just go back to the point that you made because I think you referred to the $4.5 million as 'missing'. In fact, on 2008-09 figures the amount that has been appropriated elsewhere, and I cannot give you the 2009-10 component, but it is $14.9 million. The reason the difference between the appropriations for 2008-09 and 2009-10 is only about $4½ million is that the other elements of that program have grown quite significantly. They have grown respectively by an amount which is close to $10 million so that the net difference is $4½ million. But in fact what is appropriated elsewhere, based on last year's money, is of the order of $14.9 million.

Senator HUMPHRIES—But in Budget Paper No. 2 I can only find, in respect of mental health, that cut with the Orwellian title 'Leadership in mental health reform' of $20 million. I cannot see any other new initiatives in that area. Perhaps I am missing something—you might like to point me to it, if I am.

Mrs Krestensen—There is $3 million extra for the bushfire response.

Senator HUMPHRIES—Where is that? Which page is that?

Mrs Krestensen—It is included in Budget Paper No. 2 in the total figure.

Senator HUMPHRIES—All right. I will find it later on. Could I just ask about the national mental health program. You told us last year, Mrs Krestensen, that that had been reduced from $40.2 million to $31.8 million.

Ms Halton—Just for your information, that mental health money is in PB2. It is at page 297.

Senator HUMPHRIES—All right. I will go back and have a look at that.

Ms Halton—And the other money which is included underneath that is the mental health money in respect of drought.

Senator HUMPHRIES—Thank you for that. We were told that there was $35 million provided over four years for 1,070 postgraduate masters degrees scholarships and mental health nurses, 100 of which were targeted for rural or remote areas. I expressed some scepticism about whether you get the thousand nurses into that program. Are you tracking to achieve that target at this point in time?

Prof. Calder—Our workforce colleagues manage that program. That question could be taken later if you would be comfortable, or we could call for it now.

Senator HUMPHRIES—No, I will leave that. If you could provide that information later, that would be fine.

Prof. Calder—Thank you.

Senator HUMPHRIES—There was a cut with respect to postnatal depression. You are expecting to get $30 million out of an $85 million program from the state and territory governments to support a federal initiative on postnatal depression. Have the states and territories signed up to provide the $30 million?

Mrs Krestensen—Perinatal depression measures are on track in terms of us having provided funds to the states and territories and us working very closely with the states and territories about their own jurisdictional investment plans. Those plans are put forward in a draft implementation plan for perinatal depression which would be going to AHMAC within the coming weeks. That will contain the jurisdictional plans of state and territory governments. I feel it would be inappropriate for me to advise what is in those plans because they will be made public at the point of AHMAC considering and approving those plans. But we have made it very clear in our ongoing negotiations with the states that Minister Roxon's view is that their contributions would match the $30 million contribution that we are providing to perinatal depression.

Senator HUMPHRIES—Thank you.

Senator BOYCE—I have a question for you first, Minister. The *Towards recovery* report of the Senate community affairs committee's inquiry into mental health was tabled in September 2008. We have yet to receive a government response to that. Would you be able to tell us when that might happen?

Senator McLucas—As soon as possible, Senator, is the answer. As you know, it was a very comprehensive report. It is the subsequent report to the initial report, as I understand it. Is that right—

Senator BOYCE—There was an interim report which was produced in 2007, but the final report came out in September 2008.

Senator McLucas—I think the answer is as soon as we can, and if there is any change to that from the minister's office I will come back to the committee.

Ms Hart—Senator, if I could just add to what Senator McLucas has said, which is correct. We are in the final stages of putting together the responses to the recommendations. There were some 26 recommendations that were across quite a wide range of government activity. We do have a draft, as Senator McLucas says, that needs to be approved by the minister, but it is in the very final stages of completion.

Senator BOYCE—Thank you, Ms Hart. I have just a general question which I raised with FaHCSIA in the appropriate area too, around their mental health services. This report was not unusual at all in finding that the major problem in the mental health area is stigma. Three weeks ago, at a national mental health council conference, the same point was raised. I think we probably started on this topic about 10 years ago, and certainly there have been improvements, but stigma remains the No. 1 problem in the mental health area. What is the department doing in that area? I know we have beyondblue and all that, but what else?

Prof. Calder—There is a range of activity that Ms Krestensen will talk to you about.

Mrs Krestensen—Senator, it is something, as Professor Calder has said, that we are working very closely with the sector on and have been for several years. There is a range of very effective NGO activity, which we are funding, taking place in this sphere. One of the most high profile of those is the SANE StigmaWatch program, which provides an NGO sector based watchdog on the media. It is independent of government, but it provides somewhere where people can raise concerns if they read something they think is stigmatising. If they see something they think is inappropriate, they can raise concerns.

Senator BOYCE—How do you promote that website?

Mrs Krestensen—SANE fairly actively promotes the website, and it is also promoted very heavily through our media Mindframe project, which works closely with the media to ensure that they are aware of the importance of not using stigmatising language and that they are aware of the importance of appropriate reporting of suicide and mental health issues. So it is promoted very actively in that way.

Senator BOYCE—Thank you.

Mrs Krestensen—And there are also a range of other activities where we are integrating, I guess, mental health literacy into our school based programs and others so that the importance of not treating people with mental illness with stigmatising approaches is built in a range of ways into a range of professions.

Senator BOYCE—Thank you. I just have one or perhaps several final questions. What knowledge would the department, or does the department, have of the use of treatments—not the process but the actual delivery of treatments—of electroconvulsive therapy in Australia?

Prof. Calder—That is not something that the mental health area monitors. Professor Whiteford?

Prof. Whiteford—Senator, ECT, electroconvulsive therapy, would be given in both the private and public sectors. If it is given in the private sector, in a private hospital, there would be a Medicare item for it. I do not have that information, but that would be collected in the state run public sector mental health services. There would be registers kept at all the hospitals where ECT is given. To my knowledge, we do not routinely collect and aggregate that data for reporting at a Commonwealth, or national, level.

Ms Halton—But I can tell you, Senator, that I had occasion to look at the data in respect of those MBS items fairly recently, and the item was not what I would describe as prevalent. In fact, it was used less than I thought it might have been.

Senator BOYCE—My questions actually go specifically to its use or alleged use on teenagers in Queensland.

Ms Halton—That was the data that I was actually looking at, as it happens.

Senator BOYCE—Are you able to answer that question, then, for me? Is it used on under-14-year-olds in Queensland, Ms Halton?

Ms Halton—I would have to get the data out and have another look at it, to be honest. I can not remember particular age cells by jurisdiction. The numbers were very low, and in a number of cases it was not used, although there were some cases where there was an asterisk which implied there were one or two. I would have to reacquaint myself with that, but we can answer that on notice.

Senator BOYCE—Would you be able to, yes, provide all that information on notice?

Ms Halton—Yes. We would be happy to.

Senator BOYCE—Thank you. That is it, Chair.

CHAIR—Thank you. That is the conclusion of outcome 11.

Senator McLucas—Excuse me, Chair. I do apologise for this, because Senator Humphries has now gone, but I think it is worthwhile noting that, whilst there have been changes in the mental health expenditure, funding for mental health specific programs, including Indigenous programs, will nearly double over the next four years: $923.6 million over the four years from 2008-09 compared to $516.5 million from 2004-05 to 2007-08. We acknowledge there has been a shift in emphasis, and that does not mean that the issues of national leadership and a lot of the other work is forgotten, but the focus has certainly moved to mental health service delivery. I thank you for your indulgence.

CHAIR—Thank you. That completes outcome 11. We will now move to outcome 12, and we will go to the items under 12.1, then 12.2. I take it, Senator Williams, you have questions under 12.1?

Senator WILLIAMS—Yes.

Ms Halton—Senator Boyce, I will just see if I can get that data this evening for you on ECT.

Senator BOYCE—Thank you.

Ms Halton—I have just asked somebody to go and see if they can find it, because I have seen it in the recent past.

Senator BOYCE—Thank you.

Senator CORMANN—Senator Fifield asked you whether there was an update on the continence pad. You were going to come back with something, apparently. Do you know what I am talking about?

CHAIR—Senator Fifield raised the issue this morning.

Ms Halton—He did, and I do not know whether they have got that information. We will ask.

Senator CORMANN—Yes.

CHAIR—We are starting with rural workforce, 12.1. Senator Williams.

Senator WILLIAMS—Thank you, Chair. Are we waiting for more people from the department or, Ms Halton, are you—

Ms Halton—Give us your best shot, Senator, and we will see whether the relevant office is in the room!

Senator WILLIAMS—I would like to talk about the number of GPs per population in Australia. Do you have any figures on those?

Ms Halton—Yes.

Senator WILLIAMS—Let us talk about doctors.

CHAIR—I have the feeling, Senator Williams, that is a wider issue than just a rural one. Nonetheless, we can get that question on the record.

Ms Cole—In Australia in 2006, according to the medical labour force survey, there were approximately 22,000—nearly 23,000—people employed in primary care. That is broader than just GPs.

Senator WILLIAMS—Twenty-three thousand GPs?

Ms Cole—That is primary care practitioners—largely GPs but not solely GPs.

Senator WILLIAMS—All right.

Ms Cole—According to our Medicare data, in terms of GPs in headcounts for 2007-08, there were 24,903. That is headcount; that is not full-time equivalent.

Senator WILLIAMS—Yes. So, on those figures, it is roughly one per 1,000 Australians—if we look at 21 million people?

Ms Cole—Just slightly over, yes.

Senator WILLIAMS—Do you have figures for GPs per head of population in rural and regional areas?

Ms Cole—Yes, I do, Senator. If we are looking at the GPs—this was given to me as full-time work equivalent, which is slightly different from the headcount numbers that I just gave

you—I have actually only got absolute numbers, but we can give it to you on notice if you would like it as a proportion. Do you want absolute numbers now?

Senator WILLIAMS—Yes, that will be fine.

Ms Cole—In absolute numbers in 2007-08, there were, in capital cities, approximately 12,200; in other metro, a further 1,500; in large rural communities, 1,150; and in small rural communities, 1,300. 'Other rural' is around 2,000, and then in the 'remote' and 'other remote' there were around 250-odd.

Senator WILLIAMS—Ms Cole, I am trying to draw a comparison between the GPs per capita in urban areas compared to the GPs per capita in rural areas. I am looking to see if that rate of GPs per capita in rural areas has increased as per doctors, not per patient. In other words, has it got better over the last three or four years? They are the statistics I am looking for.

Ms Cole—Mr Dennis here might be able to answer that one better for you.

Mr Dennis—We can provide you with the figures going back some 10 years. In fact, the doctor-to-population figure has improved across all rurality and urban measures, I suppose. We have found that the least improved are the doctor-to-population ratios in the remote areas, but there has been improvement across the sector.

Senator WILLIAMS—What about general surgeons? Have you got a list of the same things? I raise the question because I know of some large country towns—for example, the town I live in has 12,000 people and a shopping area of probably 17,000. It does not have a resident surgeon. In the case of any emergency, even things like a broken arm—if a youngster were to play minileague on Saturday and break an arm, he would have to go up to Armidale to have it set in most cases. Do you have figures on those lines of those general surgeons in country communities as well?

Mr Dennis—Sure. General surgery is a subspecialty of surgery, and we do have figures concerning the number of general surgeons, as we do for most subspecialties.

Senator WILLIAMS—And up-to-date figures on dentists as well?

Mr Dennis—Dentists is another area entirely.

Senator WILLIAMS—I may be able to get that later on.

Ms Halton—Senator, can I just make one point, though, in respect of the comment you made about a child and a broken arm. We should remember that procedural GPs in some instances are able to undertake that kind of matter unless it is complex. It is important just to remind ourselves that sometimes procedural GPs will do that kind of work.

Senator WILLIAMS—Yes. Sometimes they do. But, in the case I was referring to, a friend of mine had a young fellow who broke an arm playing minileague and he had to drive him off to Armidale, about 120 kilometres. When they got there, they said, 'Look, we can't do it today; will you bring him back tomorrow?' so he drove home 120 kilometres and did the same trip again the following day. I relate that back to when my daughter broke her arm on two occasions. It was just done locally at the local hospital and done very well. So I question why the same thing could not have been done today?

Senator McLucas—It is a good question.

Ms Halton—It is a good question, and it may well have been able to have been but—

Senator WILLIAMS—I think it comes down to being sued if it is not done right, if I am being frank about it, but—

Ms Halton—I am not sure about that.

Senator WILLIAMS—We will just move along and mention, as Senator Crossin mentioned earlier on, the RAMU scholarships. We have had some 144 now qualify as finishing their intern year and their three registrar years. Is that correct? Correct me if I am wrong, but to become a GP, there are five years at university, one year as an intern, three years as a registrar and then that is about the average nine-year span to become a qualified GP. Is what I just said correct?

Ms Halton—We will not get into the postgraduate—

Senator WILLIAMS—No.

Ms Halton—model, Senator. There are a number of ways to become a GP, but it is of that order.

Senator WILLIAMS—Yes. The RAMUS Scheme started in 2000. I believe we have about 144 now who have qualified. Ms Jolly, do you know if that is true?

Ms Jolly—In the particular scholarship scheme that you are talking about, the figures here are that 872 students have graduated from that particular scheme.

Senator WILLIAMS—Eight hundred are said to have completed their five-year term at university, at medical school.

Ms Jolly—Yes, that is correct.

Senator WILLIAMS—Do you know how many of those have actually gone on to become GPs?

Ms Jolly—We do not.

Senator WILLIAMS—Has there been any study to follow their course after they finish their degree?

Ms Jolly—We do not actually track the RAMUS students in that way that allows us to pinpoint whether that particular group of students has gone on to study a particular discipline. The RAMU Scholarship Scheme is designed to encourage rural students to come and study disciplines, and I guess that the success of those programs is measured in the attraction of those students.

Senator WILLIAMS—Yes.

Ms Jolly—We have not yet then tracked those, at this stage, through to their final employment location.

Senator WILLIAMS—Seeing that the program was introduced to encourage country people to study medicine, going on previous statistics that 92 or 93 per cent of those country people who studied medicine actually returned to a country area, shouldn't you be tracking,

when they complete their field, where they actually go, because if you do not keep a track of it and these people stay in the cities, for example, doesn't that mean that the program has not been successful? I think it would be rather vital that you track these people right through their qualifications and see whether they practise in an urban area or a regional area.

Ms Cole—Senator, we have actually funded a program which is called the MSOD project and, basically, that is exactly the kind of research that we will get out of that project. It is a longitudinal study of medical students. It is all medical students. It did not commence till 2004, however. Actually, the development work on the project commenced in 2004, and we will not have the first exit survey, which is looking at where they are going after they finish their medical degree, until next year. That is the first exit survey in that longitudinal study.

Senator WILLIAMS—When you say next year, is that early in the year, late in the year or in the middle of the year?

Ms Cole—I suspect that the exit survey will be done at the end of the academic year, but we will take a little while to get the results after that. It is intended that that longitudinal study will look at what happens to them over time and what their intentions are over time, so what they are intending to do at the beginning of the course, at the end of the course, perhaps after their intern years, and then, as they go into specialist training, where they might end up.

Senator WILLIAMS—Yes.

Ms Cole—It is a long process tracking students, as you can imagine, so I think it will take some time before we are able to use that data source to give you the definitive kind of evidence that you are looking for.

Senator WILLIAMS—To me that would be vital data because it would see whether the whole scholarship scheme is working as it is intended to work, surely.

Ms Cole—That is right.

Senator WILLIAMS—To monitor those qualified specialist practitioners and see whether they do actually go back to where the whole scheme was targeted for—

Ms Cole—That is true. We will get some indications, too, with the bonded scholars at about the same time.

Senator WILLIAMS—This is probably an opinion—perhaps I should not ask it—but do you see any way that the RAMUS Scheme could be improved? Perhaps that question is to the parliamentary secretary?

Senator McLucas—Are you talking about the remote—

Senator WILLIAMS—The Rural Australia Medical Undergraduate Scholarship Scheme.

Senator McLucas—RAMUS as opposed to RRMA.

Senator WILLIAMS—Yes, R-A-M-U-S.

Senator McLucas—I think the point you are making about tracking people post graduation is important, and I was pleased to hear that we are doing that now. The other point you make, Senator Williams, that if you attract people from rural areas they are more likely to return to rural areas has been proved at James Cook University in the first graduation there

recently. A very high number of people went back into rural areas, areas that had not seen doctors for a very long time. And I know that—what is the university based down here, the one with multiple campuses?—there is another one that has got a medical school that has also got exactly the same—

Senator WILLIAMS—UNE.

Senator McLucas—Is it UNE?

Senator WILLIAMS—UNE has one. It started two years ago. It has about 70 students in it now and has been very successful.

Senator McLucas—Yes, and they go back to rural areas. I thought that that model—

Senator WILLIAMS—We hope so.

Senator McLucas—The JCU data is very good.

Senator WILLIAMS—Yes. Hopefully, soon we will see a similar scholarship scheme for country dentists, because we need the same effect, to have that—

Senator McLucas—I am very pleased to say that the investment in the dental school is very welcome in Far North Queensland.

Senator WILLIAMS—Not only the dental school, Senator, but the scholarship scheme to help those people from rural and remote areas go through dentistry. We are looking at nine years to get a GP out on the field.

Senator McLucas—That is right.

Senator WILLIAMS—With dentistry, it is five or six, and we could get results a lot quicker, which—

Senator McLucas—I think the important point you make, Senator Williams, is that when you plan for a workforce, you do it 10 years prior.

Senator WILLIAMS—You do.

Senator McLucas—And if you do not plan, you end up in circumstances like our country is facing at the moment.

Senator WILLIAMS—That is right. And if I can just add to that, John Anderson and Michael Wooldridge attracted a lot of criticism when they started this plan in 1999. And it is only in the last couple of years we have seen results. But thank goodness they started, because the results are now showing.

Senator McLucas—I think it is broader than a scholarship system.

Senator WILLIAMS—If I read the graph correctly on page 305, the number of students enrolled in nursing shows a projected good rise in the next four years. The number of medical undergraduates rose slightly, but those taking up dentistry have flatlined. Back to that point I made of dentistry, that is obviously a concern.

Mr Groth—Senator, firstly, I think you asked before about distribution of dentists.

Senator WILLIAMS—Yes.

Mr Groth—Do you want me to answer that now?

Senator WILLIAMS—You could if you like, yes, certainly.

Mr Groth—The figures are based on Australian Institute of Health and Welfare figures for the year 2005: major cities—this is again per 100,000 of population—58.6.

Senator WILLIAMS—58.6 dentists per 100,000 people in major cities.

Mr Groth—Yes. Inner regional, 34.6.

Senator WILLIAMS—So suburban, or close to the major cities, you would say?

Mr Groth—Yes. Wollongong apparently is classified as inner regional. Outer regional, 28.5; remote and very remote, 19.8.

Senator WILLIAMS—I just want to touch on that, if I could please, Mr Groth. One of the concerns I have is the average age of dentists, we are talking of a specialist field. My concern is that in regional areas, of those 19.8 or 28.5, those bottom two figures you gave me, that many of those dentists—figures I have had given to me is up to 45 per cent—are soon to retire in the next five or six years. Are you tracking the actual age of those dentists? In other words, to get an idea of where how much of their working life in their profession is still there?

Mr Groth—The only figure I have in front of me at the moment, Senator, is an average age across the whole of the dental population. It has been split. It has an average age here of 44.5 years. There is a percentage of the working population, though—again, these are from the same source—of dentists with an age over 50 years of 35.4 per cent. It is not available here, but I am more than happy to see if it is available in other tables and split it by the remoteness categories that we have just discussed.

Senator WILLIAMS—Yes. You know the point I am driving at, and I come back to the problem of dental care in rural and especially remote areas of Australia. I am no doctor, far from it, but dentists tell me that if you do not have good dental health, that whole dental sickness can flow through your body and end up promoting other sicknesses as well. That is why dental health is so vital. But that is another story. The graph on page 306 shows a sudden increase in locum placements in the bush. But for the next three years there is virtually no increase predicted. Why is this so?

[5.51 pm]

CHAIR—Ms Flanagan, you do know that we are now going across both areas? We have gone into rural workforce and workforce, but I know the officers are available.

Senator WILLIAMS—Yes. Sorry, I am confusing you a bit here.

Ms Flanagan—They know what they are doing.

Senator WILLIAMS—I am glad of that.

Mr Dennis—I believe the graph the senator is referring to is the number of placements that are included in the new budget measure, our national rural locum scheme. Is that correct?

Senator WILLIAMS—Yes.

Mr Dennis—The graph rises steeply this year. It starts out at 42. Given that this is a new program and it is likely that there will be some lag until we gain full momentum, given that we have discovered that practitioners who are likely to participate in the scheme will require

some training, and that is another component of this, it will rise through to 84 next year. As we get national recognition of this scheme between both prospective locums and users of that locum service we anticipate that it will plateau at that particular level, 140, and that is why there is the steep rise. Essentially, we are describing an increasing awareness of a program that has never been in place before.

Senator WILLIAMS—I would like to close by saying that I am not going to go into the changes in the budget to the Youth Allowance in relation to the specific areas and the effect on rural and regional people. We will handle that in another arena.

CHAIR—I am pleased you got that in, Senator. Senator Adams, are you looking at rural health?

Senator ADAMS—Yes, starting with rural and then I will—

CHAIR—If you could start with rural, that would be good.

Senator ADAMS—I will just start with rural. I have just recently attended the National Rural Health Conference in Cairns, which was very good. Senator McLucas, I am sorry I missed you there. I was there at the start; you were there at the end.

Senator McLucas—As it happened, I could not be there, but we were represented.

Senator ADAMS—Anyway, this is an organisation with 27 national bodies, and the conference had an attendance of 950 rural health professionals plus everyone else. I have a recommendation for you—

Ms Halton—Can I just be clear, Senator: we are not actually in rural yet. I have got some people who can do some—

CHAIR—This is rural workforce. This is a question I am about to ask which came from the conference.

Ms Halton—It depends on the question, as usual.

Senator ADAMS—Yes, I know.

Ms Halton—I have the really important part of the team here, but not necessarily with underpinnings, if you see what I mean.

CHAIR—Senator Adams, your question is about workplace.

Ms Halton—In answer to Senator McLucas' question, it is Charles Sturt. We figured it out.

Senator ADAMS—The second recommendation from the conference states they would like a speeding up of the rate of development of a new health professional role for physician assistants, nurse practitioner, and advanced allied health practitioners, and the expansion of existing roles such as ambulance officers, paramedics and Aboriginal and Torres Strait Islander health workers, which I know we will discuss tomorrow. I just wonder if the department has looked at any model for these people to help the existing shortage of workforce in the rural workforce.

Ms Cole—Senator, you would be aware that there is a budget initiative around nurse practitioners, which is—

Senator ADAMS—Yes, I know. I will ask about nurse practitioners separately.

Ms Cole—which is particularly focused around primary care in rural and remote, in particular. So I guess it would be fair to say that the department has looked at the issues around nurse practitioners. The department is also well aware of the trial that is being conducted in South Australia and Queensland of the physician assistant role. That is going to be evaluated, I understand, over the next 12 months.

Senator ADAMS—Right.

Ms Cole—I expect that all governments will be interested in the results of those trials.

Senator ADAMS—Is there something going on with an advanced allied health practitioner role.

Ms Cole—I understand from my colleagues in some of the states and territories that there has been some consideration of some of those roles, but it is not something that we have looked at in the department.

Senator ADAMS—Will you be looking at it with the shortage of the rural workforce? These suggestions, as I said, have come from a very large group of people with all the grassroots information, so I am just trying to highlight that for them and see if the department might pick up on some of these issues later.

Ms Cole—I think a lot of these roles are very new still, Senator—

Senator ADAMS—They are.

Ms Cole—and require quite a bit of trialling in small pilot studies before we can really consider them in a wider, national application.

Senator ADAMS—This is really what I am getting at. Is the department prepared to look at these initiatives?

Ms Cole—Senator, I believe that it is really also, to some extent, a government policy that would have to be made before we would consider some of these roles. There would need to be some inclination.

Mr Groth—Senator, within the COAG space my colleague is mentioning, there is consideration from the Commonwealth end and an application of nurse practitioners and other roles and some extensions there. There is ongoing discussion between officials, I think, through COAG arrangements around better collaborative arrangements and integration of care across a range of professionals, including allied health and nursing, which includes the sorts of professionals you are speaking about, but also enhanced roles in some cases for existing professionals. I suspect what you are getting at is whether specific new roles would be considered. I suspect they would be, but in that context. But there is no specific consideration that we are giving to any particular role at the moment.

Senator ADAMS—I am just trying to flag the recommendation; will it be something that will be ongoing. And we can talk about it later. How many nurse practitioners have we got physically working in rural areas at the present time? Do you have any idea of that? Or you can take it on notice, if you want to.

Ms Cole—I will have to take on notice the rural distribution question you just asked. There are only between 300 and 350 nurse practitioners in Australia at present.

Senator ADAMS—But a lot of them, unfortunately, are not working in the rural areas, where, originally, that was really the role for a nurse practitioner.

Mr Groth—Senator, there is a scholarship program for nurse practitioners, and I understand that was certainly more than fully subscribed. There was something like 20 full-time equivalent positions and about 36 people were awarded that, obviously, mostly on a part-time basis. I will be able to check shortly and come back to you about that, but I think there is a rural emphasis. There certainly is, at least, with a great deal of the scholarship programs that are offered.

Senator ADAMS—Yes. I am fully aware of those. This was the sixth recommendation from the conference. They were calling on equivalence of incentives for education training, recruitment and retention of rural and remote health professionals across all disciplines. It really is coming back to the multidisciplinary team approach and early training. There is the fact that medical students, nursing students and allied health students, perhaps, could all be trained, in that first year, anyway, together. I know that there are some universities looking at that. But it also, I think, enhances—if you start off with a group like that—the situation that we do not end up with all the health professionals being in silos as it was many years ago. It is getting better, but it is still not good enough. But could you comment on that?

Ms Cole—In the COAG workforce package which in large part is around improving clinical training arrangements, there are two components that are looking at those issues that you raise. One is whether or not there would be some ability to encourage a greater number of rural and remote clinical training placements for all students in the health disciplines. The other thing that the clinical training arrangements are likely to look at are interdisciplinary team type clinical training arrangements that you have talked about so that you might have a variety of students in a general practice rather than just medical students or nursing students to gain an understanding of team based work for later professional life.

Senator ADAMS—I think that is very important. With your indulgence, Chair, I would like to ask about the new national men's health strategy. This was recommendation number 10. The participants at the conference were hoping that there would be specific measures for rural and remote areas. I know prostate cancer may be a special area that male nurse practitioners could work in. So I am just flagging this. That might be something to, perhaps, look at, because rural men are very difficult to get to go and have something done and visit the GP, because they are usually all too busy for that. I think that that might be something that we could, perhaps, look at as an incentive for male nurse practitioners.

Mr Groth—Senator, just to follow up on the earlier question about nurse practitioners and distribution, of the 36 nurse practitioner scholarship holders, 16 or about 45 per cent of them are in rural areas.

Senator ADAMS—Good. That is a start. I think I will leave it at.

CHAIR—Are there any other questions on rural workforce?

Senator CORMANN—Do you have any involvement in terms of specialist medical services in rural areas?

Ms Halton—Are you talking about MSOAP?

Senator CORMANN—No, I am talking in general terms about the issue. We all know there is a shortage of doctors, in particular in regional areas, and there is a reluctance, I guess, in general terms, for a range of reasons, for Australian trained specialists to work in rural areas. And so there is a heavy reliance on overseas trained doctors. I see you nod. You know the issue I am talking about. There is a whole range of issues of process involved that make it quite difficult to get those overseas trained doctors into position. There has to be a process to ensure that they are appropriately qualified, that it is safe et cetera. So it is a matter of getting that balance right. I am just wondering whether you could talk us through some of the things that you might be doing, from a Commonwealth point of view, to address the issues? I am sure you are aware of them, but I am keen to understand what it is that we are doing, from a Commonwealth point of view, to resolve this.

Senator McLucas—Just before the officer starts, Senator Cormann, you said 'specialists' at the front of your commentary. Do you want us to talk about specialists, or general practitioners?

Senator CORMANN—My question was about specialists, but you might tell me that this is not the right area to ask it.

Senator McLucas—No. I think we are right. I just want to be clear about the area.

Senator CORMANN—The background to it is that I have been meeting with a series of regional hospital medical directors in Western Australia and they consistently raise similar issues like how it is very hard to attract Australian trained doctors. I am sure you would be aware of the reasons for that. There are a lot of overseas-trained doctors who are very burned out once they get into position because they can not get anybody to take on-call services for them. I am very pleased to see you nod, because you obviously know what I am talking about. But essentially, the general problem, as I am told, is that there is a lot of interest for doctors to come to Australia and to provide services across regional Australia but it is very difficult to work your way through all of the system, even for those who quite patently are sufficiently well qualified. It is a very genuine question.

Ms Cole—There have been significant problems for some overseas trained specialists to work their way through the assessment processes in Australia. As a result, in 2006 it was agreed that there would be a nationally consistent assessment process set up for overseas trained doctors. That assessment process basically looks at all overseas trained doctors, not just the specialists. But it did look at the specialist stream and made a number of changes to the processes to speed them up while keeping them safe processes for all Australians. Those changes have been in place since 1 July 2008. They are still being tweaked a little bit to make sure that they work as smoothly as possible, and they are likely to roll into the National Registration and Accreditation Scheme. The main thing that we were doing in that was standardising processes across all states and territories as much as possible and clarifying the steps that had to be taken for a practitioner. A lot of the difficulties that practitioners were experiencing were in actually working out what they had to do.

Senator CORMANN—But isn't one of the problems that for an overseas trained doctor to be able to operate as a specialist they have to have an Australian fellowship, and if they do not

they can only work in an area that has been defined as an area of specialist need, which is something that is determined by the states?

Ms Cole—Yes.

Senator CORMANN—Do you think that we are getting the balance right in terms of making sure that everybody that is properly qualified actually is able to practise in Australia even in areas that are not defined as areas of specialist need? Is there a bottleneck somewhere that should be unplugged is really my question?

Ms Cole—It is always difficult to make sure that the balance between regress assessment and facilitation is right. I do not believe that there is a specific bottleneck in the assessment of overseas-trained specialists in Australia. I do believe that some of the processes have been slow in the past and are improving.

Ms Halton—This is something that we are acutely aware of.

Senator CORMANN—I am sure you are.

Ms Halton—As Ms Cole has tried to indicate, one of the reasons we are creating this national process is, firstly, to have some consistency. I think we have seen a number of cases, in terms of safety and quality, where people's assessment has probably not been up to scratch.

Senator CORMANN—Sure.

Ms Halton—But at the same time we need to have a process which is achievable and reasonable. And that is something that we keep a very careful eye on and we have taken, as I think has been indicated, a number of steps in that respect.

We are also, even for domestic graduates who are interested in specialist training, looking at the kind of locations in which they could do that training in order to spread their experience around public, private, regional et cetera. So I can say to you—and I made this comment earlier on today—that, with the creation of the new workforce agency with the national registration and accreditation arrangements and a very clear focus by all governments on the need to address workforce issues, I can promise you it will absolutely stay on the radar.

Senator CORMANN—Thank you very much, Ms Halton. A final question on this: there are only very few specialist training positions in regional areas, are there not? Is there anything planned in terms of specialist training positions in regional areas?

Ms Cole—We do have the ASTPRA program, a long-running program which my colleague can answer questions on.

Ms Jolly—We have a number of specialist training programs, many of which target rural and remote areas. Particularly, we have the Advanced Specialist Training Posts in Rural Australia, which is designed specifically for rural posts. We also have the Expanded Specialist Training Program, which has a significant proportion of places in rural and regional locations, although that is not its primary focus. I could get you some figures on that if you would like.

Senator CORMANN—Thank you very much.

Senator BARNETT—I have a short question and I apologise if you have already answered it. I am after the report assessing the future health workforce requirements per state for allied, medical and nursing graduates. I understand it has been prepared by

PricewaterhouseCoopers for MINCO and I understand that Peter Carver from the National Health Workforce Taskforce has had carriage of the brief.

Ms Cole—There is, I believe, a current report by PricewaterhouseCoopers on the National Health Workforce Taskforce website which outline some of the issues around modelling of health workforce. There is also a national modelling tool which is being developed by the National Health Workforce Taskforce for use by all states and territories, but that modelling tool is not yet complete.

Senator BARNETT—When will it be complete?

Ms Cole—I think you would need to ask the National Health Workforce Taskforce that question directly.

Senator BARNETT—Do you have an estimate or a time frame? Is it in the next three months?

Senator McLucas—You need to ask the National Health Workforce Taskforce.

Senator BARNETT—You have got no idea; all right. When was the PricewaterhouseCoopers report put on the website?

Ms Cole—Only quite recently. Perhaps in the last three weeks.

Senator BARNETT—All right; thank you.

Senator ADAMS—I have several questions just on nurses. How many nurses have re-entered the workforce as part of the Bringing Nurses Back into the Workforce 2008 budget measure? Sorry to do this to you.

Mr Groth—No, that is okay. We are currently—as of this week—receiving updated data from the fund holders of every state and territory and a number of private hospitals who have entered into arrangements with us on this. At the end of last year we had reported—and I think it was provided in a question on notice—310 up until December. We know we have had more since then. We are getting the data in. We have not had everyone report. The latest report was due this Monday. We are actively chasing those up and hope to have those figures in the next few weeks. It has obviously gone up since.

We did have some reporting in March which was incomplete and that has not given us any real idea about how many are out there. As I said, we hope to have that information in the next couple of weeks. I think I would give the same answer that my colleague from aged care gave: we are still tracking modestly, but it is tracking upward. We have had an interesting development in the last two weeks since the advent of a targeted promotional campaign; that has not translated into people re-entering the workforce at this point, but we have had a surge of probably tenfold on our hotline about the measures since that commenced.

Senator ADAMS—Would you be able to provide those answers on notice, please?

Mr Groth—Yes.

Senator ADAMS—The second question is how many nurses have received the six month $3,000 payment but not continued with their employment contracts. Have you had any problems with that?

Mr Groth—I think it will be contingent on getting that same information.

Senator ADAMS—All right. Please you could take that on notice too. The last question: have you received feedback from employers as to the success of nurses re-entering the workforce? Has there been any follow-up in that respect?

Mr Groth—I will take it on notice and get onto it.

Senator ADAMS—All right. Thank you very much.

Senator CROSSIN—I might ask a question. Tell me if this is the right place to actually ask a question about your new retention payments for remoteness. Is that related to your workforce?

Ms Halton—While the parade is changing, can I just go to Senator Fifield's question about continence?

CHAIR—That was a question on notice this morning.

Ms Halton—The advice from the officers is that we do not actually get it down to the level of the individual. We get quarterly figures which are aggregate; we do not get the line by line figures. We are happy to go back to the provider and see whether they are prepared to give us anything, but certainly we will not be able to do anything more on that today.

[6.15 pm]

Senator CROSSIN—General Practice Rural Incentives Program is, as I understand it, the budget initiative relating to the rural incentive payments. Is that what it is now known as?

Mr Dennis—It is the General Practitioner Rural Incentive Program. Could that be correct? It has two components. It is part of the new budget initiatives. One component is a relocation component. The other is the retention component, and I believe you are referring to the retention component.

Senator CROSSIN—Both aspects. My reading of this is that it replaces the old RRMA classification scheme. Is that right?

Mr Dennis—No, it is actually an amalgamation of two programs. The program is currently, and was previously, known as the Rural Retention Program and there is a similar device for registrars. The RRMA vehicle that you talked about is a geographical classification system that was previously, and remains currently, in use and it is used to determine the eligibility for particular workforce incentive programs, including all the programs that we are talking about.

Senator CROSSIN—Just let me get this right then. The RRMA system still exists in relation to incentives?

Mr Dennis—Incentive programs.

Senator CROSSIN—I question whether they are incentives, but programs that GPs can actually access around the country. Is that right?

Mr Dennis—It does at the present time. It is planned that the RRMA system will be replaced by a new geographical classification system in July 2010 and from that point

onwards the majority of workforce incentive programs will have their eligibility determined by that new geographical classification system.

Senator CROSSIN—Currently, if I am doctor located in Darwin and Palmerston, I am still classified as RRMA 1?

Mr Dennis—Correct.

Senator CROSSIN—And I am still eligible, though, to apply for those incentives? I do not get them automatically but I can still apply for incentives. Is that correct?

Mr Dennis—Each program or each incentive has a different set of eligibility criteria. As a RRMA 1, Darwin is eligible—doctors practising in RRMA 1s, including Darwin, are not eligible for a great many of those incentive programs.

Senator CROSSIN—But they are eligible to apply?

Mr Dennis—Anyone can apply but they are unlikely to receive funding or grants as a result of the fact that most eligibility for rural programs is generally considered to be RRMA 3 to 7 and the RRMA 3—

Senator CROSSIN—You would automatically get, or may not get automatically get, but you have the right to apply. Is that right? I thought there had been some tweaking of the RRMA eligibility for urban places like Darwin and Palmerston in the Northern Territory to allow them to actually apply.

Mr Dennis—What you may be referring to is that under the current situation—under RRMA—Darwin is a RRMA 1 and hence doctors practising there are not eligible for very much at all because it is considered to be a capital city. Under the new system, ASGCRA remoteness area, which is the new geographical classification system that we will be moving to in July 2010, Darwin is considered to be what is called a remoteness area level 3, which means that doctors practising from that area will be eligible for a much broader range of incentives, and the effect of this is, of course, to encourage doctors to practise in Darwin and remote areas generally and retain them there once they arrive there.

Senator CROSSIN—You will be moving to that system on 1 July next year?

Mr Dennis—That is correct.

Senator CROSSIN—It does not just apply to Darwin, though, does it?

Mr Dennis—No.

Senator CROSSIN—It applies to—

Ms Bennett—Across Australia.

Senator CROSSIN—a range of places across Australia that will be classified as an area 3, 4, 5, 6, 7, is it not?

Mr Dennis—RRMA has seven categories. That will be a thing of the past. The remoteness area classification system has five and it will relate to the entire land mass of the country. So all of the land mass of Australia will be reclassified into one of those five remoteness classifications.

Senator CROSSIN—Have you got an idea of what area would be an area 5?

Mr Dennis—Yes. Area 5 is the most remote of localities. Do you mean some towns?

Senator CROSSIN—Yes. I want you to give me a place and tell me what will I get under this new scheme if I were a doctor in Sydney and I wanted to move there.

Mr Dennis—Wilcannia, for instance, in New South Wales is an RA5. If you move from inner suburban Sydney to Wilcannia, you will receive in the first instance a relocation grant of $120,000 to do that. And, of course, there are certain conditions and qualifying periods, but assuming that you are eligible you will receive $120,000.

If you remain in that RA5 area, in the first six months you will receive a retention payment of $8,000, and the second one at the end of your first year. After that year you will receive $13,000. In your second full year in the RA5 you will receive $18,000 as a retention bonus; in years 3 and 4, $27,000, ultimately rising to $47,000 in your fifth and subsequent years.

Senator CROSSIN—If I am moving to an area 3, what are the comparable figures there?

Mr Dennis—Again, from a suburban area in Sydney or inner-metro Sydney, in the first six months you will receive $4,000; after your first year of service, $6,000, rising to $8,000 in the second year. In years 3 and 4 you will receive $13,000, and again in year 5 and the years thereafter you will receive an annual retention payment of $18,000.

Senator CROSSIN—Do I get a relocation allowance on top of that as well?

Mr Dennis—Yes, you do. In the first instance you mentioned, going from inner suburban Sydney, which is what we call an RA1, to an RA5, you will receive $120,000. I think I mentioned that. In the second example, from a major city to an outer regional or RA3, you receive $30,000 in relocation grant.

Senator RYAN—May I ask one very quick question about those numbers? Excuse me for my ignorance. Are they taxable, those payments?

Mr Dennis—Yes, they are all taxable.

Senator CROSSIN—If you are moving to an area 3, will you still be entitled to apply for other incentives, like to get your office computerised and training for your nurses? Will they still apply?

Mr Dennis—I am not familiar with the office measure that you have spoken of, but there are a range of workforce incentives that are geographically based and you will be entitled to apply and receive all of those that are relevant to your particular situation so that—

Senator CROSSIN—Are they going to move? If they are currently under the RRMA system, will they move to line up with the new geographical system you are going to introduce?

Mr Dennis—The vast majority will be moving on the date I mentioned, 1 July 2010. The vast majority of those workforce incentive programs will transition to ASGCRA on that date.

Senator CROSSIN—How will you advertise this in the capital cities? What are you going to do to get the message out?

Mr Dennis—Over the next 12 months—within the budget of some of these initiatives provision has been made for communication strategies, advertising, targeted advertising

campaigns to reach the particular target audiences that we are aiming for. And, of course, those are not just in inner suburban areas or major capital cities. There are relocation grants that are available for doctors to move from regional or rural centres to more remote centres also. In relation to the initiative that you have expressed interest in this evening, all doctors are eligible to receive a grant under that particular program by moving to a more remote area than they are currently practising in.

Senator CROSSIN—Have you got an idea of how many doctors this might move around the country into rural and remote areas?

Mr Dennis—Yes, we have a series of projections that our costings are based on.

Senator CROSSIN—What are they?

Mr Dennis—Was there a particular area of interest?

Senator CROSSIN—I am assuming you are hoping that, within one or five years of this new measure, so many doctors from the capital city belt will have moved.

Mr Dennis—Yes. Let me provide you with an example and then you can, perhaps, continue from there. And, remember, these are the basis for our costing, so these are our costing projections. In the first year of function of the program, which will be, as I said, July 2010 to July 2011, we anticipate that the number of those inner suburban RA1 doctors moving to RA2, which is a regional centre, will be 30. The number moving to RA3 localities will be 15. The number moving to RA4, which is a remote locality, will be 10. And we anticipate that five will make the transition from inner metro to remote areas, which is RA5. That is in the first year of operation, and that is moving from that inner metro area to those various rural localities.

Senator CROSSIN—I see. I would have thought it might have been more than that, but I suppose you are just aiming for a low baseline and some measure of success, I guess, to start with.

Mr Dennis—I hope you are correct. It is one of those instances where I would be pleased to be proved wrong. I hope you are correct and many more take up the opportunity.

Senator CROSSIN—What is the AMAs view about this? I have not seen anything publicly. Have they expressed a view about it?

Mr Dennis—Yes, they certainly have. I guess their view would be best categorised as one which is shared by the RDAA, the Rural Doctors Association of Australia, and that is that, in general, they endorse the sentiment and the principle that underpins not just the budget measure that you have inquired about but the entire package.

Ms Halton—Senator Boyce, you asked about ECT in Queensland—for which age group?

Senator BOYCE—Yes. I was specifically interested in its use for under-14-year-olds in Queensland, but other information you can give me would be useful as well.

Senator CORMANN—Just table all the papers that you have got.

Ms Halton—Essentially, what I can tell you is that in Queensland in 2006, 2007 and 2008 there were no benefits paid for ECT—so therefore it is a private procedure; it is not a public procedure. I cannot tell you about public procedures for anyone under the age of 16.

Senator BOYCE—Okay.

Ms Halton—There was a very small amount paid for the age group 16 to 18. It is not disaggregated below that. Those amounts were: for 2006, $9,885; for 2007, $2,899; and for 2008, $3,887.

Senator BOYCE—Do we have any sense of how many treatments that is?

Ms Halton—No, I could not tell you that. But what I can tell you is those numbers were for two things: item 14224 and an anaesthetic item, which is 20104. So you can probably work it out just by looking to see what the benefit levels are for those two items.

CHAIR—Senator Cormann has one last question under this area, and then we are going to close off outcome 12.

Senator CORMANN—Does the department recognised osteopaths as allied health professionals?

Mr Groth—Yes, they do. Osteopaths are recognised as allied health professionals.

Senator CORMANN—The reason I am asking is because the osteopathic profession has expressed a concern that they never seem to be referred to in any of the reviews of health policy in terms of the contribution the profession can make to preventative and primary health care; and there have been a number of these reviews in recent times. I guess the question is: why are they not included in these things?

Mr Groth—There are a great number of allied health professionals, and quite often there are examples given to give people an indication without giving a fulsome list of everyone in it. There are, I think—

Senator CORMANN—It is a five-year degree with very specific qualifications.

Mr Groth—I am not suggesting that the failure to mention them in every case—

Senator CORMANN—Or involve them.

Mr Groth—specifically indicates anything anti them. What I would put forward, though, is that osteopaths are actually being recognised and considered in the national registration and accreditation system, which is, I think, a fair recognition. The other thing I would mention—and I have not looked through every report—is that I would probably dispute the assertion that they are never mentioned at all.

Senator CORMANN—Not my words.

Mr Groth—I know that in the glossary of terms about the rural workforce report they are specifically mentioned as allied health professionals. I have not been through every report, but I certainly take the point that maybe the example needs to be made more often.

Senator CORMANN—Can you, perhaps, on notice, just give me a list of all of the reviews and reports where they have been mentioned in the last three years?

Ms Halton—In all seriousness, let us cut to the chase here. If they are feeling a fraction unloved and they want to talk to us, we would be delighted, but in an environment—

Senator CORMANN—If we do a deal and you look after them for a while then I might not put on notice the question that I have just flagged.

Ms Halton—But you understand my point?

Senator CORMANN—I will just make a specific reference. There are the NHHRC preventative health and primary health care reports that have been commissioned by the minister. In all of them they feel that they could have made a valuable contribution. They make the point that they have made representations to be heard and did not feel—

Ms Halton—Did they make a submission?

Senator CORMANN—They say they did; they say they have written. I will just make that point.

Ms Halton—Yes.

Senator CORMANN—And if that point is not made, you can take it on board and then—

Ms Halton—The point is made.

Senator CORMANN—Thank you very much.

CHAIR—Thank you. That completes that outcome. In the period after dinner, because of the interest, we are going to have time limits for each of the areas. I will let you know at the beginning of the period what the time limit is, and then when the time is finished that item will be finished. Thank you. Pharmaceuticals, outcome 2 is next, so we will start on that when we come back.

Proceedings suspended from 6.33 pm to 7.31 pm

CHAIR—We are going to recommence in outcome 2. As I have said, I have time limits for each of the items, and the first one is for outcome 2: it is going to go for an hour, so at half past eight we will end. Senator Cormann is kicking off.

Senator CORMANN—Thank you very much, Madam Chair. Mr Dellar, this will be the third estimates in which I have asked you questions about what the government describes as 'more efficient' arrangements for the payment of benefits for chemotherapy drugs but which essentially are nothing more than a $100 million budget cut to chemotherapy services. In October you said it was still a way off because it was supposed to start on 1 July. In February you told us that you were still waiting for feedback from your consultations.

Mr Dellar—Yes.

Senator CORMANN—In these estimates now, we know that it has been delayed by two months, presumably because it all turned out to be more difficult and complex than you thought. Is that right?

Mr Dellar—We got lots of feedback. I said in February that we were still waiting for feedback from people. We had invited comments on a paper that we had written. A number of issues have been raised with us. In terms of the measure, there are quite a few things that we have done to respond to feedback that we have received, but there are some matters outstanding. So the minister has asked us to take a little extra time to talk to the people that are involved, or will be involved, in the measure and ensure that, when we implement this measure, we get it right.

Senator CORMANN—What have you done and what are the matters outstanding?

Mr Dellar—To date—and I will get my colleague here to help me—we have made some adjustments to the way copayments work. I think I indicated this was coming in the February discussions. The important feature of that is that patients who are undergoing chemotherapy should pay no more for their chemotherapy services than they do currently. So we have an arrangement whereby the payments on repeat prescriptions will be suppressed. The current arrangement is that you will pay for one prescription per month. With the new arrangements, you will still pay for one prescription per month at either the concessional copayment level or the general level, depending on your circumstances.

Linked to that is a measure we have agreed to implement to assist clinicians. Clinicians were concerned that the move from monthly prescriptions to prescriptions based on infusions would lead to a lot of extra work. To mitigate that, we have reviewed, with the help of the PBAC, both the dispensed maximum quantities, which are the limits of a prescription that can be written without special authority, and increased the number of prescription repeats that can be arranged for a particular measure. Those two things, taken together, mean that there is no net increase in workload for a clinician.

In addition to that, we have reviewed the medicines which are within the measure and we have renewed the number where the life cycle or the volume of the medicine is such that it is not possible to avoid wastage and, for those medicines which are within the measure still, we have in some cases identified wastage factors. We accept and recognise that there can be some wastage in relation to the measure.

Could I go back a step and explain why there is a measure here and what it is we are trying to do. I need to draw you a picture of how a prescription is developed and written. The parallel is the kind of script you get. If you go to a doctor and they issue a script, you take your script down to the chemist and you get it filled, and it is a very simple, straightforward transaction. With this arrangement, it is different because these drugs are dangerous and we do not let people go to a local pharmacy and pick them up and then take them to their clinician for infusion.

What happens currently is that a clinician will write a script for a month's supply. Typically it will look like this: 10 vials of X, six vials of Y, four vials of Z. Then the person receiving infusions will come from time to time to their clinician for their infusion. Exactly how often they come and exactly what is done to them varies from condition to condition. What the clinician will do on or about the time the person presents for an infusion—and it varies from place to place—is check the body surface area of the patient, look at their condition, check the blood tests, which will have been done either on that day or earlier in the week, and order the actual infusion. The pharmacist then will make that up and either on the same day or within a day or two it will be infused into the patient.

The important point is that 10 vials might have been ordered but the vials delivered to the patient will vary. It might well be that, in relation to an individual patient, only eight vials will be given to the patient, so that is one source of the wastage which occurs.

Senator CORMANN—You used the word 'wastage', but it is essentially the part that you can no longer use, because it is an extremely volatile drug which you need to use within a very short time frame and unless you have enough volume you will not be able to use it

within a very short time frame. It is not wastage so much; it is a proportion of the chemotherapy drug that you are no longer going to be able to use. That is an inefficiency, for sure. The question is whether that is an inefficiency you can avoid and whether what you are proposing to do through this measure is the best way of doing it.

The specific question I have in relation to this is: if the vial size is not appropriate, why wouldn't we be approaching the suppliers of the vials to deliver smaller vials rather than going through this whole process? It is going to penalise somebody. I hear what you are saying about wanting to protect patients, but if you are going to save $100 million this way, somebody is going to pay. If you are going to do it so that patients are not out of pocket, then what you are saying is that the pharmacist has to cop it on the chin somewhere along the way. If you are going to take $100 million out of the system—you call it wastage, but it is part of the drug that has been provided that can no longer be used and that is going to be charged for by the supplier—somebody has got to pay the cost of that.

Mr Dellar—What I am trying to say is that, within this system, there are disconnects. A prescription is, for example, for 10 vials—

Senator CORMANN—I understand that.

Mr Dellar—and not in every case are 10 vials used.

Senator CORMANN—I understand that.

Mr Dellar—I am not talking about—

Senator CORMANN—I asked a specific question about the size of the vials. Why wouldn't we go to the pharmaceutical manufacturer, the people that supply them in the first place, to ask them for smaller sized vials so that there is not such a large proportion of the drug that is not able to be used?

Mr Dellar—I will answer the question. We have talked to a number of companies about the size of vials. A number of companies in relation to the medicines produce a range of vial sizes, so that it is possible to collect one of these, one of these and one of these and get very close to the dose that that particular patient requires. Other companies have been less willing to provide vial sizes which vary from the ones they currently provide. What they consistently explain to us is that we purchase around two per cent of their sales across the world and that, while we might have our needs, there are other needs and, generally speaking, Australia's particular concerns about the vial sizes are not taken into account.

Senator CORMANN—So it is too hard to go to the big pharma companies. We have tried that, and we cannot do it because—

Mr Dellar—I could not say that we have had no success in that regard. We have just had limited success in that regard.

Senator CORMANN—Last year in the budget papers you were planning to save $105.4 million from this measure. You have taken $5.4 million out in the budget papers and now it is $100 million.

Mr Dellar—Essentially correct.

Senator CORMANN—Is that because in two months that is $5.4 million?

Mr Dellar—That is a very simple calculation. That is the cost of two months delay.

Senator CORMANN—Is that right? So you have taken two months out—that is $5.4 million—but you are still expecting to save $100 million. But you have removed some drugs from the applicability of this particular savings measure. How come you are still expecting to save $100 million?

Mr Dellar—We always had room within the measure to tune the measure to meet the needs of delivering this service.

Senator CORMANN—So you overestimated.

Mr Dellar—No, we did not overestimate. At the very outset we knew that we would make some adjustments to the nature and details of the vials that would be used and how they would be used and the medicines that would be involved. We have done that consultation and we have eliminated those things where we think the measure cannot work. What is left is still on track to deliver—

Senator CORMANN—What sort of modelling have you done to come up with the $100 million saving over the forward estimates?

Mr Dellar—It relates to the volumes that are used, the size of those vials, the size of dose and the difference between those things.

Senator CORMANN—Where will that $100 million come from?

Mr Dellar—It comes from not paying for vials which are not provided to a patient, or parts of a vial not provided to a patient.

Senator CORMANN—Who is going to pay for the parts of the vial from an open vial that has been used and cannot be used anymore, because within a certain number of hours it is no longer usable? How many hours? Is it 48 hours or something? Less?

Mr Dellar—That is not a simple question. Can I go back?

Senator CORMANN—I have heard that a lot today, but can you give me a rough answer. Are we talking 24 hours, 12 hours?

Mr Dellar—The proposal that we have does not involve opening a vial, using part of it, putting the rest in the fridge and pulling it out a day or two later. What a chemotherapy provider who makes up infusions does—and this occurs in small services and larger services—is have an array of patients who, for example, are going to have chemotherapy for breast cancer using Herceptin, or trastuzumab. They will make up the infusion for person 1 and then they will make it up for person 2 and so on. The vial they need is the next vial they take off the shelf. They do not throw the remnants of vial 2 away—

Senator CORMANN—No, I understand that. I am not using all the technical lingo, but I think you know what I mean. Obviously the amount of the drug that you are going to use is going to depend on body weight and a series of variables, so with some patients you use more and with some patients you use less. If you have got 10, 12, 20, 100 or however many patients and you can spread it around, then you are clearly going to have less wastage, as you would call it, or fewer drugs left over that you cannot use.

Mr Dellar—That is correct.

Senator CORMANN—I understand that. But you have got this initiative in the budget to create 11 regional cancer centres around Australia.

Mr Dellar—Yes.

Senator CORMANN—Presumably in those cancer centres the idea would be for patients to be able to access this sort of treatment. How are they going to have the volume that would make it efficient and that would allow you to achieve your savings the way you want to achieve them?

Mr Dellar—I have looked at the way in which vials are used in the country right now and I can say that most cancer treatments do occur in capital cities and larger regional centres.

Senator CORMANN—But the government wants to change it by having 11 regional cancer centres. Are you saying they are not going to provide treatment?

Mr Dellar—No, I am not saying that at all, but a regional cancer centre presumably would have a volume of people coming through and it is very likely that they will be able to achieve efficiencies in the use of their vials. Remember that I am saying that some vials are never opened in relation to the treatment of a person. Some vials are opened and partly used and at the end of a chain of creating infusions there might be something left over in the last vial for the last person. We have allowed some wastage in this equation.

Senator CORMANN—I do not find that very convincing. Let us go to the consultation side of it. You would not be surprised to hear that I have been approached from various stakeholders that have an interest in this. I have been told invariably that there has not been any consultation until very recently with oncologists or patient groups or pharmacists, both from the public or private sector. You were talking to us about consultation when we met in February. Who exactly did you consult with in January-February?

Ms Campion—We have been consulting with stakeholders since the measure was announced.

Senator CORMANN—Can you give me, perhaps on notice if it is too complicated—

Ms Campion—We have got a very comprehensive table here showing who the stakeholders are and when they were consulted. Several of them we have consulted on multiple occasions.

Senator CORMANN—Do not read back the list that you read out in October. I am interested in the people that you have consulted with this year.

Ms Campion—This year?

Senator CORMANN—Because the other one is already on the record.

Ms Campion—Would you like it on notice? It might take me a while to read it out.

Senator CORMANN—Tell me: do they include pharmacists, patient groups, oncologists? I have been led to believe that you have been talking to approved software suppliers and companies, but not with the healthcare professionals that are involved with this at the coalface. Can you tell me that some of the people that you have talked to in January-February are people that are involved at the coalface?

Ms Campion—Yes. We sent an information document out to people explaining how the measure would work and invited their comments back and we have been working our way through those comments. Some of those comments resulted in the amendments that Mr Dellar just mentioned. Since then we have been going around talking to a range of different groups and they do represent the people that you just mentioned, including private pharmacists—

Senator CORMANN—When did you speak to the private pharmacists?

Ms Campion—During May—in the last couple of weeks.

Senator CORMANN—During May. Recently.

Ms Campion—That is the most recent.

Senator CORMANN—That would qualify as recently, wouldn't it?

Ms Campion—You did ask about what we have done since February.

Senator CORMANN—Yes.

Ms Campion—More recently, we have been around and spoken to pharmacists who are providing these services.

Senator CORMANN—But this measure was in the budget this time last year, 12 months ago. We talked about this in October and in February and I was led to believe that there was all this consultation with people that were affected. You are now telling me that you talked to these people in May. You would be aware that there was quite a historic gathering recently of concerned stakeholders at the Cancer Council of Victoria offices to discuss this measure. Are you aware of that?

Mr Dellar—We were there. Yes.

Senator CORMANN—Present were patients, patient advocacy support groups, specialist doctors, private hospitals, community and hospital pharmacists, as well as pharmaceutical manufacturers, wholesalers and, interestingly, third-party compounders. That is quite an interesting mix of people. The release they put out said:

If this budget cut is implemented it will undermine the provision in both public and private sectors of timely, affordable and equitable treatment to cancer sufferers.

What is your comment on that?

Mr Dellar—Can I start by saying that it would be important not to leave you with the view that that was the first time we had seen those people. That was the first time we had seen those people as a group, but I do not know that there was anyone in the organisations represented in that room who had not been talked to at some point over the previous months.

Senator CORMANN—When you say 'talked to', could you define that for me? Was it, 'This is our proposal. We want to hear from you how this could work. What are your thoughts on this?'

Mr Dellar—There have been three distinct phases in the rollout of this measure. There was an early phase when the measure was first announced, there was a period up until February, when we issued a paper, and there has been a period since February when we have been

consulting on some details which were put on the paper and which go to some of the things I detailed at the beginning.

Senator CORMANN—I am going to ask you a very direct and very specific question. There was this community meeting in Melbourne on 7 May. A communique was put out. The advice I have got is that the first time you consulted with the people that I listed—like pharmacists, patient groups, oncologists et cetera—was on 9 May, two days after the communique was put out. I am told that you never had any formal consultations with any of these groups before, that the people that you spoke to were approved software providers. Can you clear this up for me once and for all. Is it true to say that 9 May was the first time, after all these people put out their communiques, that you properly sat down with them to talk through the implications of this measure and how it would work in practice?

Mr Dellar—What I have said is that that was the first time we sat down with that whole group in one room, but we had had a whole series of meetings with all of the sorts of people who were in that room over a period of eight or nine months up until 8 or 9 May.

Senator CORMANN—How will you ensure that this measure will not result in an increase in co-payments to patients? How will you achieve that?

Mr Dellar—There is legislation which regulates co-payments to patients.

Senator CORMANN—So who is going to have to carry the cost of the unusable portion of those vials?

Mr Dellar—Go back to the question—

Senator CORMANN—You said the manufacturers were too hard because they cannot really worry too much about Australia. What is our percentage of the world population?

Mr Dellar—Two.

Senator CORMANN—Two per cent. So the manufacturers are too hard. We cannot force them to do it. Obviously there would be a major outcry which would cause considerable political pain and it would be absolutely outrageous if the government did anything that would hurt patients. So who is the weak link that is going to be left holding the baby and who is going to have to fund the $100 million budget cut?

Mr Dellar—Can I make two points. If we pay for a vial of medicine for a patient, our expectation is that that vial of medicine is used for that patient. That is not always the case.

Senator CORMANN—So who carries the risk? It is hardly the pharmacist's fault if somebody's body weight is lower or higher, such that not the whole proportion of the medicine that is supplied is going to be usable.

Mr Dellar—It is not just a portion of the vial; it is also in some cases an entire vial. It is both of those things.

Senator CORMANN—That is an interesting point. If it is both of these cases, what proportion of the $100 million saving or budget cut applies to being more efficient about whole vials? Because there is a proportion of the vial that has been opened for a particular patient and can no longer be used because of the volatility of the drug.

Mr Dellar—I wish we had some data on that but we do not. All we see in the department is a claim for a completed prescription. That is data we get through Medicare Australia. We have a better understanding of how this works through the consultations we have had but we do not have the data you have just asked for.

Senator CORMANN—But you are still not able to answer the question as to who will pay the cost of the unused proportion of those chemotherapy drugs? I note that according to the TGA unusable amounts of chemotherapy drugs are not permitted to be stored—not only that but the amount left in the vial must be dispensed with immediately or within hours. How are you going to make this more efficient unless you have sufficient volumes? I congratulate the government on the initiative of regional cancer centres around Australia but, once you roll this out, I put it to you that you will not be able to prevent unusable portions of those drugs. It is practically impossible.

Mr Dellar—There is some level of wastage or non use—

Senator CORMANN—'Non use' is a much better term!

Mr Dellar—that is associated with the business of taking parts of medicines out of a vial and using parts of those medicines for individual people, but there are efficiencies which are already in practice. I need to emphasise this. I have seen chemotherapy being made up and I have seen the pharmacists doing it using vial No. 2 for patient No. 3 and essentially not using a new vial every single time a vial needs to be used to prepare an infusion for a patient.

Can I just make another point, which is that this measure is designed to allow drugs to be used more efficiently. A consequence of that is that a drug can be more cost effective. We have a live example of a medicine, Avastin, which will be listed on 1 July. The cost of Avastin has been based on that drug being able to be delivered, in due course, on a per milligram basis. That means that Avastin will be listed and will become available to people in Australia because, precisely because, we have this measure which enables more efficient use of that medicine.

Senator CORMANN—Mr Dellar, are you aware of statements from the state government in Victoria, and I just quote them to you: 'The cost of this initiative to Victorian public hospitals is around $4.5 million a year. The budget initiative plans to strip over 10 per cent of the PBS reimbursement from the subsidy of drugs. Private pharmacy services and smaller regional hospitals may withdraw services either totally or cherry-pick PBS items where profits can continue to be made. Rather than supporting a patient-centric chemotherapy treatment model this policy has the potential to push treatment back into metropolitan hospitals.' Is that what you want?

Ms Halton—Where was that statement from?

Senator CORMANN—It is from Pharma in Focus, 25 May, and it is quoting Michael Furey, Manager, Blood and Pharmaceutical Programs, Victorian Department of Human Services. I am happy to table this for you.

Mr Dellar—I have met with Mr Furey once, and others of my staff have met him on other occasions—

Senator CORMANN—That is a pretty damning assessment for a public—

Mr Dellar—Senator, it is not true.

CHAIR—Senator Cormann, let Mr Dellar answer the question.

Mr Dellar—If I did the maths that underpin that document in the same way, I would come up with the same number. That is, if I said that the savings measure is $100 million over three years, and my percentage of chemotherapy service delivery across the nation is X per cent, therefore the amount of money I need to absorb is X dollars, I will come up with a number around $4 million, which is the number they have come up with. That assumes that in some way we do not take account of the needs of the way different things operate.

Our judgment is that in the case of Victoria the amount of money that is accrued is very small—and it is still omitting a really important point: we are not talking about taking money out of the system and delivering nothing in return; we are talking about money that is used to purchased vials for infusions. If the system is such that things are wasted that do not need to be wasted, then that should not be the case. Genuine waste and lack of efficiency is the focus.

Senator CORMANN—So now you have got a pharmacist who is providing however many vials are needed for a particular patient and, given the body weight, there is a vial that is opened and there is a proportion of the vial that is left unused. What do you expect that pharmacist to do with the unused portion of that vial?

Mr Dellar—I accept that in some cases there will be leftovers that cannot be used. In many cases already that material is being used for subsequent infusions.

Senator CORMANN—But we have already established that TGA actually forbids it to be stored. It has to be dispensed with within hours. You have told me that there is some wastage, as you call it, of complete vials and where there is an unusable proportion left. But you cannot tell me, out of the $100 million budget cut, how much of it is applied to which sort of wastage, so you do not actually know to what extent the measure will apply to unusable proportions and to what extent it will apply to complete vials. How can you tell me, hand on heart, that you are not going to put the pharmacist in a position where he essentially has to pick up the cost for the unusable proportion of the vial that he is required by law to dispose of?

Mr Dellar—Can I perhaps take that last point first, because you are talking about the safe use of medicines which come in vials. TGA have rules around that and they do forbid something which is called reuse. Reuse is the process—I think, metaphorical—of putting the cork back in the bottle and taking it out of the fridge a day or two later. Multiuse is the process of having a production of infusions and producing infusion 1, then infusion 2 and infusion 3 and using successive vials as they are needed. There is nothing in the TGA rules that prevents multiuse.

Senator CORMANN—No, as long as you have enough volume. If you do not have enough volume, then you cannot do it. I am putting it to you again that, if the government goes ahead with its very commendable initiative of rolling out regional cancer centres, you will have more challenges in terms of unusable proportions of vials, not fewer. There seems to be a bit of inconsistency. Can you just confirm for me that the first time that you formally consulted with patient groups was on 27 May—a week ago?

Ms Campion—You are probably referring to Cancer Voices?

Senator CORMANN—That is right.

Ms Campion—We did meet with them on 27 May but we have had previous discussions with Cancer Voices about the measure.

Senator CORMANN—When you say 'discussions', can you define for me what that means?

Ms Campion—We have met with them and we have explained the measure to them. They have explained to us their concerns about the measure and we have recorded those concerns and incorporated them into both our further analysis of the measure and the more general feedback that we have had about the measure.

Senator CORMANN—I appreciate that you are saying patients are not going to be faced with increases out of pocket, but there is a key concern—and I hope you are taking this seriously—that this budget measure is going to lead to the closure of peak pharmacies and private oncology clinics, that we are going to end up with two major compounders who are based in Sydney providing the service and the particular product, which has to be delivered within 48 hours across Australia. We not only want those services provided into Sydney or Melbourne but also into Hobart, Karratha, Perth, Bunbury—regional centres. If you are going to end up with two providers who are going to have to supply the whole Australian market, how are you going to make sure that you can distribute this particular drug effectively, that there is still going to be timely access to affordable and quality chemotherapy treatment?

Mr Dellar—As best I can see, a lot of the regional centres are already using third-party providers, but as I said, I think in the last hearing or it might have been the one before, there is nothing in this measure that implies or suggests that we have a view that there should only be two third-party infusion providers in the country. There are a number of people who make up infusions. A lot of public hospitals do it themselves. A number of private hospitals either do it themselves or have a nearby pharmacist who does it for them. It is not clear to me that this measure drives them out of business at all.

Senator CORMANN—I am not going to go through the whole argument again that we raised in October, and I refer you to it. You know the capital investment and the difficulties involved in setting these things up. You have just made it much more expensive for the supplier at the coalface to do it, because you are looking after the big pharmaceutical companies—and you are looking after the patients. But the people that are there to provide the service are going to be the ones that get squeezed, and I put it to you that those business opportunities, if you look at the financials, are not going to be there and it is going to have an impact on the quantity and supply of services. It is not going to be a good thing, and you can hardly accuse the Victorian state government of making a political point. I am sure that that is a very sincere expression of a concern that a public hospital has about what the impact of this measure is going to be.

CHAIR—Senator Cormann, I want to go to another senator so that this hour can be shared. How many more questions do you have?

Senator CORMANN—I am happy to pass on to some other senator and perhaps come in again.

Senator ADAMS—Mr Dellar, you spoke about Avastin coming on. It has been listed on 1 July 2009. When was that first approved by the PBAC?

Mr Dellar—The PBAC makes recommendations to the minister about the listing of new drugs. That recommendation was in July last year—July 2008.

Senator ADAMS—Can you tell me why it took so long for it to come forward?

Mr Dellar—There are many reasons; many things happen after a recommendation. A recommendation is just that: it is not a decision. The sorts of processes that occur following a recommendation with a drug of this sort are that the recommendation has to go to the Pharmaceutical Benefits Pricing Authority, which occurs six weeks—always six weeks—after the PBAC recommendation. There will have been negotiations with the company. That will have involved quite significant discussions about the number of patients and the nature of those patients; the development of the restriction, which is the description of who can use this medicine and under what circumstance; the agreement about the total cost; and the negotiation of and agreement on a deed of agreement containing risk-sharing arrangements which ensure that the rules around how this thing is to be paid for are clearly understood between the parties and established.

When all of that is largely complete, it would then go to government and, because this is a drug of more than $10 million in any one year, the longstanding convention is that cabinet consider that, and that requires the preparation of a cabinet matter and a consideration by cabinet. All of those processes certainly took some time. I would say that 12 months is perhaps a little longer than it has been in recent times, but when I look at the length of time it has taken for various drugs I see it is within a normative time frame.

Senator ADAMS—I thought 12 months was rather a long time as well. Thank you for explaining that. I would like to talk about some of the off-licence drugs that are used in palliative care. As you are probably aware, a number of people with terminal cancer, with a pain threshold, can be treated at home. There are a number of drugs—they might be old-fashioned drugs—that are being used, but they are off-licence drugs. Why is there such a limitation—

Ms Halton—Senator, can I just ask you to clarify it so that I can be really clear. Are you talking about off-label use or off-patent?

Senator ADAMS—No. I have got here 'off-licence', which I would have thought was off-label, but I will tell you what the drugs are and then you might be able to clarify it for me.

Ms Halton—Yes, no worries.

Senator ADAMS—But my first question is: why is there such a limitation on palliative care drugs, including the chemotherapy drugs on the PBS, when some of them could cost as much as $50,000? These drugs are all for pain relief.

Mr Dellar—Just to answer in the abstract for a moment: a drug is listed on the PBS following an application by a sponsor to the Pharmaceutical Benefits Advisory Committee for listing. In practical terms, if it is a new drug with a high price tag, there is really in practice

only one party that could bring such an application and that is the manufacturer. They choose whether or not to bring drugs to the Australian market and at times they do it in a quick way and sometimes they do not. I cannot control that. But the moment we get an application it goes through a process, a process that is well understood by industry and has very strict time lines around it. You might be talking about medicines, therefore, that have never been brought to the PBAC. I cannot answer that in the abstract.

Senator ADAMS—One is lignocaine, which is a drug that is used for severe nerve pain in relation to cancer patients. My information is that there is a clear consensus, both nationally and internationally, that this drug is important in the treatment of severe nerve damage, and once stabilised the patient can return home. But why is it that drugs that will allow people to be comfortable while at home are not on the PBS? Lignocaine is one of them; others are ketamine, bupivacaine, midazolam, and gabapentin, as well as novel agents. None of these drugs are on the PBS. You have said that it is because the manufacturer has not applied, but is that correct?

Dr Primrose—For several years now, we have had a process through the Palliative Care Medicines Working Group to improve the access to palliative care medicines on the Pharmaceutical Benefits Scheme, and we actually have a palliative care medicines list on the Pharmaceutical Benefits Scheme that is tailored for people receiving palliative care. The progress on that is limited by really what the registration of the drug is, so you have hit the nail right on the head. These are old agents and most of them are quite inexpensive, but they do not have an approved indication for these particular applications in palliative care.

What we have done is to work with Flinders Medical Centre to get a systematic overview of the literature looking at the use of these drugs in palliative care, but there was not sufficient evidence from that systematic overview to change the registration status of these drugs. Subsequently, a program was put into place for funding primary research in this area, and that is being overseen by the Palliative Care Clinical Studies Collaborative, which is also run out of Flinders. They are running a number of trials—at least six—which include many of the agents that you have mentioned. Patients are being randomly allocated to these agents or to standard care to see what the benefit from these agents is. For some of them, there may well be no benefit, but of course it is important to show that, because all the drugs have side effects, and if you are not getting the benefit and suffering side effects there is no net advantage.

These trials have been set up in consultation with the TGA and also with members who advise the PBAC, so the data that is obtained will be useful for extending the registration of these drugs and later on for PBS listing. So we are trying to address this issue.

Senator ADAMS—Thank you very much.

CHAIR—Before we move on, Senator Adams, do you have any questions for Hearing Services?

Senator ADAMS—No, I do not.

CHAIR—On that basis, Ms Halton, with great apology, particularly to the officers from Hearing Services, my understanding is that the senator who had questions for Hearing Services has placed them on notice, and we have just been told. So to the Hearing Services

staff members I deeply apologise. We only found out just now, so I wanted to give you as much warning as possible. That will give us another 12 or 15 minutes on this item.

Senator SIEWERT—I want to follow up on the Fifth Community Pharmacy Agreement, which I asked about last time. When I was asking you previously, I raised the issue of stakeholder and community consultation as part of the negotiations for the next agreement, so I would like to ask for an update on that.

Mr Dellar—There is very little to report. We have continued to make ourselves available to talk to people who have views about the Fifth Community Pharmacy Agreement and what should be in it. I have had meetings with pharmacists' representatives; I have had meetings with wholesalers; I have had meetings with industry. They are not meetings that I have initiated. They are with people who have sought out the department and asked to come and see us. We have not yet engaged with the Pharmacy Guild on negotiations around the Fifth Community Pharmacy Agreement and we are not yet ready to embark on formal consultations.

Ms Halton—We do not have a mandate for this yet. We are very happy, if anyone wants to come and talk to us—in fact, several people have come to talk to me about it—but we do not yet have a mandate from government in this respect to negotiate with anybody.

Senator SIEWERT—Can you remind me when it expires?

Ms Halton—Mid next year.

Senator SIEWERT—That is what I thought. So basically you have got a year to do that?

Ms Halton—A fraction longer.

Senator SIEWERT—Yes, a year and a bit.

Ms Halton—Yes.

Senator SIEWERT—I have never seen a pharmacy agreement negotiated before.

Ms Halton—I have seen several, which is a bit regrettable—but keep going!

Senator SIEWERT—Is it usual that the government of the day gives you a mandate and lays out a process and a consultation process? Would that be normal?

Ms Halton—There is usually a mandate in respect of the position that the government wishes to propose, and that would inherently bring with it, depending on when the mandate is given, some implied time line. The issue about process is a matter for the individual government. The reality of these things is that they are becoming more mature as we go, which means some of those things are now more specified than perhaps they once were.

Senator SIEWERT—It would seem obvious to me that you would engage the broader stakeholder groups, health consumer groups, in any consultation process.

Ms Halton—It depends in which respect. There are a whole series of features of pharmacy agreements, some of which are germane to some particular parties more so than others, and obviously the key protagonist is the guild. But, yes, those are all matters that I have no doubt the government will turn its mind to.

Senator SIEWERT—I understand it when you say the key protagonist is the guild. But I thought the key thing here is providing medicines to the community, and I would have thought they were a key stakeholder.

Ms Halton—Yes, but there is a minor, modest issue of remuneration involved in all this.

Senator SIEWERT—Can you explain that a bit further?

Ms Halton—This is the basis of the remuneration of pharmacists for the dispensing.

Senator SIEWERT—That is what I thought you were meaning. I just wanted to make that clear.

Ms Halton—Yes, absolutely.

Senator SIEWERT—I appreciate that. There are also things that they do that consumers and members of the public would have pretty strong thoughts about.

Ms Halton—Indeed. We are very aware of that issue.

Senator SIEWERT—Would part of the negotiations be a review of the effectiveness of the current rate that is given for the dispensing of each prescription?

Ms Halton—The current which, sorry?

Senator SIEWERT—The current rate.

Ms Halton—Certainly. That is implicit.

Senator SIEWERT—So there would be a review of the effectiveness. I am not just talking about the current rate—$5.99, I think it is, isn't it?

Mr Dellar—That is the dispensing fee for—

Senator SIEWERT—The dispensing fee, yes. I presume that would be looked at against current costs and things, but I am talking about the actual effectiveness. Is this the best way to do this, or is the intention to try and improve what we have done in the past?

Ms Halton—Too early to tell.

Senator SIEWERT—Thanks. But there is a possibility that it could look at the review of the effectiveness of the way that it is operated at the moment?

Ms Halton—Certainly inside government there is no doubt there will be a very robust examination of this, and all of that will then flow into a dialogue, which will be with a number of stakeholders.

Senator SIEWERT—Thank you. Last time we also talked about the customer medicine information, CMI—yet another acronym. A day before we had the discussions last time, the survey came out on the effectiveness of that, and the number of pharmacists who actually gave information when they gave a prescription out was very low. It was about six per cent, something like that.

Mr Dellar—That is correct.

Senator SIEWERT—Has there been any action taken around that, or are you leaving it until the negotiations over the next one?

Ms Campion—We have not specifically taken any action on that issue that you raised last time, or in relation to that study, but certainly it will be something that is assessed or is part of the mix of the discussions about the future remuneration for pharmacists. As you may be aware, a component of that $5.99 that you referred to—10c—is paid to pharmacists for the—

Senator SIEWERT—Ten cents, yes.

Ms Campion—provision of those leaflets, so there will be some assessment of that as part of the next agreement, I suspect. As I mentioned last time, our focus primarily at the moment is looking at the effectiveness of those leaflets, what is in that information when it is provided to consumers, and whether the information needs improvement.

Senator SIEWERT—So there are two things there, aren't there—whether it is provided in the first place, and whether it is effective?

Ms Campion—Yes.

Senator SIEWERT—And you are undertaking studies of both of those, or you will?

Ms Campion—Not the former but, as I mentioned last time, we do have a research and development program under the agreement and part of that program is looking at the effectiveness of consumer medicines information and ways in which it could be improved.

Senator SIEWERT—And presumably—stating the obvious—that will then be fed into negotiations for the next one. Is the 10c flat? So the dispensing fee is $5.99 and the flat rate is 10c regardless.

Ms Campion—Yes, that is right. It is an averaging. So it is not assumed that a pharmacist will provide a CMI every time they dispense a medicine. It reflects an average of every 10 or 11 times approximately that they will give one out, because the recommendation is that one is provided when a consumer starts a new medicine or when a dose is changed.

Ms Halton—It changes.

Ms Campion—And that obviously does not happen every time they get the medicine.

Senator SIEWERT—So if I am on something once a month or whatever, there is no point in giving it out unless there is—

Mr Dellar—That is right.

Ms Campion—Unless it has changed.

Senator SIEWERT—Thank you. In the survey previously—and I will actually go back and double-check this—where they said the six per cent, I presume that means of people getting new medicines and things like that.

Ms Campion—Sorry, I do not recall. I suspect you are correct. I think it was of people who would be dependent—

Senator SIEWERT—Under the guidelines that are put there for pharmacists, for dispensing—

Ms Campion—Yes.

Senator SIEWERT—I have got a couple of questions in terms of some PBS arrangements that apply to Aboriginal people and Aboriginal communities. Should I wait and do that tomorrow, when we do health—

Mr Dellar—Why don't you try the question and we will see if we can answer it?

Senator SIEWERT—Okay. As I understand it, for the dispensing of medicines in Aboriginal communities, there is an additional payment of $3.62. Could you just explain that a little bit, because I must admit I am a little bit hazy about the payments involved in supply of, or dispensing—

Mr Dellar—That is not ringing bells with us. We do have an arrangement which enables medicines to be delivered to remote Aboriginal community controlled health services.

Senator SIEWERT—Yes.

Mr Dellar—It is a handling fee. Essentially what happens is that a remote pharmacy will service a number of community controlled health organisations, and they are paid a fee for that. It is not the same as a dispensing fee.

Senator SIEWERT—Sorry, that is where I am getting confused.

Mr Dellar—Is that what you are talking about?

Senator SIEWERT—That is what I am after, yes. That is where I am getting confused. So the pharmacists dispense it to the Aboriginal controlled health organisations.

Mr Dellar—That is correct.

Senator SIEWERT—So what fee is there then for a pharmacist dispensing to the Aboriginal health organisations?

Mr Dellar—There is a budget issue in relation to this.

Senator SIEWERT—Yes, I thought that there was.

Mr Dellar—The amount of money that has been in use for some time is $1.14 per script. In this budget it will increase to $2.69 per script, and that will be with effect from 1 January this year, so it has a retrospective effect.

Senator SIEWERT—And that goes to the pharmacist?

Mr Dellar—That goes to the pharmacist.

Senator SIEWERT—Do the Aboriginal health organisations then get a dispensing fee?

Mr Dellar—There is another program, which is the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander communities program.

Senator SIEWERT—Yes.

Mr Dellar—That is a program to support the quality use of medicines in areas such as this.

Ms Campion—I just need to make a distinction between the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander communities program and the previous program that you were talking about. The previous program, with the $2.69 handling fee, is only in remote communities—

Senator SIEWERT—Yes, I understand that.

Ms Campion—whereas the Quality Use of Medicines program that Mr Dellar just referred to is in non-remote communities, so it is in metropolitan and regional rural areas, but not in remote.

Senator SIEWERT—I will come back to that one. What happens once the medicines have been dispensed to the Aboriginal community health organisations? What happens from there? Do they, just as part of their work, then dispense the medicines?

Mr Dellar—Essentially that is correct. The difference is that the normal model is that you get a prescription and you go to your pharmacist and you get it filled. In a lot of these places there is no pharmacist down the road.

Senator SIEWERT—I am totally aware of that, yes.

Mr Dellar—Yes. The act of prescribing and dispensing occurs in the same place.

Senator SIEWERT—Thank you. There has also been extra funding allocated to the other program, hasn't there?

Ms Campion—No. The funding for the Quality Use of Medicines program is part of the Fourth Community Pharmacy Agreement. About $12.9 million has been allocated for that.

Senator SIEWERT—I have not got it open here because I was going back through it a bit earlier—I thought there was a second lot of money that was allocated specifically for PBS and Aboriginal communities. Have I misread something?

Ms Campion—Sorry, Senator. Was that part of the budget?

Senator SIEWERT—Yes.

Ms Campion—It was not part of the COAG Closing the Gap package?

Senator SIEWERT—No. That's alright. I will go back and check it and I will put that on notice. I thought there were two separate items, but don't worry. Instead of taking up time now, I will go back and check it.

Ms Halton—I think it is Closing the Gap.

Senator CROSSIN—Is this a section 100 issue?

Mr Dellar—The handling fee is paid under section 100 of the act, yes.

Senator CROSSIN—And so the handling fee, you are saying, has gone from $1.15 in this budget to $2.69.

Mr Dellar—$2.69.

Senator CROSSIN—From $1.15 to $2.69?

Mr Dellar—$1.14 to $2.69.

Senator SIEWERT—I actually thought there was another budget measure there, but I must have got it wrong. There is one issue that I missed, I am sorry, and I just want to go back to the CMI. Besides the research program that we have been talking about, is there any other active monitoring of the way pharmacists handle the CMI element?

Ms Campion—Not through the department. We do not formally require any sort of data provision in terms of how often CMI is provided or under what circumstances, but the Pharmaceutical Society of Australia does have a document or guidelines about provision of information to consumers, so pharmacists comply or act in accordance with those guidelines in the provision, and that says that, when it is a newly prescribed medication, all the dosages change.

Senator SIEWERT—Thank you. I know that I am running out of time, but I have two minutes, because you did promise me until 8.27 pm.

CHAIR—I did.

Senator SIEWERT—I very quickly want to go to the PBS cost recovery issue. For us it is back on the agenda again. The last time we had a discussion about this, there was a lot of concern about non-orphan drugs and, if I remember correctly, the regulations went out for further discussion.

Mr Dellar—There have been two Senate inquiries on the cost recovery and quite a number of consultations. I have to say, it all rather stopped a few months ago, because the measure was not proceeding but, now that it has been back to the House of Representatives, we have invited all the stakeholders to a meeting on 11 June and we will go through in quite some detail a refresher course on everything you always wanted to know about cost recovery and, in addition to that, some quite detailed stuff about invoices and dates and how things work. One of the things that we will have to do—and this is assuming that it is passed by the Senate—is consult over the start date for cost recovery. The minister said, in the House during the debate, that she would determine the commencement date of cost recovery, following consultation with industry, following the decision by the parliament to approve or not the measure.

Senator SIEWERT—If I recollect and understand correctly, there was the first Senate inquiry, then we did the regs, and there was some consultation on the new regulations at the time.

Mr Dellar—That is correct.

Senator SIEWERT—That stopped when the bill went down?

Mr Dellar—Yes. The community have seen two versions of the regulations so far, or people who are interested to see these things have seen two versions so far.

Senator SIEWERT—And then the next go at it is on 11 June.

Mr Dellar—That is correct.

Senator SIEWERT—Thank you. Is it possible that the new set of draft regulations would be amended again?

Mr Dellar—Yes.

Senator SIEWERT—I am talking about the new draft regulations following the consultation.

Mr Dellar—The caveat they will need to put on it is that the minister also said in the House that she would be willing to discuss certain amendments with the opposition. I do not

know whether there will be amendments or not but, if there are amendments to the primary legislation, that has inexorable consequences for the secondary legislation.

Senator SIEWERT—As I recall the debate, a lot of the issues were around the regulations. It was not just about the bill but it was the regulations.

Mr Dellar—Yes.

Senator SIEWERT—And certainly from our perspective it was ensuring that those non-orphan drugs were being taken care of.

Mr Dellar—Yes, that is right. The provisions were essentially that where a drug is classified as 'orphan' by the TGA—and they have a definition which they use—there would be an automatic exemption from fees, but where there was an argument, 'While this drug may not be an orphan drug, there are circumstances where we ought not charge,' then we had a whole series of waiver provisions which enabled a company to draw our attention to the circumstances for a delegate within the department to decide, 'Yes, this is not a case where we should charge for this service.'

Senator SIEWERT—I think one of the issues that was put up during the time of those discussions was the timing of when that decision was made about when fees were waived.

Mr Dellar—What we have said and have to continue to say, I think, is that we do not know what we do not know. We would need to see the details of a proposal and have some understanding of what it was and how many people are likely to use it before we would be able to say whether or not we could offer a waiver in that case. We will have ongoing communications with the industry about these measures. We will be setting up an ongoing communication and consultation arrangement so that the sorts of issues that arise can be dealt with as they come up and we can both learn how to do this as time goes by.

Senator SIEWERT—Thank you.

CHAIR—That is the first hour but, because of the break with Hearing Services, there is another 15 minutes, so I am going to go to Senator Barnett, then Senator Adams and then finish off with Senator Cormann. Senator Barnett.

Senator BARNETT—I will be as brief as possible. You know the question I am going to ask regarding insulin pumps. What is the answer?

Mr Dellar—I will assume this is the question.

Senator BARNETT—You're a champ!

Ms Halton—It is a safe assumption, Senator.

Mr Dellar—As at today, or actually yesterday, 30 subsidies have been approved and paid. You will recall that in February it was five.

Senator BARNETT—Yes, I do recall.

Mr Dellar—There have been 108 applications and a total of 364 inquiries. If you want to know about website hits, I will get my colleague here to answer that.

Senator BARNETT—All right. Just re the 30 subsidies approved and paid, how much has been paid and what has been the average subsidy?

Mr Dellar—The total amount paid for those 30 subsidies is $68,671.

Senator BARNETT—That has been paid in subsidy?

Mr Dellar—To the 30 people. There is probably a better way of describing it than to say 'average'. Twenty-two of the 30 applicants received the maximum.

Senator BARNETT—As in 2½ thousand?

Mr Dellar—That is correct. The other eight, therefore, did not receive the maximum, and there has been a range of a minimum of $500 to a maximum of $2,167.

Mr O'Connor-Cox—The average subsidy paid to date has been $2,289.

Senator BARNETT—One hundred and eight applications, 364 inquiries, and how many hits?

Mr O'Connor-Cox—3,502 views of the webpage.

Senator BARNETT—You had budgeted for $1,068,671 for a subsidy. In total what has been expended to date this financial year? You have to pay JDRF and other costs. Let me put on the record my strong support for JDRF and the good work that they do. What is the total expenditure to date for this financial year from 1 November, when the scheme started?

Mr Dellar—We had not thought of it in that way, so we do not have a year-to-date cost for you. We will have to take that on notice.

Senator BARNETT—All right. But can you confirm that you have budgeted for a $1 million spend this financial year from 1 November to 30 June?

Mr Dellar—I will check that. My recollection is that it was a little lower than that.

Senator BARNETT—It was very close to that, from memory.

Mr Dellar—For the year, taking everything into account, the budget was $1 million. The total amount of money within that $1 million that we thought we would spend on pumps was $359,000. So you should compare the $68,000 to the $359,000.

Senator BARNETT—I am with you. The minister, when she announced the program, said that up to 700 young people under 18 years would benefit. How many did she budget to benefit in the first financial year?

Mr Dellar—Approximately 174.

Senator BARNETT—And the second, third and fourth financial years?

Mr Dellar—In year 2, 232; in year 3, 174; and in year 4, 116—making a total of approximately 696. I say 'approximately' because when you have a variable amount of money going to an individual the actual number of people may vary a bit at the margins.

Senator BARNETT—Indeed, but that is what the minister said publicly on 1 November when she announced the program. It is still a $5.3 million program over four years, as originally announced?

Mr Dellar—That is correct.

Senator BARNETT—Do you still accept that there are 11,000 young Australians, under the age of 18, who have type 1 diabetes, with an extra 1,000 new cases each year?

Mr Dellar—I do not recall those figures, but they sound about right.

Senator BARNETT—Are you happy to confirm that on notice?

Mr Dellar—I will have to take that on notice.

Senator BARNETT—This question is for the minister, Senator McLucas. I had dearly hoped that this program would have been overhauled in the budget. We had a discussion in February, and I was dearly hoping that would occur. I can only ask you again to please reconsider the need for an overhaul, the need to increase the subsidy. The subsidy is clearly insufficient.

Can I make it clear that, if you have private health insurance, you pay about $1,000 or so and you can get the pump essentially for free—it costs seven or eight grand for the pump and you get it for free. If you use this system and you do not have private health insurance—as we know, more than half the population does not—the pump costs $7,000 or $8,000 and you get a maximum subsidy of $2,500. You are going to have to kick in up to $5,000 or thereabouts.

There is no sense in that, with respect. Why wouldn't you wait the 12 months, save up your money, put $1,000 down, get private health insurance and then get the pump for free, rather than paying $3,000, $4,000, $5,000, or $6,000 to get the pump now? People in this situation, and families in particular who are struggling to make ends meet, simply will not do that, and that is the reason the uptake is so low. I raise that with you again and seek reconsideration. If you would like to respond now, that would be fantastic. I leave it with you, Minister.

Senator McLucas—Senator, I know that the minister is open to thinking about this. We are in a difficult economic circumstance, but I thank you for your comments. I have heard them before but that does not mean you should not say them as many times as you can.

Senator ADAMS—Can I ask questions about the Improving Maternity Services Package and eligible midwives' access to PBS.

Mr Dellar—You can ask those questions, Senator.

Senator ADAMS—As it is PBS, I thought I might be able to. Could you tell me what qualifications are required for eligible midwives?

Mr Dellar—I do not have the qualifications to answer that question. We will be working together with a number of divisions, and part of the initial work, as I understand it, is to define the scope of practice. This is for both midwives and nurse practitioners, because they are both getting some access. Then we will rely on a competent authority—for example, the national registration authority—to ensure that a person who gets prescribing rights is qualified to prescribe medicines.

I have been reminded that the decision about who can or cannot prescribe is essentially a state and territory government decision. We have this relationship where a person is entitled to prescribe, and then the prescribing rights that we would subsequently offer people enable them to access the PBS—the major difference, therefore, is that a prescription that a person with PBS access can write would flow to a controlled price for the consumer. So the primary benefit at the end of this chain for prescribing rights under the PBS is reduced cost to patients.

Senator ADAMS—Do you have a list of medications to be prescribed by eligible midwives that are expected to attract the PBS benefit?

Mr Dellar—We have not begun that process yet. This measure is due to take effect in October-November 2010, so it is a way off. That list will be informed very much by what the state and territory governments think, and we will be working very closely with them. We will also be consulting very widely with clinicians, midwives and consumers in developing that list, and we will be taking advice from our professional clinical body, the Pharmaceutical Benefits Advisory Committee, which in the end will give recommendations that will then be considered by the minister in setting out what medicines can be prescribed and under what conditions.

Senator ADAMS—Probably much the same questions apply to nurse practitioners, so because of time I will put the two together, the nurse practitioners and the eligible midwives. As far as prescriptions go, do you think there is going to be a big increase?

Mr Dellar—No. There is an expectation that there will be some increase but we think that, largely, prescriptions written by nurse practitioners and midwives will be substituting for prescriptions that would have been written by doctors in the current arrangements.

Senator ADAMS—In relation to nurse practitioners, in the final year of the forward estimates period, 2012-13, what is the estimated number who will be accessing the PBS under this measure? Do you have any idea about that?

Mr Groth—As we were discussing earlier, there are something like 300 nurse practitioners in the country at present. That is likely to grow. The majority of them, we understand, work in public acute settings and a range of other settings. We do not expect to have a huge shift per se out of that. It is an estimate based on around 50 nurse practitioners, but, as Mr Dellar suggested, it is an area that will need considerable development over the next few months in relation to nurse practitioners and midwives to get the formulae right and what will be prescribed and how people will be working. The number of nurse practitioners may have changed by the time it comes in. It is hard to predict at this stage because we do not have a great deal to base it on. We have made estimates based on an assumption of about 50.

Senator ADAMS—At the moment there are currently around 50 working out in rural and remote areas.

Mr Groth—That was the question we were not able to answer at that stage. I think we took on notice exactly where their spread was. We know more about the settings they practise in and not a great deal more, but I think we are in a position to try and get that information.

Senator ADAMS—When do you think you will have worked it all out and have the end result ready to go?

Mr Dellar—There are quite a few things to be done. The first major thing is to change the legislation. I did mention at the last hearing that to give prescribing rights to any new group requires a change to the act, so the government will be introducing changes to the primary legislation in the parliament sometime in the near future. Then there is a whole period of consultation and there is quite a lot of work involved in the pharmaceutical list. As I said, we need to take into account what states and territories do, what sorts of things midwives do, and

that is going to be informed in part by some work that is still to be done in that area. Then there is a filtering process and each medicine needs to be considered in terms of what kinds of restrictions need to be put on that medicine and what the rules will be about repeat prescriptions and maximum quantities. We have no doubt we can have that all in place in time for the start of the measure. I would not think that the final list—and there will be many versions and they will be circulated progressively—will be in place until much before, say, September next year.

CHAIR—Senator Cormann.

Senator CORMANN—Thanks, Madam Chair. I only have a short time, so if you could keep your answers tight. I would like to go back to the $100 million budget cut to the chemotherapy treatment services. I have had some emails from distressed pharmacists who have been listening in to this evidence tonight who are telling me that the suggestion that there are unopened vials being discarded is just completely untrue.

Mr Dellar—No, I did not say unopened vials were being discarded. I said that 10 vials might be written out in a prescription but 10 vials might not be used in all locations.

Senator CORMANN—But who writes the prescription? That is not the pharmacist. The pharmacist in fact is prevented by the PBS act from getting himself involved in the prescription, even though—

Mr Dellar—I am not saying that pharmacists have done something inappropriate or improper here. That is the nature of the change in the measure. At the moment a bulk prescription is written out for a month's supply. The proposed change is that a prescription will be written for an infusion, so the circumstance which currently can arise, where a number of vials are written on a prescription which are not all used, will not be able to arise when this measure is implemented on 1 September.

Senator CORMANN—But the reality is that you are not able to take on big pharma and you have protected the patients. The doctor who makes the prescription, which may be a prescription that is larger than what is required, is not going to carry the cost, so it is going to be the pharmacist who is going to carry the cost, and the advice I have got is that the shortfall, for example, for Herceptin, the breast cancer drug, is up to $600 per patient, which can be thousands of dollars a day and tens of thousands of dollars a week. Does the government think it is reasonable for a pharmacist to provide chemotherapy treatment at a loss?

Mr Dellar—If I could just remind you that we do have some extra time to listen to the community, and we have been doing precisely that, and we will be giving the results of—

Senator CORMANN—So it may well be that you will not achieve the $100 million cut.

CHAIR—Senator, I am not going to let you keep talking over the answer. I am sorry, Mr Dellar. You can now answer the question. You will not be interrupted again.

Mr Dellar—We will be providing the results of our communications and our consultations to government for their consideration. That is the point of having consultations.

Senator CORMANN—So will you release to the people that you are consulting with the model as to how you expect to achieve the $100 million in savings?

Mr Dellar—I have described the model broadly to a very large number of people on a very large number of occasions, but the model itself is a matter for cabinet.

Senator CORMANN—Are the needs of Australian cancer patients very different from the needs of European or American cancer patients? I will explain. Wouldn't there be a better way, where the TGA and the FDA and the European regulators come together and approach the manufacturers—so, rather than represent two per cent of the world population, we might represent a larger proportion—and say, 'Why don't you make those vial sizes more appropriate?' rather than to end up squeezing the community pharmacist? Is that something that you have explored as an alternative?

Ms Halton—But let's not conflate use of vials with reimbursement systems. You have just conflated about four things in there.

Senator CORMANN—No, I have not. The problem is that there is an unusable proportion. There is a proportion of an opened vial that cannot be used and there is inefficiency there, and the question is: who is going to have to carry the cost of that inefficiency? The pharmacist will have to discard the drug within a few hours—that part of the drug that cannot be used—so clearly there is a problem. Mr Dellar has said it has been raised with big pharma companies before and they have said, 'Well, you're not big enough to matter.' Given that Australian cancer patients, I would have thought, are not that unique in the world in terms of their physiology, unless you tell me otherwise, isn't there an opportunity for countries with similar population characteristics, and with populations of cancer patients with similar body and other characteristics that matter for these things, to work together to get a more appropriate way of providing those vials so that there is not the same amount of what you call wastage or unusable proportions of the drug? I am trying to assist you with finding a better way.

Senator McLucas—Maybe I can help. The way I read it, you have got two types of vials: you have got used vials and unused vials. In the unused vial section, there are those that will have to be discarded, and they currently are.

Senator CORMANN—That is not the problem.

Senator McLucas—The other group is those that are unopened and should not be wasted, and I do not know anyone who would say that it is not a laudable objective to try and save the taxpayers of our country the cost of those vials which are unopened and can be used.

Senator CORMANN—I think Mr Dellar is talking about vials that have been opened and where there is a proportion of them that no longer can be used, but I think that is not quite right. This is my final question, because I do not want to upset the chair. The chair has been very good to me and I appreciate that. Has the government considered approaching generic medicine manufacturers, who might be more willing to adapt their vial sizes? If not, why not?

CHAIR—Mr Dellar, I think you should take that question on notice. My understanding is that you did answer that question earlier in your evidence, but Senator Cormann has put that as another question. If you would care to make a response on notice, that is the end of this session. We have now finished outcome 2. Thank you very much for your patience.

[8.49 pm]

CHAIR—We are now going to move to outcome 3.1, Medicare services. There was going to be 40 minutes for outcome 3, but we will see how we go.

Senator BOYCE—I am sorry, Chair. Where does the Teen Dental Plan come under?

CHAIR—Ms Halton, the Teen Dental Plan? I do not think it is your area.

Ms Halton—It is actually acute care, but we do have the officer concerned.

Senator BOYCE—But it us under outcome 3?

Ms Halton—Yes, and we have got the officer concerned.

CHAIR—We did all of that yesterday.

Ms Halton—Yes, we did take questions on teen dental yesterday.

CHAIR—We did, under acute care. If we have time, we will get back to it. Medicare services, 3.1, Senator Siewert.

Senator SIEWERT—Thank you. What will the new Medicare Benefits Schedule fee for cataract surgery be under the changes?

Mr Kingdon—There are a number of items for cataracts, but the most common one is item No. 42702 and the new fee will be $419.85. That is an estimate.

Senator SIEWERT—An estimate. Okay.

Ms Robertson—A lot of the fees under the MBS are indexed on 1 November and we do not have that indexation amount as yet, so we have made an assumption of around 2½ per cent and come up with $419.85.

Senator SIEWERT—What is that down from?

Mr Kingdon—It was originally $831.60.

Senator SIEWERT—Which is essentially a 50 per cent cut.

Mr Kingdon—Yes, essentially.

Senator SIEWERT—Could you tell me on what basis you made the calculation that it should be a 50 per cent cut?

Mr Kingdon—We looked at the relative work value associated with this item and we took into consideration factors such as what was being paid in the public sector. We also looked overseas to see what rates were paid—we looked at the US, for example—and we came to the conclusion that, on the basis of time and the nature of the service, around $419 was a more appropriate level.

Senator SIEWERT—Do the overseas examples use the same equipment?

Mr Kingdon—We would expect so in the United States. We are certainly not talking about the Fred Hollows Foundation example, where they talk about it costing $25. We did not go that far.

Ms Robertson—Can I talk about equipment for a moment. Around 96 per cent of these procedures are performed on an in-hospital basis.

Senator SIEWERT—In hospital?

Ms Robertson—That is right. So what happens is, because we are talking about private services—and by and large these people would have private health insurance—their private health fund pays a bed fee. The prosthesis is also paid by the private health fund, as well as any theatre fee that is required as part of that. So on top of the Medicare fee, on average, there is around another $1,700 that is paid per cataract procedure from the private fund.

Senator SIEWERT—What happens for non-private patients?

Ms Robertson—The public sector will get picked up by the states and territories.

Senator SIEWERT—But what are the costs? Did you look at the costs in the public sector?

Ms Robertson—It is very hard to pull apart and compare apples with apples in the public sector, but certainly we have looked at those numbers, yes.

Senator SIEWERT—You made a calculation on what is paid based on overseas examples and what they are doing in the public sector, I thought, Mr Kingdon.

Ms Robertson—Yes, partially, as well as the time taken for the procedure.

Senator SIEWERT—Did you find a significant difference in the time taken for the procedure when it is in the public system?

Ms Robertson—We did not look at the time taken in the public sector. What we have looked at is evidence around time taken overall, and there are a number of different sources. One of the reasons why we are introducing a new complex item at the same time is recognising that there are some people out there who have medical conditions that make their procedure more complex. This is going to be for the most common procedures, the ones that take up to 15 to 20 minutes.

Senator SIEWERT—Sorry, I am a bit unclear how you benchmarked the 15 to 20 minutes.

Ms Robertson—There are a number of sources with the 15 to 20 minutes. Certainly the Fred Hollows Foundation talked about the time taken in that regard. There are a lot of other companies that provide information on their websites that say it takes 15 to 20 minutes, and these are companies in Australia.

Senator SIEWERT—I am really not trying to be pedantic here, but a little while ago you said that you are not using the Fred Hollows example, where it costs $25. On one hand you are using it as an example and on the other hand you say you are not using it as an example.

Mr Kingdon—The difference was the cost, not the time. The time is important, and that is what we factored in. I just used the example that there seems to be an awful disjuncture between what is being suggested it costs overseas under the Fred Hollows program—which says you can save sight for $25—as opposed to what we are paying. I was really just suggesting that we certainly were not using that as a benchmark and we felt that the US, which usually is regarded as a higher cost health system than our own, was not an unreasonable one. Otherwise then you are in more the public system as you have in the UK and we have also the public system in this country.

Senator SIEWERT—I am not going to go near the Fred Hollows thing again, because it seems to me it is apples and oranges and, when they are doing that, they are not using the high-tech equipment that I understand is used now. So I am still coming back to this 15 to 20 minutes. Is that the standard in a public hospital? You have not established that, have you?

Ms Robertson—No. The 15 to 20 minutes has been reported to us over many years. In fact, there was a report on the ABC in Canberra just this morning where an anaesthetist rang in who had personally observed an ophthalmologist do 22 patients between 8.30 in the morning and two o'clock in the afternoon, which is roughly one every 15 minutes. He was saying the operating time took around five minutes.

Senator SIEWERT—The rebate has been reduced and it is part of the extended cap provisions as well. I realise that we are tight for time, so could you quickly explain what happens there as well and how you work that out.

Ms Robertson—With the cap that has been placed on the item, for those four to five per cent of services that are done outside hospital or on non-admitted patients, there is some evidence to suggest that the classification of the patient is undertaken based on whether or not they are privately insured. What happens is that an average of $1,700 is paid by the private fund for the service. There is some suggestion that that is being put onto the top of the professional fee so that the patient can get 80 per cent of that out-of-pocket cost back through the Extended Medicare Safety Net.

Senator SIEWERT—Thank you. I have got other medical services questions, but maybe we should finish off cataracts.

CHAIR—Are there any other questions on cataracts?

Senator BARNETT—Yes, thanks, Chair.

CHAIR—You can have two questions.

Senator BARNETT—On cataracts? I am filling in for Senator Cormann on this.

CHAIR—Yes.

Senator BARNETT—I hope I can get a few more than two, Chair. You said 'overseas examples'. Which countries and which examples?

Ms Robertson—In the US the fee paid in some cases was around $500, and that included equipment and indemnity.

Senator BARNETT—What is the scientific basis on which the decisions have been taken to reduce the rebate? Has any modelling been done?

Ms Robertson—We do modelling based on the fees charged and the time that goes into the service. When this service was first put on the Medicare Benefits Schedule, the time taken was around 45 minutes per procedure and over time—

Senator BARNETT—Do you have that modelling?

Ms Robertson—Not with me. It is part of the overarching MBS model.

Senator BARNETT—Could you take that on notice. We are a bit tight on time.

Ms Robertson—Yes. What exactly?

Senator BARNETT—I would like to see the modelling, firstly, for the basis on which the decision was made to cut the rebate and, secondly, the modelling which will show what is done and how that will affect the service delivery, particularly for those who have a low income and those in rural and regional Australia.

Ms Robertson—I will give you a couple of scenarios in that regard. There is no difference to the services provided in rural and regional Australia from the rest of Australia with regard to cataract services. In fact, the vast majority of the services are provided in urban and metropolitan areas.

Senator BARNETT—That is the point, though. There are rural and regional areas that will be impacted by this.

Ms Robertson—But I do not see how rural and regional areas will be impacted any further than anywhere else.

Senator SIEWERT—To prove that point, perhaps we could ask on notice where the bulk of the services are delivered. You are saying 90 per cent of whatever is provided is in the city areas. If you are able to take on notice where those services are provided, that would solve—

Senator BARNETT—That is a very good question, thank you, Senator Siewert, particularly for south-west Western Australia, I know, in terms of ophthalmologists. I would like to know where they are, so I thank Senator Siewert for that question on behalf of another member. Could you take that on notice?

Ms Robertson—In regard to the modelling to cut the rebate, that is really cabinet material.

Senator BARNETT—I am not asking for cabinet material but for what material you have within your purview and department.

Ms Robertson—Evidence, you would say.

Senator BARNETT—Just do the best you can, if you could.

Ms Robertson—Yes.

Senator BARNETT—What consultation was held with the industry prior to this taking place?

Ms Robertson—This was a budget measure.

Senator BARNETT—So that is 'nothing'? Nil?

Ms Robertson—There have been many occasions where we have talked cataracts with the profession over the years. I could not say.

Senator BARNETT—But, in terms of this rebate cut, there was no consultation in advance of the budget decision?

Ms Halton—Correct.

Ms Robertson—That is right.

Senator BARNETT—Thank you.

Senator SIEWERT—There was discussion, though, on the obstetrics measure, wasn't there? That was on the radio. I heard that before the budget and I heard doctors talking about it and saying they were consulted.

Ms Robertson—Certainly not by the department.

CHAIR—Senator Barnett, can you put the rest on notice?

Senator BARNETT—Yes. I will try to be very quick and then I will put the rest on notice. What percentage of the patients who undertake cataract surgery are on low incomes? How many are over 65 years of age? How many are veterans? I am happy for you take those on notice. The veterans issue is a very important one. Can you guarantee that all veterans will not be affected by this reduction in the rebate? Can you answer that question?

Ms Robertson—Veterans are not paid through the MBS but through the Department of Veterans' Affairs. They have a different fee schedule to the MBS.

Senator BARNETT—So they will not be affected?

Ms Robertson—I cannot say that. That would be a question for the Department of Veterans' Affairs.

Senator BARNETT—All right. What will be the impact on the public hospital waiting list?

Ms Robertson—We cannot predict that either.

Senator BARNETT—Why not? This has a direct impact on public hospital waiting lists and waiting times.

Ms Robertson—It depends on whom you talk to, I think.

Senator BARNETT—Have you done modelling on it?

Ms Robertson—We have done modelling on the services that exist now, but how those services change between public and private sector is not something that we would know with any certainty.

Senator BARNETT—I think everybody would know that it will put more pressure on the public system if you increase the cost of the private system. It is the same with the private health insurance rebate.

CHAIR—Senator, I am happy for you to continue with this question if you give up the MRI question.

Senator BARNETT—No. I will give up there, if you are happy to take that question on notice.

Ms Robertson—I do not think I will be able to give you information on the low-income patients, because we do not have that information within the Medicare database, but I can certainly give you information on over 65-year-olds. I can tell you now that the majority of people having cataract surgery would be over 65.

Senator BARNETT—Thank you. Thanks, Chair.

CHAIR—We are moving to outcome 3.3, where I know Senator Siewert and Senator Barnett both have questions. We have limited time, so see what you can ask and then put the rest on notice.

Senator SIEWERT—Okay. I very quickly wanted to follow up with a general overarching question about the changes that were made to both MBS and PBS. With the changes that have been introduced through the budget on MBS—let us stick to MBS—was there any consultation with any consumer groups?

Mr Kingdon—If you are referring to the safety net changes and the cataract changes, no, because they were budget measures. But a review was undertaken of the safety net, and that was quite extensive. That was reported to parliament on budget day.

Senator SIEWERT—I definitely heard on ABC Radio in Perth a discussion around the obstetrics measures and heard doctors say that there had been some consultation, so there obviously was some consultation by somebody with some sectors. Could you take on notice whether consumer groups were consulted during that process as well, Senator McLucas?

Senator McLucas—For the obstetrics?

Senator SIEWERT—For the obstetrics or any other measures.

Senator McLucas—I will see what I can find out for you.

Senator SIEWERT—Thank you. In terms of PET—and I will try to be quick; I will let you know that I have a lot of questions to put on notice—I would like an update, please, on where we are with the provision of PET services on the MBS and which are the new services that are being included. I am aware that there are budgetary items there.

Mr Kingdon—We have six items now on the MBS, of which three were introduced some time ago. The more recent three were introduced on 1 December 2008. They were for colorectal cancer, melanoma and ovarian cancer. We have one scheduled for implementation for 1 July, which is for oesophageal and gastric cancers.

Senator SIEWERT—From 1 July, did you say?

Mr Kingdon—Sorry, GEJ cancer.

Senator SIEWERT—Could you tell us where PET scanner facilities are available that can access the MBS PET items, please.

Mr Kingdon—Yes. We have 18 PET scanners operating out of 15 locations: six in New South Wales, six in Victoria, one in Western Australia, three in Queensland, one in Tasmania and one in South Australia.

Senator SIEWERT—Is it possible for you to perhaps provide on notice the actual locations. I will not get you to say them now.

Mr Kingdon—I could take it on notice but I could give it to you now if you wish.

Senator SIEWERT—I am conscious of time, so, if you could, do it on notice. I know Senator Barnett has some questions there as well. I have quite a long list of questions but I will put them on notice.

CHAIR—There is nothing else you want to ask at this stage?

Senator SIEWERT—No, I have done that.

CHAIR—Senator Barnett, you have PET and MRI.

Senator BARNETT—Yes, thank you. I will not be too long, I do not think. We will continue with PET: there is one scanner in Tasmania?

Mr Kingdon—Yes.

Senator BARNETT—When did it commence? What is the funding allocated to it and its location—Hobart?

Mr Kingdon—It is private and it is in the Hobart Private Hospital. It commenced operation in December 2008. Naturally, it would have access to the six MBS items that have been approved and with a seventh coming on in a month's time.

Senator BARNETT—At the last federal election, Labor committed $3.5 million towards a new PET scanner for the Royal Hobart Hospital if elected. Do you have advice regarding the PET scanner targeted for the Royal Hobart Hospital?

Mr Kingdon—Money has been set aside for that, yes.

Senator BARNETT—How much?

Mr Kingdon—$3.5 million.

Senator BARNETT—When will that be promulgated?

Mr Kingdon—When the Tasmania government confirms that they would like to use it.

Senator BARNETT—Is it location specific?

Mr Kingdon—It was at the Royal Hobart.

Senator BARNETT—Why would you have two PET scanners in one city?

Ms Halton—The commitment was made, I think, before the advent of this private PET scanner was known. It was an election commitment from the government. I know that Minister Roxon has had a conversation with Hobart Private Hospital about this matter.

Senator BARNETT—Yes, and why would you have two PET scanners in one city of 200-odd thousand?

Ms Halton—You are asking for an opinion now.

Senator BARNETT—Do you have any briefing papers, documents, letters relating to the appropriate location of PET scanners in Tasmania?

Ms Halton—This was an election commitment.

Senator BARNETT—No, sorry: answer the question please, Ms Halton.

Ms Halton—Not that I am aware of.

Mr Kingdon—No, it was an election commitment.

Senator BARNETT—Yes, I am aware of that. I am trying to ask questions and being specific. When is that expected to commence?

Ms Halton—When the Tasmanian government decides it wishes to take up the offer.

Senator BARNETT—Have you been advised of the date?

Mr Kingdon—No. We have been informally advised that they do, and I think that came out in a press release, but we have had no formal application.

Senator BARNETT—You have not received a letter, advice or communication from the state government as to the commencement date?

Mr Kingdon—Not at this stage, no.

Senator BARNETT—What is the total cost of the MRI? There is $3.5 million from the feds. What is the total cost?

Mr Kingdon—You are talking about a PET, aren't you?

Senator BARNETT—Yes.

Mr Kingdon—I could not give you a total cost, but they usually run to about $8 million. It all depends. The thing is that the machine runs at about, I think—I would have to take it on notice—$4 million, but then you have the accompanying bunkers and the associated works that go with it, which puts a considerable cost on to it.

Senator BARNETT—About double that? I am not sure what it would be. Can you give an estimate—double or less than double?

Mr Kingdon—We would have to take it on notice.

Senator BARNETT—Thank you. Let's move to the MRI. This was an election commitment too, Ms Halton. Prior to the election there were full-page ads committing an MRI to the north-west coast of Tasmania.

Mr Kingdon—Yes.

Senator BARNETT—Where is it?

Mr Kingdon—We had an ITA process, in which people were invited to tender to provide MRI through the Medicare system. We went through a process and we did not have one applicant that was able to meet the financial criteria necessary to deliver it within the funds available.

Senator BARNETT—Therefore?

Mr Kingdon—So the ITA process was cancelled and the government took a decision to reallocate $3.6 million for priority health projects in the north-west Tasmania region.

Senator BARNETT—And that $3.6 million was originally targeted for the MRI.

Mr Kingdon—That would have been, yes.

Senator BARNETT—How many MRIs are there in Tassie and where are they located?

Mr Kingdon—Four MRIs. There are two in Hobart and two in Launceston.

Senator BARNETT—Are you aware of the considerable angst on the north-west coast? The councils, the people, the communities and the health organisations are incredibly upset by the broken promise that has now occurred as a result of that decision. Are you aware of that?

Mr Kingdon—Naturally we are disappointed, too. We went through a process, and it would have been good if we could have got an MRI up through the process, but that just was not to be.

Senator BARNETT—Did that process conclude with a report or a paper?

Mr Kingdon—Yes.

Senator BARNETT—What was the name of that report?

Mr Kingdon—When I say 'report', it was an ITA process. It is like a tendering process, and it went through a very formal process, and at the end there was—

Ms Halton—It is a normal commercial assessment that we do in relation to ITAs. So we have a standard process when we go to tender or have any of these kinds of processes.

Senator BARNETT—But there must have been some final report which said, 'This is not viable,' or whatever the words you used—

Ms Halton—No.

Mr Kingdon—No. It actually ended up with a recommended provider, but the provider was unable to offer the service within—

Senator BARNETT—Who was the recommended provider?

Mr Kingdon—I think that is unfair. I cannot say that.

Ms Halton—We cannot say that. It is a commercial-in-confidence matter.

Senator BARNETT—That is not a legitimate defence in terms of refusing information. If it is not in the public interest, that is a defence.

Ms Halton—We will ask the minister whether she wishes to invoke the public interest immunity test in respect of commercial-in-confidence.

Senator BARNETT—Thank you. So where is that report? Can we have the final report and recommendation?

Ms Halton—Ditto.

Senator BARNETT—Thank you.

CHAIR—Senator Barnett, you may as well stay, because we are now moving on to program 3.5 and your questions about Launceston hospital and oncology services.

Senator BARNETT—I am on a roll.

CHAIR—You are.

Senator BARNETT—I will try and be brief. In relation to cancer support services for Launceston hospital, $7.7 million is listed for the linear accelerator. I could not see that in the budget. Could you point me to the provision in the budget papers which refers to that $7.7 million commitment?

Mr Kingdon—It was in last year's budget, so it would not have been repeated.

Senator BARNETT—Is there any reference at all to it in the budget papers? I am happy for you to take it on notice, if you cannot find it straightaway. I looked up hill and down dale trying to find it and it was not there.

Mr Kingdon—I think if you looked in last year's budget you would have found it, but it would not have been repeated for this—

Senator BARNETT—It was promised prior to the last election, and we have been waiting for years for action, but action has not occurred. Would it be in the budget papers? Are you saying it is not there?

Mr Kingdon—It would not be in the budget papers, because it would be included in the total appropriation for that particular outcome.

Senator BARNETT—Is that normal? Ms Halton, can you help me there?

Ms Halton—Yes.

Senator BARNETT—That is normal?

Ms Halton—Yes. If something has been appropriated and the money is still there waiting to be expended, it would not be appropriated as a new measure a second time.

Senator BARNETT—But isn't there a reference to it?

Ms Halton—No.

Senator BARNETT—So it is not identified?

Ms Halton—No.

Senator BARNETT—Was there a statement made by the minister or any other member of the government, in and around budget time, relating to that commitment?

Ms Halton—Which budget? This budget or the last budget?

Senator BARNETT—The most recent budget.

Ms Halton—Not that I am aware of, nor would there have been.

Senator BARNETT—I am happy for you to take it on notice.

Mr Kingdon—I will take it on notice, but it is very unlikely.

Senator BARNETT—Thank you. Are you aware of a letter from the Tasmanian minister for health, in September last year, recommending that Launceston be the location for that linear accelerator?

Mr Kingdon—I am not personally aware.

Senator BARNETT—Can Ms Halton assist?

Ms Halton—I am not aware of any particular letter, but then again that does not surprise me. I do not see every letter that the minister receives.

Senator BARNETT—Presumably it would have been drafted by either you or someone in your department.

Ms Halton—Sorry, you said a letter from the Tasmanian minister—

Senator BARNETT—Excuse me. There was a response from the federal minister to the Tasmanian minister for health recommending that the linear accelerator be nominated and set up in Launceston. That letter was in September 2008 and it included a 30-page report recommending Launceston as the location.

Ms Halton—I am not aware of that, but then again, I would not expect to be aware of every piece of correspondence.

Senator BARNETT—Is that something you could take on notice?

Ms Halton—Yes, and, if there is anything we can tell you, we will tell you.

Senator BARNETT—I would like a copy of the letter and a copy of the report. If you cannot provide the letter, I would at least like the report that has been referred to.

Ms Halton—Which report is that supposed to be?

Senator BARNETT—It is a report that has been prepared by the Tasmanian government that was sent to the federal minister for health.

Ms Halton—So why would the federal minister for health be writing back with that report to the Tasmanian minister if it has come from the Tasmanian minister?

Senator BARNETT—I do not know that she would. I am asking for a copy of the report. It is within your possession; it is in the department.

Mr Kingdon—There has been considerable discussion between ministers over the location, and the minister confirmed in a press release that Launceston was chosen as the location.

Senator BARNETT—You can take that on notice.

Mr Kingdon—We will take that on notice, but clearly that decision was taken. But I am very unclear about this other exchange of correspondence.

Senator BARNETT—I am happy for you to take it on notice. Could we move to the funding for the accommodation services that support the WP Holman Clinic. I understand that funding has gone to Cancer Council Tasmania.

Mr Kingdon—Not to my knowledge. The money has been put into an appropriation that will go to the state government.

Senator BARNETT—How much was that?

Mr Kingdon—One million dollars has been set aside.

Senator BARNETT—Was that in accordance with their request? How much did they request? I understand the request was for a larger number. What was the number?

Mr Kingdon—It could have been a higher number, but it was all that was available.

Senator BARNETT—What was the number? Can you tell me now or will you take it on notice?

Mr Kingdon—I cannot. I would have to take that on notice.

Senator BARNETT—All right. When will that funding be expended for accommodation and upgrade Launceston?

Ms Halton—That is a matter for the Tasmanian government.

Mr Kingdon—As soon as the Tasmanian government indicates to us their time lines.

Senator BARNETT—Is $1 million set out in this financial year?

Mr Kingdon—There is half in this current financial year and half in the next financial year. So in fact there was an expectation to start the process something this year. We would like a contract signed.

Senator BARNETT—Prior to 30 June.

Mr Kingdon—If we signed a contract this year, we would be able to pay half, and then we would pay the other half on completion.

Ms Halton—Balance on completion.

Senator BARNETT—As in prior to 30 June 2009?

Mr Kingdon—Yes.

Senator BARNETT—So $500,000 by 30 June 2009?

Mr Kingdon—Yes.

Senator BARNETT—Going back to the $7.7 million, can you break that down as to when that would be expended?

Mr Kingdon—We have got it broken down to $1 million that was to be expended in this year, $2 million in 2009-10, $3.9 million in 2010-11 and then there would be an ongoing $0.4 million in 2011-12 and 2012-13.

Senator BARNETT—Thank you.

Mr Kingdon—Those are our best estimates.

Senator BARNETT—They are in the budget papers. I am just asking you for what is in the budget papers.

Mr Kingdon—That is right.

Senator BARNETT—That is fine.

Mr Kingdon—But they are still best estimates, because until we get confirmation from Tasmania, we will not be able to give you—

Senator BARNETT—We have been waiting several years, so that is why I am asking the questions.

CHAIR—Senator Adams, I know you have many questions.

Senator ADAMS—I have just got one.

CHAIR—If you can ask one and then put the rest on notice, thank you.

Senator ADAMS—One important one. I note in the budget papers that the government is going to expand the specialist workforce needed to provide radiation oncology treatment and work with the sector to fund training and development programs. These machines are becoming highly complex. I cannot think of the right term for the person who is in the background and calibrates the machine and all the pieces of the machine.

Ms Halton—Are you talking about the medical physicist?

Senator ADAMS—Yes, thank you; I just could not think of the name. I guess the department is aware that these people are in short supply. What is being done to encourage people to take up this profession and to try to retain them? I am aware that they do not get paid very well when they are qualified.

Mr Kingdon—We work with the college on this and they will be organising those extra 15 places that have been funded in this budget over the next four years.

Senator ADAMS—Are there any scholarships available for these people, or anything like that, as an incentive to go forward? I can see what will happen. These machines are going to become so complex that we are just not going to be able to provide the services because there will be no-one able to deal with the machines. It is nice to see you again, Mr Groth.

Mr Groth—And you, Senator. There are, as we mentioned before, a range of allied health scholarship programs, and these people certainly are eligible to apply for them. I do not pretend to be an expert in all of the professions involved. One aspect, as we mentioned before, is that they may be eligible to apply but also there is an onus on trying to get a reasonable spread of these sorts of skills across the country, into rural and regional, and utilising some of the other infrastructures in place, like the university departments of rural health—drawing on those sorts of links.

One of the measures in the budget around this did include, I think, an increase in scholarships specifically in this area, and I think we are talking about 15, but I can clarify that and get those details.

Senator ADAMS—I would be very interested in that. I am gaining my information from Royal Perth Hospital, and they are becoming desperate and looking to the future as to how many people are trained.

Dr Richards—The department works very closely with the states and territories and with the relevant professions to address workforce issues, not only in relation to radiation oncology medical physics but also in relation to radiation therapists and radiation oncologists themselves, and we support undergraduate training and postgraduate and registrar training and ongoing education for a range of professions involved in radiation oncology. We certainly understand that, as the population ages and cancer incidence increases, the need for these services will increase. As we build more bunkers and put in more linear accelerators, we need the appropriate staff, and the Commonwealth is active that area.

Senator ADAMS—That is a very good sign. Thank you.

CHAIR—You have a number of questions to go on notice?

Senator ADAMS—No, that was it.

CHAIR—Thank you very much to the officers.

[9.26 pm]

Professional Services Review

CHAIR—We now have the Professional Services Review agency. Welcome. I know that Senator Boyce has questions.

Senator BOYCE—Thank you, Chair. Dr Webber, I do not recall, in the couple of times I have been to estimates, that we have called the Professional Services Review before, but you would appreciate that the work that your group does has become somewhat more topical because of the work that is going on around Medicare compliance audits. I was wondering if you could talk me through where the separations are going to come between inappropriate practice and fraud, which is the basic item that will be looked at.

Dr Webber—Fraud is a criminal offence.

Senator BOYCE—Yes, that is right, but there will be two bodies now checking. Medicare will be looking for compliance—assuming the legislation passes the parliament—and they will be looking more closely and in greater depth at claims to Medicare, looking for what was described to our committee as 'fraudulent activity', but they would still be referring inappropriate practice, where they saw that, to you. I presume you have had discussions with Medicare about where the boundaries on this are. Can you talk me through it, please.

Dr Webber—It is a very confused area and there is a very fine line between the two.

Senator BOYCE—I am glad you said that, because that was certainly what I was feeling.

Dr Webber—Sometimes the distinction is quite blurred. Inappropriate practice can be defined in a lot of ways, but probably the best thing to do is to give you some examples to flesh that out. Inappropriate practice may be the inappropriate use of medications for a particular condition by a clinician, it may be the inappropriate use of certain operations or the inappropriate use of the MBS item.

Senator BOYCE—Could I stop you there for a moment, because that is where I think the particular crossover is quite confusing. We had evidence when we were discussing Medicare compliance audits that, given the complexity of the system right now, people inadvertently using the wrong Medicare item was not uncommon and in many cases was not deliberate. Have you seen cases of that?

Dr Webber—We do see it now, but I would hope that with Medicare's compliance audits they would be able to sort those problems out before they come to us.

Senator BOYCE—You are saying that into the future you would not expect to get those cases where people have accidentally used the wrong item numbers, for instance?

Dr Webber—In discussions with Medicare, that would seem to be the case.

Senator BOYCE—But you do get those cases now?

Dr Webber—We do get them now.

Senator BOYCE—Or you get cases now which are referred to you for you to decide whether it was an accident or a deliberate attempt to defraud. Is that the case?

Dr Webber—That is true.

Senator BOYCE—Sorry, I interrupted you to clarify that. Could you talk me through where you see this divide sitting, please.

Dr Webber—Fraud implies intent. A lot of the inappropriate practice that we see is because people are seeing very large numbers of patients, rushing people through, not giving them adequate care, not recording things properly, missing vital bits of clinical information. That is inappropriate practice; it is not necessarily fraud.

Senator BOYCE—Thank you. Have any formal distinctions or definitions been developed?

Dr Webber—No. It is a grey area.

Senator BOYCE—Under the new system, Medicare would decide whether they dealt with it themselves or referred it to you.

Dr Webber—In the new system, and in the old system, if Medicare detects what they think is fraud, they will handle that. In the current system, if we find something that we think is clearly fraud, we will send that back to Medicare for them to deal with.

Senator BOYCE—I was just looking at both the report that you put out a couple of months ago and the PBS. You had 50 referrals in 2007-08.

Dr Webber—That is correct, yes.

Senator BOYCE—And 136 in 2008-09.

Dr Webber—No. To date it has been 137, in fact.

Senator BOYCE—I note that you have commented that you just never know what the workload is going to be until Medicare gives it to you.

Dr Webber—That is true.

Senator BOYCE—And you are anticipating that the workload would go back to 65 in 2009-10 or you simply funded for it to be 65 in 2009-10?

Dr Webber—We are funded to be about that rate, yes.

Senator BOYCE—We have had a bit of an increase and then a big spike between 2007-08 and 2008-09. What is that about?

Dr Webber—It certainly has been a very large increase.

Senator BOYCE—More than double, yes.

Dr Webber—More than doubled and certainly strained our resources. My understanding from Medicare is that that is partly due to a change in their internal processes, where in the past practitioners were reviewed a number of times, which may go on for 12 months or more. They have now tightened that time line, and a lot of people who were essentially in Medicare's pipeline got shot out the other end in a bit of a hurry and that is why many of them came to us.

Senator BOYCE—Does that mean medical practitioners are not being given as many second chances?

Dr Webber—The process is considerably shorter than it was from Medicare's end, yes.

Senator BOYCE—You speak in your report about the number of cases in 2007-08 that involved the prescription of narcotic analgesics and benzodiazepine type drugs.

Dr Webber—Yes.

Senator BOYCE—Is that what you saw again in 2008-09?

Dr Webber—Sadly, yes.

Senator BOYCE—Can you talk a little bit more about that?

Dr Webber—Sure. Many of these cases obviously are not yet finalised. But there has certainly been increasing evidence that we have found where several of the practitioners have been prescribing very excessive quantities of particularly benzodiazepine drugs. Often this is not picked up by Medicare because many of these drugs these days—Valium, Serapax—are quite cheap.

Senator BOYCE—So it does not trigger a spend level or something?

Dr Webber—It does not trigger a PBS benefit. The PBS quantity of Valium is 50 tablets, and very commonly I am seeing prescriptions for 200 tablets at a time by practitioners to patients, which will not appear on Medicare's radar and is not being picked up in any other way. So I am certainly concerned about the increase in this sort of very inappropriate prescribing.

Senator BOYCE—What is the purpose of this inappropriate prescribing in your view?

Dr Webber—Many of the people that we have seen over the last 12 months or so have been not only prescribing one benzodiazepine drug to a patient but sometimes up to five different drugs to the same patient on the same day. That is not only dangerous, it is very bad medicine.

Senator BOYCE—So the implication is that the patient is not really taking these drugs; they are for another purpose. Is that what you are saying?

Dr Webber—Either they are taking them or they are selling them, because certainly there has been an increase in the use of these drugs on the streets as well.

Senator BOYCE—I am being asked to wrap up by the chair, Dr Webber, so I will start to ask this question. I found it complex, so whether you will be able to answer it for me quickly, I am not sure. You have noted a large increase in 2007-08 in the requests from Medicare to review a practitioner for a second or subsequent time—in fact, 19. Was that on top of the 50?

Dr Webber—That is part of the 50.

Senator BOYCE—Has that figure continued to increase as well?

Dr Webber—About 17 per cent of our referrals are re-referrals.

Senator BOYCE—What is the most referred person, because you seem to be indicating here that some people come back and back and back.

Dr Webber—Fortunately it is only a minority. It is not a pleasant process to go through. Mostly, if people come back, it is only once and usually for a different reason from the previous reason. We have had one chap who has been back five times.

Senator BOYCE—Is this a GP?

Dr Webber—Yes.

Senator BOYCE—Is that person practising?

Dr Webber—Yes. The reason why that has happened is that I think at least two of his cases were held up for many years in the Federal Court and that is why he accumulated several referrals from Medicare.

Senator BOYCE—He is just a slow learner. Is that what you are telling us, Dr Webber?

Dr Webber—A very slow learner.

Senator BOYCE—Thank you.

CHAIR—Thank you very much, Dr Webber.

Senator BOYCE—I could have kept going for some time.

CHAIR—Absolutely. It is really interesting. We will have you back. We will take a break now and then we will come back to primary care.

Mr Kingdon—Excuse me, Madam Chair. I gave Senator Barnett an incorrect figure.

CHAIR—If you put it on record, we will make sure he knows.

Mr Kingdon—For the record, it was for the $1 million to be spent on the accommodation in Launceston. I said half a million dollars in 2008-09. It should have been 2009-10 and 2010-11.

CHAIR—Okay.

Mr Kingdon—So there was no money for this financial year.

CHAIR—There is no money for this financial year?

Mr Kingdon—Yes.

CHAIR—Thank you, Mr Kingdon.

Proceedings suspended from 9.38 pm to 9.46 pm

[9.46 pm]

Primary and Ambulatory Care Division

CHAIR—After much heavy negotiation, we have said that we will not require the presence of the Australian Institute of Health and Welfare. We are now moving on to primary care. My understanding is that we have questions from Senator Cormann and Senator Boyce, and Senator Adams is going to put her questions on notice. Senator Cormann is asking mainly about the GP superclinics and then Senator Boyce wants 10 minutes with the General Practice Education and Training Ltd portfolio agency. So they are the officers that will be required.

Ms Halton—I promised I would remind Senator Boyce she wanted to ask about the PIP software.

Senator CORMANN—Before I get into where the superclinics are at, Senators Eric Abetz and Guy Barnett, senators for Tasmania, have asked me to see whether I can get an update from you in terms of the GP Assist (Tasmania) program.

Ms Morris—Yes.

Senator CORMANN—Where are things at? Senators Abetz and Barnett were here earlier but they had to leave.

Ms Morris—GP Assist (Tasmania) has a funding agreement with the Commonwealth. It covers the period 1 July 2008 to 30 June 2010. Funding for 2008-09 was $3.2 million, GST inclusive. The funding for 2009-10 is yet to be finalised. The issue at stake here was the funding of the nurse triage component of GP Assist. It is the Commonwealth's policy that it will not pay twice over for nurse triage and Tasmania has joined the National Health Call Centre Network. The network service commenced in Tasmania in May 2009. GP Assist maintained that excising the nurse triage component from the service was not straightforward as it is an integral part of the service. With GP Assist's agreement and the National Health Call Centre Network's agreement we commissioned an independent consultant to talk to GP Assist and to NHCCN and report to us. We have received that report but we have not yet talked to the company about the outcome, so I am not really willing to say much more than that tonight.

Senator CORMANN—Thank you very much. When do you think you will be in a position to say a bit more?

Ms Morris—It will be within the next couple of weeks. We can take it on notice and inform you of the outcome.

Senator CORMANN—So once you are able to tell us more, then you will?

Ms Morris—Yes.

Senator CORMANN—Thank you very much for that.

Ms Morris—We are very happy to.

Senator CORMANN—That is fantastic. When we talked about the superclinics in February, we did not yet have one that was seeing patients and you thought that June was your target time. How are we looking in terms of the first superclinic to see patients?

Mr Singh—The first superclinic that will be fully operational will be Ballan and we are expecting that to happen from August 2009. However, we have been speaking with a number of the other successful applicants in relation to staging commencement of services and we have obtained a number of agreements. Would you like me to run through what those are?

Senator CORMANN—Yes, please.

Mr Singh—The superclinic at Southern Lake Macquarie will have hydrotherapy and a rehabilitation service established by the end of this year. The Blue Mountains superclinic has recruited an additional GP who is practising from April this year. North Central Coast are developing an interim site near Warnervale, which will be operational from August 2009. That should have two GPs, a practice nurse and some allied health services. The site we expect to be operational first—Ballan in Victoria—have already hired an additional female GP and a practice nurse and their new pap smear clinics have now been fully booked ahead of time for six months. Devonport is expected to commence diabetes, asthma and falls prevention clinics in early July. Bendigo was also to trial their model of care—a fully integrated, team based

arrangement focusing on diabetes—but unfortunately, as a result of the bushfires, they have been unable to access the demountable that would allow them the space to proceed.

Senator CORMANN—Thank you very much for reading that into the record. How many are we talking about where there is a beginning of—

Mr Singh—Two are basically providing services now.

Senator CORMANN—Two of them are providing services now?

Mr Singh—That is right.

Senator CORMANN—When you say, 'Two are providing services now,' you are talking about, for example, the Palmerston clinic in Darwin—

Mr Singh—No—

Senator CORMANN—that is operating as an after-hours clinic, or are you saying that there are two superclinics that are operating as a superclinic per se?

Mr Singh—Two funding applicants are currently providing some additional services as a result of the funding.

Senator CORMANN—But the superclinic per se is not operating yet?

Mr Singh—The full suite of services we expect the superclinic will eventually operate are not yet fully operational.

Senator CORMANN—When is your target deadline for that?

Mr Singh—The first of those will commence from August 2009.

Senator CORMANN—Which is Ballan.

Mr Singh—That is right.

Senator CORMANN—For all of the services that you have read out, are you able to provide us an estimated time frame for when they are expected to be fully operational?

Mr Singh—I can. I do have that information here, but obviously it would take some time to run through in detail.

Senator CORMANN—Maybe just table it, if you have it in a form that is easily—

Ms Morris—Can you table it?

Senator CORMANN—I do not want to put you on the spot. If you have got it in a form that is easily—

Mr Singh—Are there any sites you are particularly interested in? We could run through those now.

Senator CORMANN—Sure. I am. But it might be easier, if you have an update and you have them there, rather than jumping from one to the other—

Ms Halton—Looking over his shoulder, there are other things on that sheet as well.

Senator CORMANN—As I said, I am not trying to put him on the spot. Perhaps then, on notice, you could provide to us the information I have asked for. You have read some information into the record about where things have started. If you could provide us,

essentially, with a status update for each of the 31 sites, where things are at and what is now your target date for them to become fully operational, that would be fantastic.

Ms Morris—We will be able to do it for those sites that have funding agreements.

Senator CORMANN—Yes, sure. Then for the other sites you will say, 'Still pending until we have a funding agreement.'

Ms Morris—Yes.

Senator CORMANN—Understood.

Ms Morris—Thank you.

Senator CORMANN—There is a view that perhaps GP Super Clinics are encouraging some doctors to close smaller suburban practices and move into larger corporate practices. Is that something that has been raised with you or that you have observed as a trend?

Mr Singh—No, it certainly has not been raised with me directly. I have observed that in my history in primary care. It is a trend of long standing. It is part of the move from general practice as a small cottage operation to a larger, more professionally run enterprise.

Senator CORMANN—Yes, but a larger and more professionally run enterprise, as you describe it, also means it is more centralised, whereas the one GP operation, for example, is more likely to be closer to the people that require its services.

Ms Morris—It really depends on the area. You do not get large corporate practices in country towns, for instance. You will probably always have relatively small practices in smaller towns. But, yes, there has been a trend to corporatisation over the last several years.

Senator CORMANN—Who has the ultimate accountability for those multidisciplinary teams that will be working in those superclinics? Who leads them? How is that working in practice?

Mr Singh—We ask each applicant to detail their clinical and organisation or governance arrangements.

Senator CORMANN—So there is no standardised arrangement across all clinics?

Mr Singh—That is correct. It has to fit the local needs and so the service mix will differ, therefore the governance arrangements will differ.

Senator CORMANN—What are the arrangements going to be for the ones that you know are about to become operational?

Mr Singh—Given that we signed 17 funding agreements—

Senator CORMANN—But give me the flavour. Who would it be in the normal course of events and what are the exceptions to cater for local circumstances?

Mr Singh—One model that we certainly have seen is practices that run a number of streams of care—for example, something specifically for diabetes or other forms of chronic disease. Each of those streams would have its own governance arrangements. Often there would be a team that would meet that would involve the GP. If it is the diabetes stream, it might also involve the diabetes educator, a dietitian and a practice nurse, and they would

regularly meet and discuss individual cases. They might also just talk about the sorts of protocols they are using and the types of patient flows that they are seeing.

Senator CORMANN—So it is not necessarily the doctor or the GP that coordinates the different health professions that are operating in the clinic?

Ms Morris—It really varies by application. Some of them, for instance, are joint applications with tertiary institutions, so you have senior health teaching professionals from the university involved in the clinical governance because there is a very strong focus on training health professionals in the multidisciplinary team there. It varies by application; it really does. But there has to be a clinical governance.

Senator CORMANN—Quite sincerely, there has to be a certain level of standard and quality assurance.

Ms Morris—Yes.

Senator CORMANN—You are satisfied that, with the way it is developing, that is going to be maintained?

Mr Singh—Yes.

Senator CORMANN—Even in the absence of a doctor being the one—

Mr Singh—I would say it would be very rare. In fact, I personally have not seen any example where there is not a doctor involved in the clinical governance.

Senator CORMANN—That is why I was asking the question. I guess the question is: who is ultimately responsible? Who is coordinating it? I will just move through these questions quickly in the interests of time. What does the government intend to do, or what does the department intend to do, if no tenders are received to construct and operate certain clinics? You have mentioned that you have had applications for some—17?

Mr Singh—We have signed 17 funding agreements.

Senator CORMANN—You have signed 17 agreements?

Mr Singh—Yes.

Ms Morris—Some of them have been direct funding agreements, yes.

Senator CORMANN—How many of them have you had applications for?

Ms Morris—The ITAs?

Senator CORMANN—Out of the remaining ones that you have not signed?

Mr Singh—We have basically 29 processes that are being or have been conducted.

Senator CORMANN—So there are two of them where there is no process at present?

Mr Singh—In fact, three, because while there are 31 GP superclinics, one is across two sites and there was a process undertaken for each site.

Senator CORMANN—Okay, so—

Senator SIEWERT—How many of them are seeing patients?

Mr Singh—Effectively, there are two. Two are starting to provide services to patients that were not previously available.

Senator CORMANN—Let me just go back. We have got 31, which essentially is 32 because one is over two sites. For 17 you have got signed agreements.

Mr Singh—That is right. Two are currently open.

Senator CORMANN—But that is part of the 17, presumably?

Mr Singh—No.

Senator CORMANN—Two are open and 17 are needing some funding agreements, so that is 19.

Mr Singh—That is right.

Ms Morris—Two is a subset of the 17, I think.

Mr Singh—No. Can I read you the actual—

Ms Morris—I am confusing him now, too.

Senator CORMANN—Yes.

Mr Singh—We have signed 17. There are 11 competitive ITAs—invitations to apply—in process.

Senator CORMANN—Sorry, but of the 17 that you have signed, presumably you have signed a funding agreement for those that have started?

Ms Morris—Yes.

Senator CORMANN—So the two have got to be part of the 17?

Mr Singh—That is right, yes.

Senator CORMANN—That was my question.

Mr Singh—Sorry. What I meant was that two ITAs are currently open for superclinics, so we are waiting for people to apply.

Senator CORMANN—Yes, which means that nobody has applied yet.

Mr Singh—That is right. The applications will close on 30 June.

Senator CORMANN—Are you expecting applications?

Mr Singh—We have not yet had any funding round which failed to attract applicants.

Senator CORMANN—So you are confident that you will, at the end of the day, have applications for all of your sites?

Ms Morris—Yes. Of the 17 that have funding agreements signed, five of them were direct funding processes, but the other 12 were all invitations to apply. So we have had 12 processes where we have called for applications and we got applications of a standard that could be funded.

Senator CORMANN—Okay. So have you put a process in place to monitor what effect the GP superclinics are having on relieving stress on nearby hospital emergency departments?

Ms Morris—There will be an evaluation of the GP Super Clinics Program and we will be working together with state and territory governments on that.

Senator CORMANN—And it is too premature to ask when that will happen and how that will happen?

Ms Morris—It is, but it has always been considered to be a very important part of the process, and we will be working with our state and territory colleagues on it.

Senator CORMANN—Thank you very much for that. I am going to close on some questions on behalf of Luke Simpkins, the federal member for Cowan. Can you update me specifically on the progress of the superclinic in Wanneroo?

Mr Singh—The funding assessment has not yet been completed.

Senator CORMANN—Is it true that many of the expressions of interest were not actually located in Wanneroo?

Mr Singh—I am not sure we are able to talk about—

Ms Morris—You cannot.

Senator CORMANN—Are you saying that is commercial-in-confidence?

Ms Morris—Yes.

Senator CORMANN—Let me just place on record that concern has been expressed that the people that want to come into the area are not actually from Wanneroo and that they will be competing with people that are providing services in the Wanneroo catchment area. I make my point and I hear that you cannot tell me anymore.

Ms Morris—Thanks, Senator. We have heard it.

Senator CORMANN—What is your commitment in terms of the location of the superclinic? Is that something that you are still assessing on the basis of a number of funding applications or are you looking at a specific location?

Ms Morris—There were very few announcements that were location specific. They were usually: a suburb or region 'will be getting a superclinic'.

Senator CORMANN—Yes, but Wanneroo is a pretty big suburb, so—

Ms Morris—So there is no commitment to any one place within Wanneroo.

Senator CORMANN—When you make a decision on the location, will you take into account what other services are already available or will you leave it to the funding applicant to decide where they want to go, whatever effect that is going to have on other providers in the area?

Mr Singh—We do look at each application individually. We ask each applicant to assess the local need, explain their view of the local needs and how their physical location will assist in meeting that need.

Senator CORMANN—So if somebody were recommending a location that was inappropriate because there are already adequate services available, then you would ask them to reconsider or reframe the application. Is that the sort of interaction there is?

Mr Singh—We would pursue the application which most strongly meets all of the criteria.

Senator CORMANN—Thank you very much. That was very interesting.

Senator BOYCE—Just following on from that point, I am told that the location for the successful tenderer for the Townsville superclinic will be within a five-kay radius of 90 practising general practitioners.

Mr Singh—I do not have those details available to me. We have had some feedback from other GPs in the area.

Senator BOYCE—But you do not know how many GPs there are within a certain radius of—

Mr Singh—I cannot confirm whether or not it is a figure of 90 within five kilometres. The point I would make, though, is that to the best of my knowledge Townsville is not a place that is over-doctored and there may well be good reasons to locate practices near each other, near population clusters, public transport—

Ms Morris—And other services.

Mr Singh—and other services that refer to and from the clinics.

Senator BOYCE—I am also told that within a one- to two-kay radius of the new superclinic in Townsville there are at least two other clinics offering the same or similar services to those that the GP superclinic will be offering.

Mr Singh—I could not speculate on the exact mix of services for all the other practices.

Senator BOYCE—So you do not look at what is available in an area before you approve a superclinic?

Mr Singh—We provide people with a certain amount of information in the ITA process on the needs of the local community.

Senator BOYCE—You have assessed the unmet need of the area. Is that what you are saying?

Mr Singh—Yes, that is right.

Ms Morris—All the areas were announced as part of the election. Where a clinic is located is up to the provider, but—

Senator BOYCE—The government?

Ms Morris—No, whoever puts in to run a clinic and is successful has had to, as part of their application, address what other services are around and how they will address the community need.

Senator BOYCE—Do you check the information they give you?

Ms Morris—We always have somebody from either our state office or, if it is a joint funding process, from the relevant state government on the committee with us. But the focus on the clinics is looking at the local community's need and targeting unmet need and they make their application against that case.

Mr Singh—Could I also add that one of the objectives of the program, explicitly, is for the superclinics to enhance and complement local services.

Senator BOYCE—Did you receive complaints, correspondence, letters, from the local Townsville community about where they wanted the superclinic to go?

Mr Singh—I certainly have not seen anything of that nature.

Senator BOYCE—The department didn't receive anything? You go through a consultation process, don't you?

Ms Morris—Yes.

Senator BOYCE—Did anyone who came to the consultation in Townsville tell you where they thought the superclinic should go?

Ms Morris—I cannot comment on that. I have been to quite a few of the consultations. I did not go to Townsville and Mr Singh was not in Townsville either.

Senator BOYCE—Could you perhaps find that information and provide it to me.

Mr Singh—A summary of the consultation sessions is now available on the web for just about all sites, including Townsville. It is not uncommon for people to proffer opinions about their preferred locations.

Senator BOYCE—Except, from what I am being told, that local wishes were ignored in the Townsville situation. Have you had complaints from local GPs about the location of the superclinic in Townsville?

Mr Singh—We have had communication from two GPs.

Senator BOYCE—When you say 'communication', were they positive or were they unhappy about the location?

Mr Singh—I think it is fair to say that they would have preferred that it be located elsewhere. If I may, I am not entirely sure one was a GP, but it was certainly the practice manager.

Senator BOYCE—But they were people representing GP practices in Townsville.

Mr Singh—Two individuals representing medical practices.

Senator BOYCE—Does anyone else have questions in this area?

CHAIR—I have not been advised by anyone except you and Senator Cormann. Senator Adams?

Senator ADAMS—Just one on the Midland superclinic. Do you have any information on that?

Mr Singh—Again, the assessment process is not yet complete. I do expect that it will be completed shortly, though.

Senator CORMANN—Perhaps you could give us an update on all of them and where they are all at.

Ms Morris—Yes.

Mr Singh—Yes, we will take that on notice.

Senator BOYCE—Would that include time lines as to when they would be operational?

Ms Morris—That is what you were asking for.

Senator CORMANN—I think we are done.

CHAIR—Nothing else? There are no more questions on that area of primary care, so now we will call General Practice Education and Training Ltd.

Ms Halton—What about the PIP software?

Senator BOYCE—I am sorry, am I supposed to ask about the PIP software now?

Ms Halton—Now.

Senator BOYCE—Thank you, Ms Halton.

CHAIR—The agency can still come forward while we are getting the PIP software question out of the way.

Senator BOYCE—Please tell me about PIP software, Ms Morris.

Ms Morris—From memory, Senator, you were asking about medical software providers.

Senator BOYCE—Yes.

Ms Morris—I was assuming that your questions were prompted by the new PIP eHealth Incentive.

Senator BOYCE—No, I was not, but go on. Explain it to me.

Ms Morris—My colleague Mr Andreatta will give you a bit more information about the PIP eHealth Incentive and the negotiations with industry and where it is up to.

Mr Andreatta—The issue that Ms Morris raised is to do with the new PIP eHealth Incentive that is—

Senator BOYCE—PIP being?

Mr Andreatta—The Practice Incentives Program for general practice. There is a new incentive starting in August this year, which was a budget measure of last year. There are three criteria for practices to meet eligibility for that incentive.

Senator BOYCE—I beg your pardon. I was speaking about PIP; I just did not know it as 'PIP'.

Mr Andreatta—The issue relates to one of those requirements, and that is that practices have a secure messaging capability. We published information on the new guidelines in March, and issues were raised by the software industry about that particular requirement. There was some misunderstanding or confusion about what the department was asking for, given that the standards for secure messaging have not been completed as yet by NETA. We had discussions with both the medical software industry and NETA around this requirement and clarified the requirement, and the software industry is now comfortable with the wording that we provided them. Basically, instead of requiring practices to have secure messaging capability, we are now asking practices to confirm that their software vendor has agreed to participate in the development and implementation of the standard when it is finalised.

Senator BOYCE—When there is a standard to be complied with.

Mr Andreatta—Exactly. To date 4,000 practices have signed up for that incentive, so the software vendors have indicated that they are willing to participate in that process.

Senator BOYCE—Would they be ones currently using the Medical Director system?

Mr Andreatta—I suspect that would be one of them. There are many software vendors in the medical environment.

Senator BOYCE—Would you be able to tell me, say by state, where those practices are?

Mr Andreatta—The practices that have signed up?

Senator BOYCE—Yes.

Mr Andreatta—I could take it on notice.

Senator BOYCE—Yes, I am suggesting you should take it on notice. I am interested in whether there are any trends in early adopting.

Mr Andreatta—There are around 4,700 practices registered for PIP, and 4,000 have already signed up, so it is the majority of them.

Senator BOYCE—So 80 per cent or so.

Mr Andreatta—Yes.

Ms Morris—I think the indications are that there is now no problem with practices signing up for it, based on those figures.

Mr Andreatta—Correct.

Ms Morris—As I said, there had been some disquiet, and we basically sat down in a room with the people who were unhappy and with NETA and sorted it out. It is a bit old-fashioned, but it still works.

Senator BOYCE—It strikes me as extraordinarily effective and efficient, Ms Morris. I will not make any comments about aged care.

Ms Morris—They would go over my head in any case.

Senator BOYCE—Thank you.

CHAIR—Thank you very much. Now we will go to General Practice Education and Training Ltd.

[10.13 pm]

Primary Care

CHAIR—Good evening. I know we have questions from Senator Boyce, since she asked for your agency. Senator Boyce?

Senator BOYCE—Congratulations! You had 675 funded places this year and filled 675 places. Is that correct?

Mr Janssen—Yes, that is the case. We have filled all of the available entry place positions.

Senator BOYCE—You have a small increase for 2009-10 but then quite a big percentage increase going to 2010-11 and straight forward. When you are getting to those levels, is there an increasing degree of difficulty in filling those places?

Mr Janssen—With the growth in medical graduate numbers coming through the system, it is our expectation that we will be able to fill those positions. Those positions and the growth in positions is mapped against the growth in the cohort of available—

Senator BOYCE—So it is a stable percentage. Is that what you are telling me?

Mr Janssen—In terms of the percentage of?

Senator BOYCE—Of graduates.

Mr Janssen—No, the graduate pool is growing.

Ms Halton—The number of places is not a function of the number of graduates coming through, but the number of places was increased in recognition that there is an increased cohort coming through, and we were very concerned to ensure that we captured a number of them into general practice.

Senator BOYCE—Yes. One of your key focuses is putting the training supports where they are needed. Could you talk me through where you are at with that—what difficulties you have experienced and what else needs to happen?

Mr Janssen—We have an annual allocation process for training places that identifies locations of workforce shortage. We also have a particular emphasis around Indigenous health, and we have set ourselves targets around increasing the participation of registrars in Indigenous health training posts and working in Indigenous-controlled medical services. We will also look at the capacity to take registrars and meet the requirements that are part of our contractual arrangements with the department as to the terms that registrars need to undertake in outer metropolitan areas and in rural areas as part of the training process. All of that is factored into the allocation process. With the growth in applicant numbers for the program, we are able, we believe, to meet all of those obligations and continue to distribute our training places based on those sorts of criteria.

Senator BOYCE—I was hoping you might tell me about areas where you had had workforce shortages where you believe that is no longer the case.

Mr Janssen—For us that is difficult to answer. There are shortages, I think, in most areas. There is a need for additional—

Senator BOYCE—When you say 'rural' et cetera, you are not talking urban?

Mr Janssen—There are urban areas of workforce shortage. In outer metropolitan areas particularly there is a program.

Senator BOYCE—Sorry, yes.

Mr Janssen—To that extent, with the available training places and the applicants and ultimately registrars that come into the program, we seek to make the distribution meet comparative workforce requirements as best we can. We do have the overwhelming majority of registrars in the program, not just entry places, providing services in either rural-remote areas or areas identified as districts of workforce shortage or medical service need.

Senator BOYCE—Are you able to give me, on notice, a geographical location of where your trainees are?

Mr Janssen—Yes. We can do that through either the training provider or the geographical classification of the remoteness of the area.

Senator BOYCE—That would be useful. I have lost the figures for it here but, as you mentioned before, you have actually set yourself targets for the Indigenous health training aspect of your work. You are looking at an increase from six per cent next year to 12 per cent in the 2013 training year. Is that correct?

Mr Janssen—That is correct.

Senator BOYCE—Again, could I have a list of where those trainees are located, where the training places are located, or whatever is a useful way to describe those?

Mr Janssen—We can provide distribution of where current, active Indigenous health training posts are located. Going forward, our intention is to grow capacity in that area and in the range of locations where registrars are working. We certainly can give you a distribution of current, active training posts.

Senator BOYCE—Getting back to the degree of difficulty in sourcing people to do the Indigenous health training, how many actual individuals are we talking about there? How many registrars are training in the Indigenous health area?

Mr Janssen—We would have to take that on notice and provide that with the information in relation to distribution.

Senator BOYCE—Thank you. I know that there was a very significant jump recently in the number of Indigenous GPs in percentage terms but it was still quite a small number, less than 100. I think it was in 2003-04 or 2004-05, something like that. Are there sufficient graduates to fill your training courses in the Indigenous training area?

Mr Janssen—We are actively putting in place arrangements to support registrars in these Indigenous training posts. Through those sorts of measures, we would expect to be able to attract greater numbers to work, particularly in the Aboriginal medical services. All registrars are obliged to undertake an amount of Indigenous health training, but the particular posts I think we are talking about are where they do a term of training in a community controlled medical service that provides services specifically targeted to Indigenous people. That is an area where we have grown in numbers. The numbers are still small compared to the total registrar pool, but it is our intention to grow that over coming years.

Senator BOYCE—When you say all graduates are required to do training in Aboriginal medical service provision, are you saying within your course or across the board?

Mr Janssen—In the training program, the curriculum of the college requires exposure to and training in Indigenous health for all registrars coming through the program.

Senator BOYCE—What does that involve?

Mr Janssen—A range of workshops and exposure to cultural training around delivery of Indigenous health through to training around the particular health issues and needs of

Indigenous communities. It covers to some extent the skill sets that registrars—the GPs—will be required to have in order to adequately provide services to Indigenous people.

Senator BOYCE—How many Indigenous people are there in your scheme at the moment?

Mr Coote—In the 2009 entry cohort, 10 Indigenous or Torres Strait Islander doctors joined the training program. That number has been relatively static since the inception of the Australian General Practice Training Program.

Senator BOYCE—That is out of 675, is it?

Mr Coote—That is correct.

Senator BOYCE—When you had smaller numbers initially, you had about 10 as well? Is that right?

Mr Coote—During 2004 there were six applicants and that number has increased up to 10 in 2009 for Indigenous doctors.

Senator BOYCE—It is a start, I suppose. They are all the questions I have in that particular area, Chair.

CHAIR—Thank you very much. That is the end of outcome 5. Now we will move to rural health. I know that Senator Adams and Senator Xenophon have questions. Have you worked out how you are going to do it?

Senator ADAMS—Yes, I will let Senator Xenophon go first.

CHAIR—He is going to kick off? Okay, Senator Xenophon. I know you are here just because you enjoy being in this committee!

Senator XENOPHON—That is true; it is a great committee!

CHAIR—I welcome the officers from the Office of Rural Health and I do apologise that you got the last area, but someone has to do it. We appreciate your patience. Senator Xenophon.

Senator XENOPHON—Thank you, Chair. If I could ask the department about the RRMA system—

Ms Halton—Colloquially known as 'Rama'.

Senator XENOPHON—'Rama', sorry.

Ms Halton—And it often has the word 'drama' appended to it!

Senator XENOPHON—Thank you, Ms Halton. I am still learning. I am still a relative neophyte in these things.

Ms Halton—We are just giving you colour and movement.

Senator XENOPHON—It is a bit too much excitement, I think, for this time of the night.

Ms Halton—I know. At least it keeps us awake.

Senator XENOPHON—I have been contacted by constituents in Gawler in relation to the proposed changes to the classification of Gawler. There is a significant concern that that change in classification will mean a substantial diminution in health services in that area and

community and for the communities that they service. Dr Anthony Page, who is one of the doctors in GP Inc. at Gawler, says that, in April, the federal Department of Health and Ageing was in town saying that the model used in Gawler should be adopted in other regions. But, he says, only weeks later the same department pulled the rug out from under their feet. Firstly, can you comment on the changes that are proposed. Secondly, is it the case that the department as recently as April was saying that this was a very good model in terms of provision of healthcare services, and what assessment has been undertaken as to the potential impact of this change on the residents of Gawler and surrounding areas?

Ms Bennett—I will start, and then I will get my colleague David Dennis to add some detail. Yes, Gawler is one of two areas that will theoretically be impacted by the move from the RRMA classification system to ASGCRA

Senator XENOPHON—What is the other area?

CHAIR—Would that be the Sunshine Coast?

Ms Bennett—The Sunshine Coast.

Senator XENOPHON—When you say 'theoretically', does that mean that these changes will not necessarily occur?

Ms Bennett—That means that no individual practitioner will lose money under the changes.

Ms Halton—Because they are already there.

Ms Bennett—That is right. So if there is a practitioner in Gawler currently receiving an entitlement, they will not lose any money under these changes. Anyone in receipt of money under the programs in the area at the moment will have their entitlements grandfathered—

Ms Halton—Parented.

Ms Bennett—Grandparented for three years.

Senator XENOPHON—But after the three years, that is it?

Ms Bennett—Then another decision by government will be made at some point. But, for the forward period, there will be grandparenting so people do not lose entitlements. There is no pulling the rug out from under individuals' feet.

Senator XENOPHON—There is a transition period for three years—that is what you are saying?

Ms Bennett—I am saying people will retain their current entitlement for three years, and then government will determine the—

Senator XENOPHON—In terms of a decision being made, one of the arguments put by people in Gawler and the practice in the local community is that Gawler services a much wider area. It is a bit of a hub and spoke, in the sense that it services the Barossa Valley. For anyone in the Barossa to get a similar sort of facility, they would need to go into Adelaide, which could be between 45 minutes to an hour away—or even more, depending on traffic. Further north there is Clare, which would be at least an hour away. Is that something that is

taken into account before a decision like this is made? Could there be a reconsideration of the decision, given the circumstances of Gawler and that it is a bit of a hub for other areas?

Ms Bennett—To take the last part of your question first, I would say it is extremely unlikely that there will be a reconsideration of any individual area. The overall impact of the changes to the classification system is that over 500 additional communities in Australia will become eligible for entitlements and over 2,400 individual practitioners will gain entitlement to incentives that they have never had before. So the overall impact across Australia of this change is a significant benefit for rural communities and doctors working in rural and remote areas.

Senator XENOPHON—It will not be better for the Gawler community and the surrounding areas though, will it?

Ms Bennett—I would suggest that it actually will not be worse, but I will ask David to take you through the individual entitlements, because I think there is a misconception in Gawler as to what individual programs people will lose access to. A particular area of concern is around access to overseas trained doctors into the area, and that access will not change as a result of these measures changing because Gawler will remain a district of workforce shortage. But I will get David to take you through the particular programs.

Senator XENOPHON—But you can understand why there is quite significant concern in the Gawler community and surrounding areas?

Ms Bennett—There is significant concern from a small individual practice, is my information.

Senator XENOPHON—May I suggest that it goes much wider than that.

Ms Bennett—Could be.

Mr Dennis—I am actually attending the North Adelaide division of general practice, and the principals of the practice that you mentioned, on the 17th to hear firsthand their concerns. I have spoken already to the principals of the organisation that you refer to and thought I had at the time allayed some of their fears through the information that was given.

Senator XENOPHON—How recently was that?

Mr Dennis—I spoke to the principal in the order of a week ago, and I know that many of my departmental colleagues have done likewise—that is, spoken to the principal of that organisation and others who have shared those concerns—and it seems that there is a period of appeasement and then we have these concerns rebuilding. They are quick to point out that it has taken some considerable time and effort to have the geographical classification under RRMA—it did take some time to have that changed—and what this represents is a reversion to that urban status that was initially under RRMA, and now the township of Gawler is again considered to be urban, albeit under a new geographical classification system by virtue of its size and its proximity to large urban centres such as Elizabeth, Salisbury and surrounds, which I have no doubt you are familiar with.

I guess, in summary, we are talking about a very small number of practitioners. Specifically, we are talking about three registrars who are presently in situ in placements in Gawler, who will be grandparented throughout their registrar training period so that they will

suffer no financial detriment whatever. In relation to the HECS Reimbursement Scheme, there are no present recipients of the HECS Reimbursement Scheme in Gawler. Nonetheless, under the changes, Gawler will no longer be an eligible area for individuals to participate in the HECS Reimbursement Scheme. The other program of interest is the Rural Retention Program. No individuals will be affected there. There are two programs where Gawler will be affected primarily. One is the Rural and Remote General Practice Program, and that is where rural workforce agencies assist in the recruitment and retention of doctors, primarily overseas trained doctors, in what are deemed rural areas.

Previously, upon Gawler having its geographic classification overturned and being deemed rural, practices in that area were entitled to receive assistance from those agencies in the attraction and retention of, primarily, overseas trained doctors. Under the new system, practices will no longer have that entitlement. The second program which will change, in terms of the eligibility of doctors in the township, is the Training for Rural and Remote Procedural GPs Program and, as Ms Bennett has outlined, all present recipients will continue to receive a financial benefit for their participation in the program.

Senator XENOPHON—For the next three years.

Mr Dennis—For that three years, and then a subsequent decision will be made about their status. Again, a relatively small number of doctors are involved. As has been said before—and it has been highlighted by the organisation that is primary among this movement—they were extremely concerned that they would lose the entitlement to employ overseas trained doctors. I have spoken with the principal, as I said, and have explained in full the process that is undertaken to determine eligibility and have assured her that Gawler and surrounds are currently eligible, by virtue of the fact that it is deemed a district of workforce shortage and, for the foreseeable future, is likely to remain eligible for that. That determination is made completely separately from the geographical classification system, be it RRMA or be it ASGCRA. It is entirely separate from that. At the time, those assurances were understood, but I understand that this concern continues to emerge. That is the reason why I will attend upon them personally on the 17th.

Senator XENOPHON—17 June?

Mr Dennis—That is correct—just to attempt to assuage any further concerns that they may have about their loss of status.

Senator XENOPHON—So the important thing is that you are still consulting and you will listen to their concerns, and also to the wider community in terms of their concerns about this?

Mr Dennis—Yes, and I know for a fact, because my officers have been involved, that there has been ongoing dialogue from the outset and we have endeavoured to provide as much information as possible. I think that has allayed a lot of concerns, if not all, and we will continue that ongoing dialogue to make sure that everybody fully understands the situation.

Senator XENOPHON—You can see the point of those that have raised the concerns when they ask what harm would there be to maintain the status quo on a longer term, given the benefits to the community in terms of health care. I acknowledge what the government is doing in other remote areas, and that is a very good thing, but you can understand that they

are about to lose something which, I think, on any reasonable basis will mean a diminution in the number of medicos in that particular area.

Mr Dennis—I appreciate the concern. I do not know that I necessarily agree that it will reduce dramatically, if at all, the number of medical practitioners. Time will tell and we are in a position to monitor that and we will do that on an ongoing basis. The important thing to remember is that the department has not imposed a particular geographical status on the township of Gawler. It has been done by first RRMA, but that has been endorsed by an independently endorsed geographical classification system that is maintained and developed by the ABS, the Australian Bureau of Statistics. It is not something that has been in any way manufactured by the department. It has simply been adopted because it is considered to be the best instrument available for this purpose and this is the information that it has yielded.

Senator XENOPHON—Thank you. Good luck on the 17th and let's hope that it can be resolved to the satisfaction of all concerned.

CHAIR—Senator Adams.

Senator ADAMS—Thank you very much. Ms Halton, may I raise that acronym?

Ms Halton—Yes, go for it.

Senator ADAMS—As I missed the February estimates, I would just like to get a bit of an update anyway. Has the Australian Health Ministers Advisory Council reported back on PATS as yet?

Ms Bennett—No, it has not. A task force was established, as recommended by the Australian Health Ministers Advisory Council of state, territory and Commonwealth representatives. That task force met in July and August 2008 but I am advised that it has not met since then.

Senator ADAMS—Are you aware of any reason why it has not or where it is going? That is it? It has just met twice and that is the end?

Ms Bennett—They had a number of discussions about their role and terms of reference and how to make progress. They had those discussions twice and have not met again. I do not think that means they will not meet again, but they have not.

Ms Halton—I think there was a timing issue here. They were working in the first instance in the run-in to that COAG meeting. That issue was not then going to be considered in that COAG meeting, so whilst all the other COAG work was going on it was quite fast and furious and it was put into abeyance. As you know, we are not chairing that.

Senator ADAMS—No.

Ms Halton—One of the state jurisdictions is chairing that.

Senator ADAMS—Yes.

Ms Halton—There will have to be a follow-up conversation with that jurisdiction.

Senator ADAMS—That is still the Northern Territory?

Ms Halton—Yes, that is correct.

Senator ADAMS—When will the health policy priorities principal committee on the PATS task force finalise its report on the Senate committee's report?

Ms Bennett—That is the task force that I think I just referred to.

Senator ADAMS—It is the same one?

Ms Bennett—It is the same one, yes. The health priorities is a subcommittee of AHMAC.

Senator ADAMS—This is our report and recommendations from that—that will all be bundled into the same one?

Ms Bennett—Yes.

Senator ADAMS—Right. Are there any plans in relation to making PATS more uniform across Australia? I guess we will have to wait until they report. The next question I have is about development after Healthy Horizons. I note here that you were looking at developing a national strategic planning approach, starting 2009, 2010. Could you explain the process that you are going to go through to do that, please.

Ms Bennett—Yes, I can. That was one of the recommendations that has come out of the review of the Commonwealth rural targeted programs that I spoke about last time. It has been agreed by AHMAC—and in the recent budget confirmed as an area of importance to the Commonwealth—that we play a leading role in the development of a replacement to Healthy Horizons. We have the first planning meeting with the states and territories on the development of that successor in Hobart on 23 or 24 of this month, off the top of my head. We will be doing a session with the jurisdictions and we will be involving the National Rural Health Alliance in that planning session. As you would be aware, they played a lead role with the jurisdictions in the development of Healthy Horizons and are a key player to involve in the subsequent national strategic framework. That planning work kicks off in a couple of weeks.

Senator ADAMS—Thank you. I am very pleased to hear that the alliance is being included, because they are a very valuable resource. Now I would like to go to the Medical Specialist Outreach Assistance program, noting that in 2009-10 the program is going to be expanded:

... to introduce multidisciplinary teams to better manage complex and chronic diseases for Indigenous Australians living in rural and remote communities, and improve access to antenatal and postnatal services for women in rural and remote communities.

How are we going to get the workforce to expand this program? Are you going to use extra people? Where are they going to come from?

Ms Bennett—We have, you would be aware, for the mainstream—if I could call it that—MSOAP, the program that has been in place for a number of years.

Senator ADAMS—Yes, I know all that.

Ms Bennett—We have a planning process and advisory committees in each jurisdiction and they work up a service plan that considers things such as available workforce both generally within the jurisdiction but occasionally coming in from outside. So the first step in both those new expansion areas, the Indigenous multidisciplinary service teams and the

maternity services, would be to work under a similar process of initially doing some service planning with the auspice bodies. We may, and probably will, look to make sure that the advisory bodies for those new parts of the measures are supplemented as necessary with particular groups with the skills relevant to those two expansions. But, essentially, we will undergo a similar initial planning process, and an essential part of that is to identify capacity within the workforce to provide the services.

I would have to say that, while MSOAP itself was, in the beginning, quite slow to get started and to get sufficient workforce interested, these days it is a highly popular, well-regarded and fully subscribed program. So, while we have a number of workforce shortages and issues around the country in terms of on-the-ground delivery, we are reasonably confident that we will be able to get the workforce to deliver these measures. We have certainly heard in the past from the allied health sector and from the more multidisciplinary aspects that workers have always been keen to participate in a MSOAP type model. But up until now it has been, as you know, essentially for medical specialists. Both parts of the expansion have a slow build-up phase in year one. So, again, that will give us time to work on that.

Senator ADAMS—Thank you. I think that is a very good initiative. I am just going down the programs that are in the outcome with the Royal Flying Doctor Service program. You are still funding them, according to the budget, but are they being given any extra duties to perform as they move forward? When I look at what the Royal Flying Doctor Service used to do and its role now, I can see that it has certainly expanded. Are there any further roles that are coming into the program?

Ms Appleyard—In addition to the core funding provided to the Royal Flying Doctor Service through the Office of Rural Health, the Royal Flying Doctor Service are popular with other areas of the department to deliver, under their auspices, programs such as mental health initiatives and other workforce initiatives, and they continue to be active tenderers for those programs. As far as a funding agreement goes, it is fair to say that there is a steady growth in the services that the RFDS are delivering on behalf of the Commonwealth. In addition, they are certainly putting their hands up to deliver a number of additional services from elsewhere in the department.

Senator ADAMS—Good. That makes it even better for rural and remote people. I note that the Multi-purpose Centre Program goes until 30 June 2010. What happens then? Is that going to be evaluated again and continue, or where is it at?

Ms Bennett—The Multi-purpose Centre Program is one of four that will be rolled together into a new rural primary health program. Again, as part of the outcome of the review of rural health services, we are streamlining a number of programs into one new, focused program.

Senator ADAMS—Which programs, Ms Bennett?

Ms Bennett—Regional Health Services, More Allied Health Services, multipurpose centres and the specific health promotion program we had, Building Healthy Communities. They will be rolled into one new, consolidated program. There will be no diminution of funding overall in the bucket. It is essentially streamlining some of the arrangements. For example, at the moment we have a number of divisions of general practice who are funded to deliver some services via MAHS and some with Regional Health Services to do quite a

similar task. So we will be streamlining the reporting and the contractual arrangements in this measure.

A number of the contracts for currently funded services in the multipurpose centre project expire at the end of this year and others a year later. So we will extend some to go through to 2010 so that they have all got the same kind of end date. That will give us time to work with those services to make sure that we bring them into that new program. Our objective is to move them somewhat beyond the original intent, which has been in place now for close to 20 years. That was originally around just providing some sort of coordination function. It is our view that over that time that is not the priority and that it is better to help direct that money towards actual service provision for communities. That will be our objective over the next 12 months.

Senator ADAMS—What are you going to call this program that has got the four involved? Has it got a name yet?

Ms Bennett—It has got a name. I think I mispronounced it—and Sharon will remember it.

Ms Appleyard—It is called the Rural Primary Health Services Program.

Senator ADAMS—That is good. We have got rid of the Regional Health Services, so now we will have the rural one. We have to keep up with these names! Is the Rural Women's GP Service still being provided by the Flying Doctor Service?

Ms Bennett—Yes.

Senator ADAMS—Is that expanding? Are they going to more sites?

Ms Bennett—Not in this budget. There is no additional change to it in this particular budget.

Senator ADAMS—Has the number of actual participants, the number of women being seen, within the program increased?

Ms Bennett—I would have to check the figures, if we have them. If not, we would happily provide you with them.

Ms Appleyard—As you know, what happens with that program is that, to be eligible for a female GP service, there must not be a female GP in the community. What happens sometimes is that if a resident female GP moves into a community the service may be able to be redirected to a community where there is not a service. So you have got communities coming online and offline with this service. Basically, the number of services is broadly maintained at the same levels and there is a limited amount of growth built into the program as well.

As far as operational sites go, we should be able to give you some information about that. As at 6 May 2009 there are 169 operational clinics and 108 non-operational clinics. They are the ones I told you about that would have been previously approved for a female general practice outreach service but there is now a resident female GP in that community.

Senator ADAMS—It is very pleasing to hear that we have got 108 female GPs who have relocated to the bush. I have just about run out of questions, would you believe? It is getting

late. I am very pleased to see that rural health is up there, but, Ms Halton, if you could jog along the PATS, that would be very nice.

Ms Halton—Yes, okay.

Senator ADAMS—WA has become the leader in the Patient Assisted Travel Scheme. I think the other states could catch up.

Senator BOYCE—Could I put one question in there, perhaps on notice. Did we end up with a full list of the communities that are affected by RRMA changes or not?

Ms Halton—Yes, we did.

Senator BOYCE—Thank you.

Ms Halton—For the interest of the committee, I have had a text from Richard Eccles, who is at the awards night for annual reports, and this one is the only Commonwealth agency to get a gold award.

CHAIR—Congratulations, Ms Halton.

Ms Halton—Richard's team, who did that, are a terrific group of people. They do the PBS as well and they do a great job on the annual report, so it is nice that they have received that award.

CHAIR—Congratulations to the department. Thank you, Ms Halton, and thanks as always to all your officers for their attendance and their professionalism over the last two days. Thank you, Parliamentary Secretary. Thank you, Hansard and the secretariat. Our committee now stands adjourned until tomorrow when we do the cross-portfolio Indigenous issues.

Committee adjourned at 10.54 pm